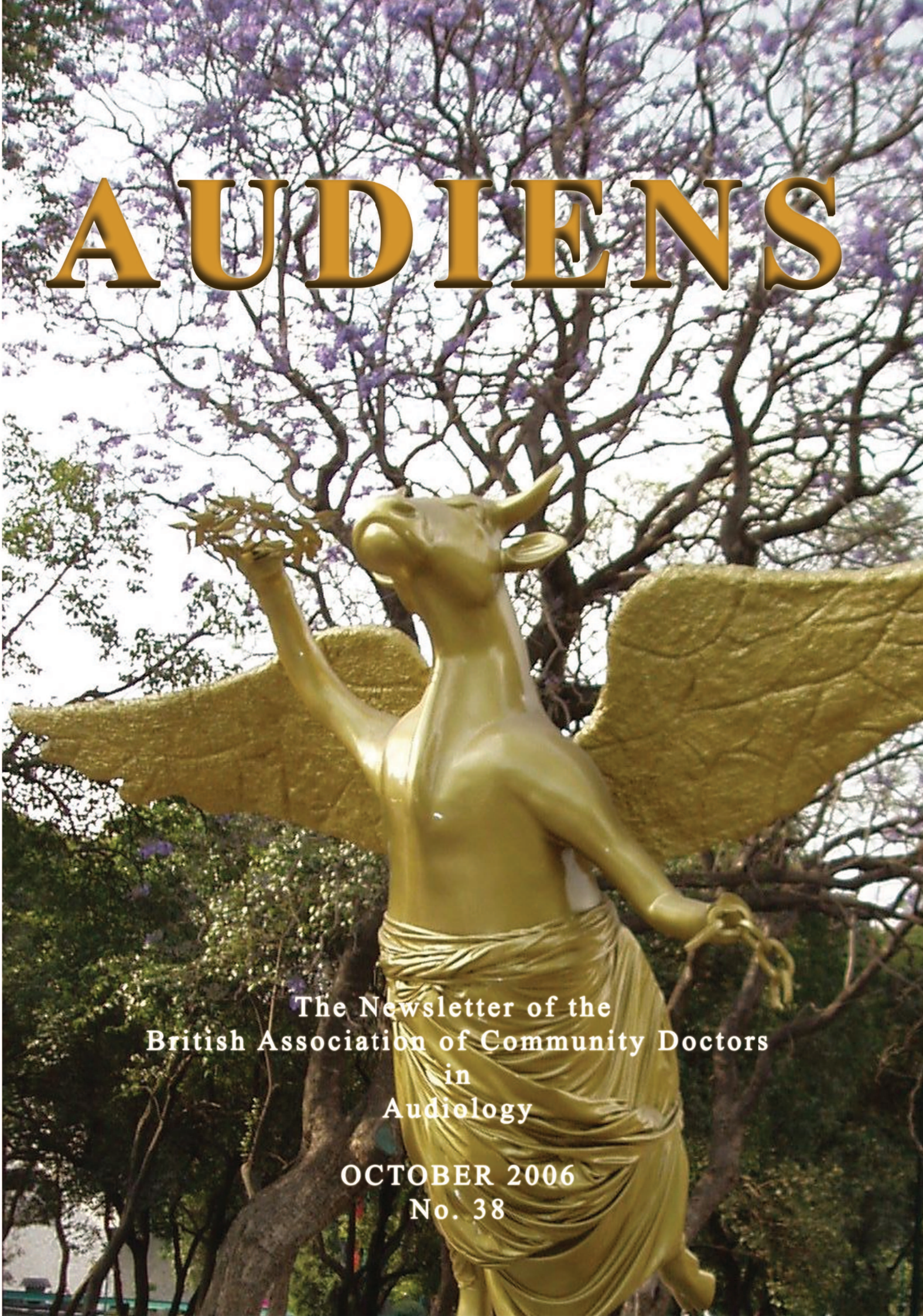

AUDIENS

The Newsletter of the
British Association of Community Doctors
in
Audiology

OCTOBER 2006
No. 38

GN Resound advert

AUDIENS

The Newsletter of the British Association of Community Doctors in Audiology

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Cover Photo: Outside the Anthropological Museum, Mexico City © Jane Lyons 2006

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Editorial

BACDA is changing! The ballot for the name change has been counted, and Susan Rose has announced the result in her chairman's report. I won't steal her thunder by telling you here, but read it in the report. Along with the name change the constitution needs amending, and the draft is also published in Audiens for members' comments. The changes will be finalised at the AGM in January.

For those not able to get for the meeting in York it was very interesting day. Elaine Giles' presentation on Fast Forward as a treatment for auditory processing disorders was very interesting and appears promising. I personally was less impressed by the Listening Programme as it seemed too all encompassing, and I could not understand how listening to filtered music can produce all the benefits claimed. The powerpoint presentations are available on the website so that members can judge for themselves (www.bacda.org.uk). Deirdre Lucas had an accident on the motorway. Fortunately she was not hurt and miraculously only late for the study day, so she presented in the afternoon, instead of the morning. The other speakers, very kindly changed their schedules to allow time for Deirdre to arrive. Despite the difficulties the day went very smoothly and was most informative.

Susan mentions the website in her chairman's report. Currently I am looking at how to update it. I have a few ideas, but would welcome members' views and suggestions. In line with the name change and new constitution we have new BACDA prize rules. These are much more flexible and allow for a wider variety of submissions. We expect that this will appeal to members and we look forward to more entrants.

Enjoy reading Audiens, and I invite members to contribute short articles you think might be of interest, e.g. local audits, service changes, interesting cases, etc., or something you find amusing.

Jane Lyons

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If your contact details have changed, please let BACDA know by sending your details to Pam Williams

Reports from the BACDA Study Day

Chairman's Report

I am writing this on yet another hot summer's day and it is strange to think that by the time you are reading it we will all, no doubt, be complaining about wind, rain and leaves on the track!!

My BACDA time and energy seems over the past few months to have been devoted largely to internal organisational issues and I am indebted to the members of the Committee and Pam Williams for their support and wise counsel. I am delighted that the Development Group continues to forge ahead with Research/Audit and Training issues.

A New Name for BACDA

I am pleased to announce the outcome of the Name Change Consultation Ballot, conducted by the Electoral Reform Society. A single transferable voting system was used and fifty eight per cent of ballot papers were returned. The name elected was the British Association of Paediatricians in Audiology (BAPA).

You will remember that the two contentious issues in deciding on a change were the inclusion or not of "vestibular" and of "community" in the title. I consider that BAPA is the reasonable compromise and has the added advantage that the acronym trips very neatly off the tongue! As Wanda Neary and Tim Williamson (who proposed this name) said in their submission "not such a difficult change after all!"

The name change proposal will be taken along with the draft Constitution to the Annual General Meeting on 02/02/2007 for ratification. And so we still have a few months left as BACDA – enjoy!

Membership List

It has come to light as a result of conducting both the Census and the Name Change Ballot that there were inaccuracies in our membership list. We, that is the Office Bearers and Mrs. Williams have been working hard to address this issue and to devise a more robust system for updating the list. The hope eventually is to keep the list updated on a secure area of the website but it will take time to redesign the website to allow for this. I should add that I did consult with the Electoral Reform Society and it was concluded that the outcome of the vote was unlikely to have been affected by these inaccuracies.

The Census and Workforce Issues

Thank you to all of you who returned your Census form. I wish to acknowledge Ann Mackinnon's truly heroic efforts in processing this data much of which she has been conducting in the wee small' hours! It has already produced much-needed information to inform work-force planning. The report is not yet finalised (an accurate membership list is necessary for this). However the preliminary data was presented at the Workforce Review meeting which Ann attended with Eva Raglan on 8th March.

The BAPA Constitution

The Committee, with the help of Dr. Gill Painter, to whom we are much indebted, have been updating the Constitution. The draft is published in this edition of Audiens, and I or any of the Committee members would be pleased to receive your comments by 1st December 2006.

The BAPA Prize

In view of the lack of submissions for the Annual Prize in recent years we have updated the rules (see separate article).

So next year please consider nominating all those unsung heroes – your colleagues or yourself – and make sure someone receives those tokens!!

The Audiovestibular Federation

The Federation between BACDA and BAAP is now well into its second year and continues to thrive (see separate Federation Report). We have reciprocal representation on each others Executive Committees as well as a biannual meeting of the Officers of each Organisation. I am finding the regular opportunity for dialogue and the shared training events to be invaluable and would like to thank Susan Snashall and Deirdre Lucas for all their support. The BAAP Conference held in Southampton in April was excellent (congratulations to Wanda Neary for this) and I would encourage all of you to consider applying for next year's Conference.

The BACDA Study Days

Northern

For those of you who managed to attend the York Study Day on 30th June, I am sure you will agree it was a most interesting day. Jeannette Nicholls, one of our Committee Members gave a very useful overview of Hyperacusis and Deirdre Lucas gave stimulating presentations on Non-organic Hearing Loss and on Tinnitus (the latter with Rosie

Kentish Consultant Clinical Psychologist).

Than Lwin is stepping down as the Northern Meetings Secretary and on behalf of BACDA, I would like to thank him for organising so many excellent programmes over the years.

London Study Day 2007

Bernie Borgstein has been working extremely hard to put together a varied and exciting Programme on the theme of "One Ear or Two".

NB DATE – 02/02/2007 (put it in your diary now)

And that's about it! I am sure many of you will feel like me that working for the NHS can be both a confusing and at times frustrating business. How can one keep up with all the organisational changes and new directives – and understand their implications for our services? However I was speaking last week to the mother of a two month old baby who has recently been diagnosed through the NHSP as having a bilateral severe hearing loss. She said how impressed she was that all the services work so well together. It is feedback like this that clarifies what is important in terms of the priority list.

Susan Rose

20 years old, 20 years on
Feedback from the BACDA Study Day 27th January 2006

Morning session - Chair: Dr. Keith Stewart

9.30 Registration and coffee

9.55 Introduction and Housekeeping

10.00 Looking Back

Dr. Hope Forsyth, Consultant Community Paediatrician (Audiology), Royal Liverpool Children's Hospital

10.40 Does he / she have the Vestibular Dysfunction? Clinical Assessment of Balance in Children

Dr. Ewa Raglan, Consultant Audiological Physician,

St. George's Hospital & Great Ormond Street Hospital, London

11.25 Coffee and exhibition

11.55 Cardiology and Deafness

Dr. Janice Till, Consultant Electrophysiologist, Royal Brompton Hospital, London

12.40 OM8—30: a new short form assessment instrument for OME and its clinical applications

Professor Mark Haggard, MRC-ESS, Children's Middle Ear Disease

Addenbrooke's Hospital, Cambridge

13.00-13.45 LUNCH and exhibition

13.45-14.45 BACDA AGM

Afternoon session - Chair: Dr. Wanda Neary

14.45 Congenital CMV and hearing loss

Dr. Mike Sharland, Consultant in Paediatric Infectious Disease

Dr. Simone Walter, SpR in Audiological Medicine, St. George's Hospital, London

15.40 Plans, Projects, Protocols

The BACDA Development Group

Dr. Lesley Batchelor, Consultant in Paediatric Audiology, Macclesfield

Dr. Sarita Fonseca, Consultant Community Paediatrician (Audiology), London

Dr. Gill Painter, Consultant Community Paediatrician - Audiology, Manchester

16.10 And here's to the next 20 years

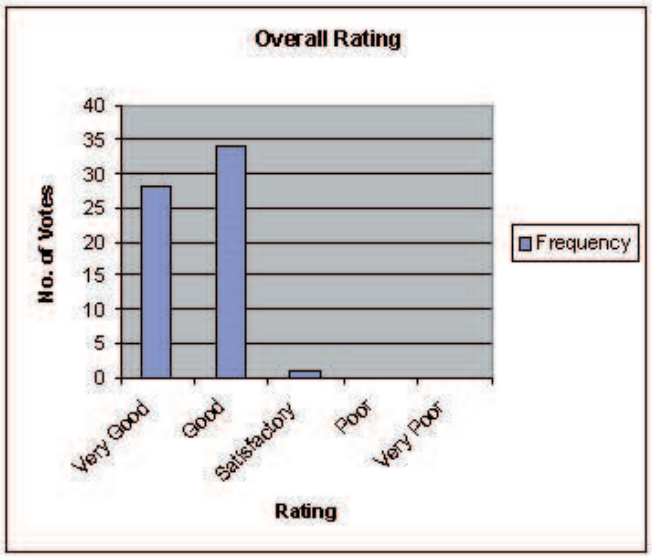
Dr. Ann MacKinnon, Chair of BACDA, Associate Specialist (Paediatric Audiology) NHS Tayside

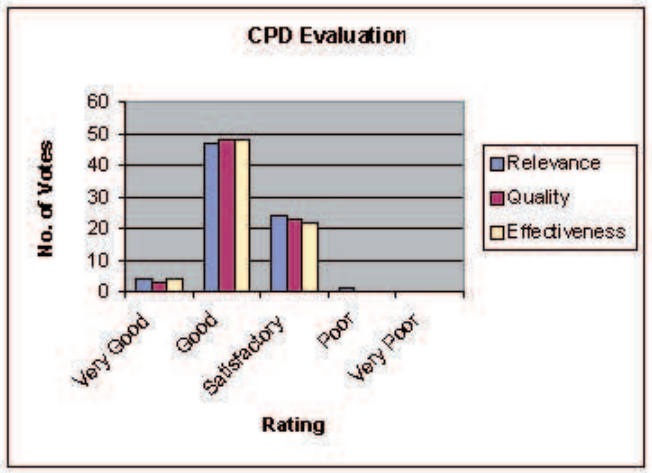
16.30 Close of Meeting

BACDA celebrated its 20th birthday at its annual London Study Day at the Brunei Gallery on 27th January 2006. The first ever Chairman, Chris Hallett, kicked off the proceedings with a speech and dissection of the BACDA cake.

There were over 130 delegates and 88 evaluation forms were returned.

Below is a summary of these forms.





The figures in the 2 graphs do not add up to 88 because not all sections of the evaluation forms were completed by everyone.

General comments from the forms

- Lovely celebratory atmosphere, excellent content, venue ideal – excellent lunch again
- Good day, good stimulus for future reading
- Would be good to have Email IDs of all speakers on the programme
- Another fantastic meeting, thank you very much to Bernie & all the speakers, coasters are lovely
- A good study day. Thank you very much.
- I thoroughly enjoyed the course. There is a lot to learn.
- Well run, good venue, interesting speakers, relevant topics
- Brilliant conference, interesting topics – a fresh change from themed conferences
- Excellent meeting. All talks relevant & stimulating especially the cardiology & CMV
- It was good that key speakers were not first on programme - inevitably people were again caught by train problems – well done. This has been a full & valuable course. Could you consider making slides available on website after conference if speakers agree. This is effective practice by other groups. And it is a good way to reinforce today's valuable learning to help improve our practice.
- Could there be some seating for lunch please
- I am retiring next week!
- Superbly organised event. Thoroughly enjoyed the day
- Superb meeting
- This has been an excellent day – lots of new thoughts & approaches & a dynamism & enthusiasm from speakers & participants. Excellent timing!
- Would be so good to be able to sit down for lunch…
- Well done for 20 years. Happy future
- I had informed that I do not eat eggs fish & I am a vegetarian. Every year I do not get any hot food. Can I suggest some food such as vegetarian curry or pizza etc.
- Food good
- Should have had coffee after lunch & fresh fruit at lunch
- Another excellent day. A pity the group has struggled to be accepted by the mainstream – see Prof. Craft's comments on PMETB
- A very useful day. It would be nice to actually have printouts of the actual powerpoint presentations as sometimes its difficult to remember/write down all figures and websites which are useful to have in black and white
- As an SHO interested in working in Audiology in future I am happy that I have attended this session, met people and now know something more to make a career decision.

Suggestions for future courses from the form

- Because of the concern from some members about balance, balance workshops as per VRA
- Down's syndrome & hearing loss – how to manage
- Relevance of TOAEs in diagnosis/screening in hearing loss
- Testing children with special needs

- It would be helpful for all speakers to give handouts in advance – would be easier to follow talks.
- Short papers by BACDA members, well recd. last year & it'd be good to blow our own trumpets again next year
- Balance of the child – a physiotherapist's view, an occupational therapist's view. Immunological/ autoimmune investigations for hearing loss – when & what
- More in depth re vestibular testing at level not relying on expensive equipment. Neurology update. Cochlear microphonics. ?Any update on management of CAPD. The eye & audiology
- Could have whole session on audiovestibular – screen, diagnosis, management
- More of same
- Adventitious hearing loss investigation & management. Diseases of adults causing HL – or do we find them in children?
- 2 people asked for 1) Repeat of basic sciences 2) VRA
- Auditory processing disorders
- Seating for lunch please
- I did not get any dessert either. There were 3 types of cakes but not even one fresh fruit. Perhaps next year I will be allowed not to pay for lunch only for the course please. I have pointed this out most years. I am sure there are other doctors who do not eat eggs or fish and are vegetarians
- Not to have courses in York – it's too far
- You do pretty well! Revisit non tertiary centre vestibular. Chemistry of inner ear? Breaking news. Family "therapy"
- Some courses for vestibular training for BACDA members
- Auditory neuropathy – diagnosis, discussion with parents, management
- ?anything new on hyperacusis?

Overall the feedback was very positive. The comments above have not been edited except where there was duplication.

Suggestions taken on board include:

Speakers email IDs on programme.

We shall attempt to do this for future meetings

Slides on the BACDA website.

The presentations by Dr. Mike Sharland and Dr. Simone Walters should be on the BACDA website soon if they are not already on by the time you read this. Our thanks to them. Permission is being sought from the other speakers for inclusion of their presentations. In future all speakers will be informed in advance that their talks will be put on the website unless they object. We are however dependent on the speakers providing us with their presentations both for the website and for including in packs as handouts.

Lunch.

Although seating for lunch may not be possible at the Brunei Gallery, this request will be borne in mind if alternative venues are used. Apologies for the lack of fruit and coffee after lunch. This had been ordered. The comments about special diets will also be borne in mind for future meetings.

Regarding suggested topics for future meetings the recurring theme was vestibular training. BACDA's Training and Development Group is actively exploring this.

Thank you to all who attended and helped make this meeting such a success. We look forward to seeing you at the 2007 meeting which is titled "One Ear or Two". We have some exciting speakers lined up.

PLEASE NOTE THAT THE 2007 MEETING IS TO BE HELD ON 2nd FEBRUARY

This is due to unavailability of the Brunei Gallery being booked on the 26th January.

The Secretary
BACDA
4 Cromwell Grove
London W6 7RG
29 January 2006

Dear Secretary

I would be grateful if you would express my gratitude and thanks to your committee for inviting me to the BACDA meeting last Friday and for asking me to cut the 20th. Anniversary cake. I enjoyed the occasion enormously - especially meeting some old friends and acquaintances such as Kathleen Mazey, Jane Lyons, Doreen Roberts and many others.

Despite being a stranger to the field for many years now, memories came flooding back and I was most impressed by the progress BACDA had made, the credibility now established, and the universal recognition accorded by all the other Specialty groups that matter.

Please may I take this opportunity to wish you all well and every success in the future.

Yours Sincerely

Dr. Christopher Hallett
MB., ChB.,
Dip.Aud.,DPH.,FFPH
Consultant in Public
Health (Retd.)

Audiovestibular Medical Federation
The Federation of the British Association of Audiological Physicians and The British Association of Community Doctors in Audiology

One year on 2005-2006

BACDA
Chair: Susan Rose
Vice Chair: Adrian Dighe
Past Chair: Ann Mackinnon

BAAP
Chair: Susan Snashall
Vice Chair: Deirdre Lucas
Past Chair: Valerie Newton

The first year

On 16th February 2005 a Strategy day was held by BACDA (British Association of Community Doctors in Audiology) and BAAP (British Association of Audiological Physicians). The full memberships of both organisations were invited to brainstorm the way forward and a decision was taken to form a Federation. The constitution of the Federation was presented to both Associations and formally accepted on 14th April 2005. The officers of the Audiovestibular Medical Federation (AMF) meet biannually, and two officers of each constituent Association attend the business meetings of the sister Association. Both Associations will send representatives to NCPA. The British Society of Audiology provides the ideal setting for dialogue and shared interests with other disciplines.

Aims of AMF

- 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

Achievements so far

- Communication between Chairs of BAA, BACDA and BAAP being developed
- Workforce representatives of BACDA and BAAP attended Workforce Review of Children's Services together in March 2006
- National Medical Audit for Audiovestibular Medicine now undertaken jointly
- BACDA and BAAP working closely together to discuss training and competency issues with RCPCH and RCP
- BAAP Clinical Standards Group has members from both Associations
- BACDA study days and BAAP annual conference (April) attended by membership of both Associations
- Contributions to RCP working party on care pathways in Audiovestibular Medicine made by members of both Associations
- Integrated/joint responses to Department of Health, NICE and other documents or issues.
- Representation of each others views at multidisciplinary meetings
- BAAP acts as nominee for ACCEA awards for both Associations

Work in progress/planned

Outcome measures remain to be developed and agreed with BAA and RCP

S. Snashall 8.3.06

Study of Unilateral Sensorineural Hearing Impairment (SUSHI)

For those who attended the annual BACDA meeting in January this is an update on the SUSHI (Study of Unilateral Sensorineural Hearing Impairment) project. We hope those who weren't at the meeting will consider participating in the study after reading this slightly modified, non-technical study protocol. Given the likely lack of databases we expect there will be roughly one to five cases per service of children aged 10-15 years with unilateral hearing loss.

A small group in BACDA has been working hard to design approximately 20 standardised forms, information leaflets and instruction sheets to make the process easier for local investigators. We have had positive feedback from NHS Research NW and a statistician who feel it is a good solid project.

There are a few remaining practical issues to be tackled including seeking external funding.

NON-TECHNICAL STUDY PROTOCOL

Aim of the study

To understand the value of carrying out magnetic resonance imaging (MRI), genetic tests for connexin 26 and 30 mutations and test for congenital Cytomegalo virus (CMV) infection when investigating the cause of permanent hearing loss in one ear (Unilateral Sensorineural Hearing Loss (USNHL)) in children aged 10 to 15 years.

Why?

Discussions with parents and professionals have shown that after confirmation of USNHL parents and young adults would like answers to the following questions:

- What is the cause?
- Is it likely to get worse and will the other ear become affected?
- What is the nature of risk in future pregnancies and is it likely to be passed on?
- How should this child/young adult be managed with regard to hearing strategies?
- How should this child/young adult be managed medically?

Why now?

An increasing number of babies with born with USNHL will be identified in the newborn period as a result of the recently implemented, national newborn hearing screening programme. At the time of diagnosis parents want to know the cause of their child's hearing loss but they also want to know more about the range of tests that can be done to search for the cause, the benefits and negative aspects of each test, the likelihood that a test will identify the cause and whether knowing the cause will make a difference to how their child is managed.

In the past Computerised Tomography (CT) scanning was used to look at the structure of the hearing apparatus only at the discretion of clinicians mainly because CT scanning carries a small but definite risk of radiation. Magnetic Resonance Imaging (MRI), which has no risk of radiation, is now widely available but there is no information available to guide clinicians about its usefulness in the management of USHNL.

A new test has been developed which uses the blood spot on the Guthrie card. This test could enable us to know the proportion of children whose UNSHL is the result of congenital CMV infection.

Finally, testing for a genetic defect that causes just hearing loss has also become more readily available recently.

All these tests are carried out routinely for children with nerve deafness in both ears and parents appreciate a search for the cause.

How does knowing the cause help?

Knowing the cause of USNHL will help guide some aspects of ongoing medical and audiological management of the child for example, in some conditions the hearing loss may get progressively worse and some may benefit from treatment.

How has this study been set up?

A group of doctors from BACDA agreed to take this study forward. Review of the literature and extensive consultation with experts in the field confirmed that results from this study would add useful information to what is known and help with clinical management of individual cases. Study details were presented at the audit meeting of British Association of Audiological Physicians who were enthusiastic in their support and agreed to participate where possible. Statistical advice has been sought. The study protocol has been peer evaluated and will be submitted for ethical approval when funding is secured.

How long will the study take?

Recruitment to the study will take place for one calendar year from expression of interest by local investigators. It is anticipated that data collection and analyses should be complete in 2 years from the start of the study.

How will the study be conducted?

What will be done before consent to participate is obtained?

Doctors working in Paediatric Audiology will be invited to contribute to the study by letter. If they express an interest, using a tear off slip, they will be sent a detailed information pack about the study including a sample letter for local R & D approval, and detailed guidelines for local investigators. On opting to become a local investigator each clinician will be assigned a code by the data manager (Gill Painter).

Local investigators will need to identify children with USNHL in their caseload and make a note of if/when each child is due a routine follow up appointment. Many

departments do not hold databases going back 15 years, and they may need to identify potential children (subjects) through colleagues in Education. Local investigators in services not routinely providing an annual medical review for these children will send information about the study to parents of potential participants.

They will be sent an appointment, (allowing extra time to discuss the study if possible), if they agree to participate. The child's GP will be notified, using a standardised letter, about the study and that the child has been invited to participate at least a week before the child's appointment date. Local investigators working in systems in which patients need to confirm that they will attend, may wish to give the child a 'double slot' to allow for time for explanations, obtaining consent and completing requests for investigations as these clinics tend to have low non-attendance rates and it may be difficult to accommodate any additional discussions.

Local investigators in services that routinely assess these children will send information to parents and GPs at least one week before the child's routine review.

Local investigators will be advised to allow 20 to 30 minutes of additional time for the consultation where possible for explanations, obtaining informed consent and a brief examination. Before the child's appointment, the local investigator will obtain and adapt a study pack for each potential subject. Individual medical records will be checked and the consent form adapted by crossing out investigations that have already been carried out.

What will happen when the potential participant attends?

When the child attends, the local investigator will discuss each aspect of the study giving leaflets to back up what they have explained. They will ask the child and parent if they wish to participate in the study and obtain signed consent.

If consent for the MRI part of the study is obtained, investigators will complete a request form in accordance with local protocol.

Likewise, if consent is obtained for genetic tests, investigators will complete locally used forms and paperwork.

If consent is obtained for the CMV part of the study

- The participant will be given an information sheet about blood tests
- A request form for the blood test will be completed and given to parent.
- Signed consent will be obtained for release of the Guthrie card should this become necessary following the blood test result.

A detailed medical and audiological assessment will be carried out and results will be recorded on a standardised data collection form. This process may take approximately 10 minutes longer than a routine review.

What will the participant have to do after the appointment?

Participants will need to drop into the department where blood tests are carried out. They should present the forms for CMV and connexin 26/30 (if consent obtained). Results of the blood tests will be sent to the investigator who will contact the family as appropriate when results arrive.

The MRI scan will usually be arranged on a separate occasion by appointment. If the result shows anything new, the local investigator will discuss this with the child and family. If the result is negative (no new findings) the investigator may decide to discuss this at the next routine appointment if that date is imminent.

All results will be discussed with participants and parents eventually and a written summary of the discussion will be sent to the child's GP.

What will the local investigator need to do following the appointment?

The local investigator will construct, and make a note of, a unique identifier for each participant, enter it on a data collection sheet and make a copy of the data collection sheet for the child's medical file. The original data collection sheet will be sent to the data manager who will send the local investigator another coded data collection sheet for results of investigations. This way the researchers cannot identify an individual child but local investigators will have access to the child's identity.

Local investigators/clinicians will inform GPs, through their standard clinic letters, if subjects consent to participate in the study. When results of investigations are received, they will be recorded on the appropriate data collection form.

If the blood test for CMV indicates a possibility of congenital CMV infection, the local investigator will complete a letter requesting the release of the Guthrie card and send it together with parental consent for releasing the card to the relevant laboratory where these cards are stored.

If any of these investigations yield results indicating that further investigation is required, the local investigator will contact parents to discuss what will happen next.

When all results have been received the completed data collection sheet will be sent to the data manager. If results are not received by the data manager nine months after a participant code has been assigned the data manager will send out one reminder to the local investigator. Local investigators will discuss all results with study participants and parents and send a written summary with a copy to the GP in accordance with standard clinical practice.

How will final results be disseminated?

When the results are analysed, presentations will be made at professional meetings and conferences and results will be submitted for publication to peer reviewed journals. Funding bodies and parents who wish to know the final outcomes of the study will be sent a summary of findings on request.

Sarita Fonseca, Lesley Batchelor, Sebastian Hendricks, Ann MacKinnon, Wanda Neary

The BAPA Prize and Honorary Life Membership

It seems, sadly, that the pressures of work and perhaps the reducing numbers of paediatricians completing MSc theses have resulted in a dearth of submissions for the BACDA prize in recent years. Therefore the Committee decided it was timely to review the rules of the Award with the intention of implementing the changes in 2007/8.

Whilst we would still wish to encourage the submission of articles we consider it appropriate to widen the categories for which the Prize can be awarded to include other forms of contribution to the field of Audiovestibular Medicine.

The BAPA Prize Rules.

1. The award is named the BAPA Annual Prize

2. Any BAPA member (Full, Associate or Retired) will be eligible for the award apart from members of the Panel (see below)

3. The award will be given for work that promotes the aims of BAPA, which are:
   (a) The promotion of standards in both training and professional qualifications of paediatricians working in audiovestibular medicine and to contribute to the training of other professionals working in related disciplines.
   (b) The promotion of multidisciplinary working for the benefit of children and their families.
   (c) The promotion of multidisciplinary working by maintaining and developing links with other professional bodies.
   (d) The holding of meetings, lectures and discussions in various regions and the publication at regular intervals of a newsletter for members.
4. This work can be in the form of:
   (a) a report or publication
   (b) a presentation to an educational or audit meeting
   (c) an outstanding contribution to service development and/or multi-disciplinary working.

5. Candidates can themselves apply for the Prize by submitting a report or presentation. Alternatively candidates can be proposed by any full member of BAPA by submission of a citation.

6. The Awards Panel will comprise three assessors, two of whom are BAPA Committee members and one non-BAPA member of standing in the field of Audiovestibular Medicine. The Panel will be nominated annually by the Committee at the Spring Meeting.

7. Submissions should be sent to the Secretariat or Chairman by 30th September each year for consideration by the Panel. If the Panel agrees to make an award this will be presented at the next BAPA Annual General Meeting. If the recipient is unable to attend, the award will be presented in absentia.

8. The award will be in the form of tokens of the recipient's choosing. The value of the award is currently £200.

Honorary Life Membership of BAPA

Whilst updating the Constitution the Committee also thought it appropriate to provide some guidance on the award of Honorary Life Membership. We propose in the new Constitution that "The Executive Committee may, at its own discretion, award Honorary Life Membership to a full member who has made an outstanding contribution to the work of the Association."

Guidance

1. Honorary Life Membership will, usually, only be considered for full members of BACDA/BAPA around the time of their retirement

2. The award will be given for a member's outstanding contribution to the Association, usually over some years, but any notable achievement on behalf of the Organisation will be considered.

3. Nominations can be made by any full member of BAPA by submission of a citation to the Chairman or Honorary Secretary.

4. Awards will be announced at the following BAPA Annual General Meeting.

I or any Committee Member would appreciate your comments about these awards by 1st December 2006. Any changes will then be tabled at the Annual General meeting on 2nd February 2007.

Susan Rose

BACDA Development Group report

Membership L Batchelor (Co-chair, Training)
A Mackinnon
S Fonseca (Co-chair - Research)
M Varghese
G Painter
D Umapathy
J Lyons (co-opted for IT)
W Neary
S Hendricks (co-opted for research)
E Harpur

Research
The SUSHI project is progressing. Some members of the group met in May and Sarita (SF) and Lesley (LB) met in early July to work on the Guidelines and all the standard letters/forms which will be needed to ensure smooth communication between clinicians, patients and the research team throughout the project. Some of these are already in 4th draft, so the process is a lengthy one. Most of the work is done by email. This all needs to be completed before the application can be sent to the Central Office for Research and Ethics Committees (COREC).

The group have a full day meeting on Sept. 13th and will meet with Dr. Mike Sharland, consultant microbiologist at St. George's to discuss how the CMV part of the study will work.

SF has spoken to the statistician at St. George's. He is happy with our estimates for the number of cases of unilateral hearing loss needed (about 80). He has offered to do the statistical analysis within existing research monies. The group need to work on accurate costings before submitting a bid to such organisations as 'Defeating Deafness'. It was never the intention of the Development Group to ask BACDA to fund the project.

MRCPCH Mastercourse
LB has been approached by the organiser of this RCPCH backed distance learning course for the MRCPCH. He is a bona-fide paediatrician working hard in the NHS. Its not a private initiative. He would like us to provide some powerpoint presentations suitable for F2s (and paediatricians worldwide) doing MRCPCH. If anyone has any material or ideas for themes which they think are a 'must' or any nice powerpoint slides, they would be much appreciated as the work needs to be done by the end of November. LB has some material from Medical student and 'SHO/Middle grade' presentations, but I'm sure between us we could do better.

Vestibular study day
No further forward as the group has not met. However will take the execs previous ideas on board. No place for role play in this though.

Date of next meeting
Thurs November 30th. Dr. Karen Whiting, consultant in neurodisability in Sunderland has been invited to discuss her 'Virtual Visit' document.

Lesley Batchelor Aug. 21st 2006

Change of address or other changes?

If any of your details have changed, please let BACDA know by completing the form and sending it to Pam Williams, 23 Stokesay Road, Sale, Cheshire. M33 6QN

Name _____
Address _____
_____
Post code _____

Preferred Email address _____

Home tel. No. _____

Work Tel. No _____.

Other changes to note _____
_____

News for Future Training in Paediatric Audiological Medicine

Since the euphoria of the mid 1990s when a number of our members became consultants, there has been increasing concern over the future of the speciality as those people approach retirement.

The officers and exec committee have explored many different avenues searching for a route for future paediatricians who wish to specialise in audiology. We have long since realised that we will never go back to the days of the CMO and SCMO although we still have a very able but dwindling workforce of SAS Grades.

The future of medical paediatric audiology in the medium term lies in finding a niche with a recognised sub-speciality of the RCPCH. Due to the tireless efforts of Dr. Sheila Shribman, former Registrar of the college, BACDA was recognised as a Special Interest Group last year. Although there were discussions about whether paediatric audiology could survive as a sub-speciality in its own right, there were a number of reasons why this was not to be.

It has, however been recognised that Higher Specialist Trainees (HST) need to have the option of being able to choose paediatric audiology in their 3rd year of HST and a 28 page Competency framework has been completed to the college's satisfaction. The question has always been – with which sub-speciality would this fit best?

The college is acutely aware of the impending crisis within the paediatric medical workforce, although many trainees in Audiological Medicine are thankfully opting to work solely in paediatrics and one of the entry requirements for the HST in audiological medicine is MRCPCH.

Against this background a meeting took place at the RCPCH on August 9th between Hilary Cass (Registrar of the college), Alison Salt (chair, neurodisability CSAC), Simon Lenton (Vice-President, Health Services) Lesley Batchelor, Sarita Fonseca, Ann Mackinnon.

The aim was to explore ways of ensuring the future of medical paediatric audiology at consultant level, in the context of clinical networks. Ultimately every district needs to have access to someone who can work at this level, even if the main body of assessment and hearing aid provision is undertaken by Band 8 Audiologists.

The possibility of audiology being added on to the neurodisability Higher Specialist training was discussed at some length. All were agreed that this would be feasible as a third year HST 'bolt-on'.

The development group needs to work on some of the documents supplied by the neurodisability CSAC in terms of the Training Pack and Virtual Visit Form. This latter is essential for the college to identify potential sites for training. These of course need to be mapped onto the existing grid of trainee posts for neurodisability. After all, an SpR would have to be really keen to do audiology to think of uprooting home and family for the sake of a 3rd year somewhere else.

The Training Pack shouldn't prove too much of a problem bearing in mind that only a year ago we completed the Competencies for Level 3 HST and these have the approval of the RCPCH even if they don't know quite what to do with them!

So the wheel seems to have come full circle since David Hall's time, and we are back talking to a new set of faces in neurodisability. We have been clear that it will be impossible for a 5th year SpR (3rd year HST) to gain all the skills which we nowadays associate with a consultant in paediatric audiological medicine in just one year. There is also the question about whether the MSc or part of it would be useful. However, it is up to us to be very specific about what is needed in the training and to consider the possibility of working with the RCP in attempting to cross-ladder with the Aud Med trainees. None of this is thought out in any detail – its just put down to give you the picture.

There is clearly a great deal of work here for the development group in developing the Training Pack. Once this has been approved and Training Sites identified, it will be time to try to attract trainees in neurodisability into the speciality.

There is still a long way to go but we now have the support of the RCPCH and a recognised sub-speciality willing to take us on.

Lesley Batchelor

Audiens 1995 - 2005

As part of the 20th anniversary celebrations all the articles from the last ten years of Audiens have been compiled into one CD in pdf format. To obtain your copy send your details to Alan Batchelor, 167 Chester Road, Macclesfield, Cheshire, SK11 8QA. Enclose a cheque (£10 per copy) payable to BACDA

BACDA CENSUS 2005

In Autumn 2005 a census questionnaire was sent to all individuals on the membership list provided by BACDA. Subsequent to the questionnaire being sent out it became apparent that there were some discrepancies between the membership list that had been sent to the census co-ordinator and the actual membership list. Many members who had previously been members and had resigned were sent questionnaires.

Work undertaken by the Treasurer, Chairperson and Secretariat has clarified that at the current time BACDA has 213 members. This compares to 259 members when the previous census was undertaken in 2000, an almost 18% drop in membership numbers. This is a worrying, but not entirely surprising trend given the ageing nature of the workforce that was highlighted by the previous census.

Census forms were distributed in October 2005. Non respondents were sent a further form in December 2005. Regional representatives followed this up and encouraged the completion and return of forms.

By the end of March 2006 174 forms had been returned, 149 from members (70% of the membership) and 25 from non members. 20 forms were received from individuals not currently working in audiology. These were excluded from this analysis. The 154 returns analysed included those from 5 doctors who had retired but were continuing to undertake sessions related to paediatric audiology.

The census form requested information about working practices, teaching commitments, travelling time within work, number of clinical and administrative sessions and continuing professional development.

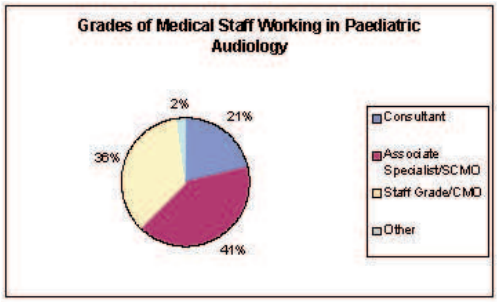
This is a summary of initial analysis of the information. More detailed analysis will be undertaken to consider regional variations and individual grades of doctors.

Grades of Doctors Responding

Consultant 34 (29 members and 5 non-members)
Associate Specialist / SCMO
63 (55 members and 8 non-members)
Staff Grade / CMO
54 (40 members and 15 non-members)
Specialist Registrars
2 (1 member and 1 non-member)
Specialist Paediatrician'
1 (non member)

The consultants mainly described themselves as consultants in paediatrics or community child health (audiology). There were also 3 consultants in audiovestibular medicine (2 members, 1 non-member).

REPLIES - AREAS OF ORIGIN



CCST

27 consultants (79%) stated that they have a CCST. These are reported to be in the following specialties

- Audiological medicine 5
- Paediatric audiology 3
- Community paediatrics 2
- Paediatrics 17

5 Associate Specialists (8%) have a CCST, the specialties being as follows

- Community Paediatrics 1
- Paediatrics 3
- Public Health 1

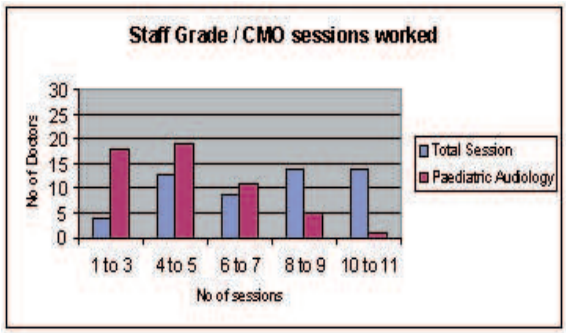
1 of the Specialist Registrars has a CCST in Paediatrics.

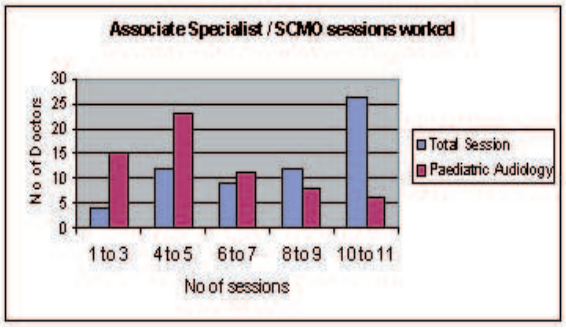
Paediatric Audiology Sessions worked per week

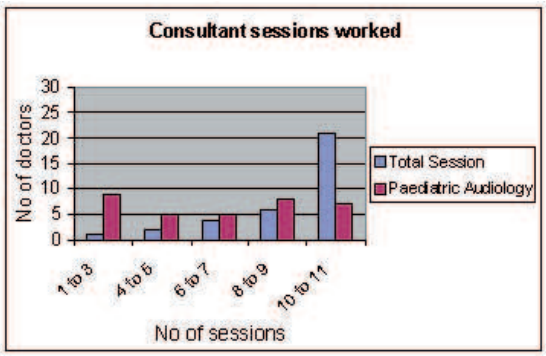
	Number of sessions worked in Paediatric Audiology			
	1 - 3	**4 - 5**	**6 - 7**	**8 or more**
Consultant	**13**	**5**	**11**	**4**
Associate Specialist / SCMO	**22**	**23**	**12**	**6**
Staff Grade / CMO	**36**	**11**	**7**	**1**
Specialist Registrar	**1**		**1**	
Other	**1**			

Sessions Worked

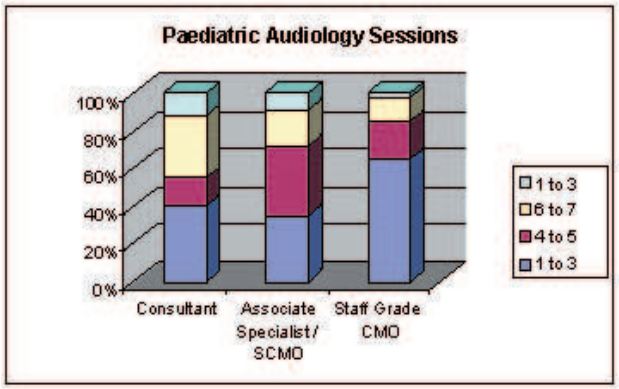
Individuals were asked how many sessions in total they were contracted to work, and how many of these contracted sessions were specific to paediatric audiology. The following 3 tables show the variation across the different grades of staff and compare the sessions contracted with the number of sessions working in paediatric audiology



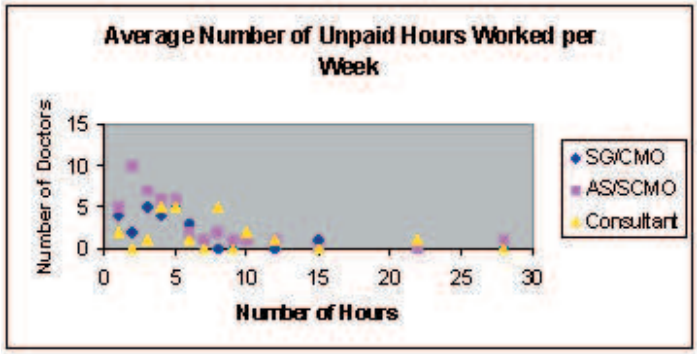




73% of doctors are working 5 sessions or less in paediatric audiology, with 47% working 3 sessions or less. Further interpretation of the census data is required to ascertain if there is any correlation between the number of sessions worked in paediatric audiology and the level of the service being worked in. Are doctors who are only working 1 or 2 sessions a week confining their practice to secondary level services or are they working in tertiary centres? Further questions need to be asked about maintaining level of skills in those doctors working only 1 or 2 sessions a week.



There is variation in the number of sessions worked in paediatric audiology across different grades of doctor. Many doctors of all grades are working extra sessions unpaid in addition to their contacted hours of duty.



Places of work

Doctors work in a variety of settings. Community includes health centres, community clinics, schools and homes.

	Yes	%
Teaching Hospitals	46	30
District General	85	55
Community	142	92

Many doctors work in more than one setting. The majority of doctors do at least some of their work within a community setting.

Outpatient Clinic Sessions

Number of children appointed

87% of eligible respondents stated they were involved in second tier audiology clinics and 42% in third tier clinics. 30 % work in both sections of the service.

There was considerable variation in the number of children appointed to clinic sessions. The minimum number appointed in one clinic session varied from 1 to 14. The maximum number varies from 4 to 22. Not enough detail was requested on the census form to enable further investigation into this huge variability. Presumably very different types of children must be attending the different clinics. A young child with complex needs will obviously require a lot more time than a secondary school child attending for a pure tone audiogram.

Doctors were asked to estimate the average number of children attending paediatric audiology clinics. This varied from 4 to 16, with a mode of 8.

Range of ages of children seen at clinics

	Number of Doctors	% of eligible replies
Under 6 months	80	52
6 months to 3 years old	134	87
3 to 5 years old	141	92
5 to 16 year olds	137	91
Adults	20	13

A small but significant number of doctors are involved in the provision of adult audiology services. It is thought likely that the majority of adults being assessed by paediatricians have a learning disability.

Testing of children's hearing

137 doctors (89%) are directly involved in the testing of children's hearing.

There is a variety of other people involved in testing – other doctors, nurses, educational psychologist, teacher of the deaf, educational audiologists, speech and language therapists, audiologists, audiological scientists and Health Care Assistants.

Other tasks undertaken

	No of doctors involved	%
Hearing Aid Fitting	18	12
Hearing Aid Follow up	41	27
Aetiological Investigations	74	48
Hearing Aid Budget Control	5	3
Staffing Budget Control	11	7

Not surprisingly all 5 doctors with hearing aid budgetary control were consultants. 10 of the 11 in control of the staffing budget were also consultants. The other was an Associate Specialist.

Supporting Professional Activities

Clinical Educators

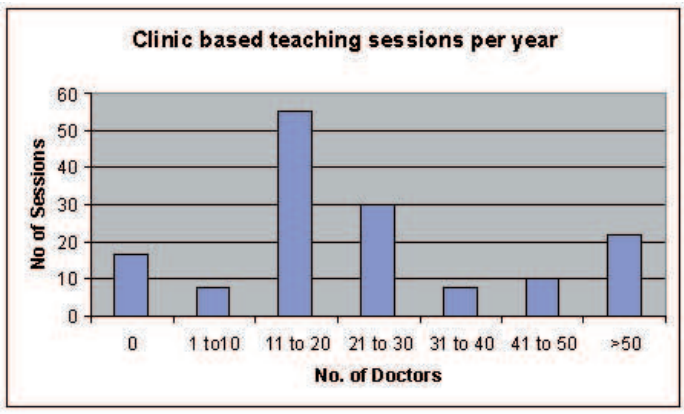
13 doctors are certified clinical educators, with a further 6 in the process of gaining recognition.

Teaching during clinical sessions

	Yes, No. of doctors	%
Medical Students	98	64
Training grade doctors	125	81
Audiologists	56	36
Speech and Language Therapists	26	17
Audiology BSc and MSc Students	43	28
Nurses	104	68
Newborn Hearing Screeners	35	23

General Practitioners, teachers of the deaf, educational audiologists and social services staff also attended clinical teaching sessions.

17 doctors (11%) do no clinic based teaching. The number of sessions others are involved in teaching ranges from 1 to 200 per year.



Non clinic based teaching

Involvement in non clinic based teaching (lecturing, supervision of placements, audit projects and research etc.) varied greatly with almost one third of doctors having no involvement in this area through to three doctors who spent over 100 hours a year on this type of teaching.

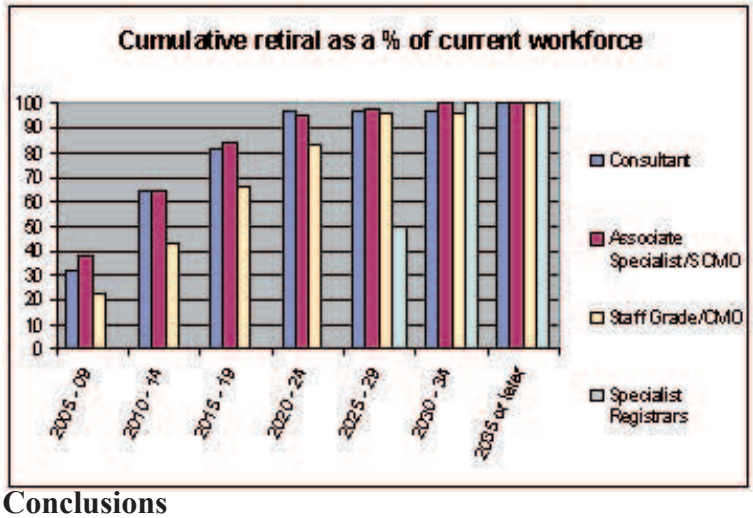
Continuing Professional Development.

125 doctors (81% of respondents) are achieving their 50 CPD points each year.

Projected Year of Retiral

It is already well known that the medical workforce within paediatric audiology is an ageing one. There are not enough doctors entering this area of work in order to maintain the current workforce numbers. Information from this census confirms that the ageing workforce continues to be a major area for concern.

Anticipated Year of Retirement	2005 –09	2010 –14	2015 -19	2020 -24	2025 -29	2030 -34	2035 or later
Consultant	11	11	6	5	0	0	1
Associate Specialist/ SCMO	24	17	12	7	2	1	0
Staff Grade/CMO	12	11	12	9	7	1	1
Specialist Registrar	0	0	0	0	1	1	0
All	47	39	30	21	10	3	2



43% of those working in paediatric audiology are expecting to retire within the next 8 years. This will have a major impact on the provision of services.

Conclusions

It is acknowledged that the information from the census does not cover all doctors working in paediatric audiology. Disappointingly 30% of BACDA members did not return the census despite several reminders and we are aware of doctors working in paediatric audiology who are not members of BACDA. We did try and encourage these people to send in a census but it is unlikely that all submitted census forms. Despite these limitations much useful information has been gained.

The ageing nature of the workforce has previously been highlighted as a concern. Information from this census has been helpful in highlighting issues with the Royal College of Paediatrics and Child Health and the National Workforce Review Team. Discussions are under way with the college about training needs for doctors in paediatrics audiology. It is difficult to attract paediatricians into the specialty, as at the current time there is no identifiable training pathway.

Many doctors work very few sessions in paediatric audiology. This has implications for maintaining skills and ensuring high quality ongoing services. It is known that different paediatricians have different roles within the paediatric audiology team, with some being very involved in hearing assessments, issuing of hearing aids etc. and others providing only the medical input to the team. This was not explored in this census, but should be explored more fully in the future.

There are great variations in the number of children being seen in clinics. Figures from the census would indicate that in many clinics too many children are being seen to be able to offer a quality service. All audiological paediatricians should be following the standards previously laid down by the British Association of Audiological Paediatricians (BAAP).

The census also highlights the large amount of teaching and training that is being undertaken by paediatricians working in audiology.

This is only an initial analysis of the information obtained. It is planned to undertake more detailed analysis which will consider regional variations and differences between grades of staff.

In order to gather as comprehensive information as possible I would like to encourage anyone who has not yet completed a BACDA census to do so. These can be completed on line through the BACDA website or paper copies can be obtained from Pam Williams.

Ann Mackinnon , August 2006

The Constitution of the British Association of Paediatricians in Audiology

1. TITLE

The Association shall be known as "The British Association of Paediatricians in Audiology" (hereinafter called the "Association").

2. STATUS

The Association is a registered charity and shall be voluntary and non-profit making.

3. AIMS

The aims of the Association are:

(a) The promotion of standards in both training and professional qualifications of Paediatricians working in audio-vestibular medicine and to contribute to the training of other professionals working in related disciplines.

(b) The promotion of multidisciplinary working for the benefit of children and their families

(c) The promotion of multidisciplinary working by maintaining and developing links with other professional bodies.

(d) The holding of meetings, lectures and discussions in various regions and the publication at regular intervals of a newsletter for members.

4. MEMBERSHIP

4.1 Full membership shall be open to medical practitioners with an interest in audiovestibular medicine and shall confer an entitlement to vote.

4.2 Associate membership at a reduced rate shall be extended to non medical professionals with an interest in audio-vestibular services. Associate Members may attend business meetings but have no voting rights.

4.3 Retired membership at a reduced rate may be offered to those who are members at the time of their retirement. Retired members may attend business meetings but have no voting rights.

4.4 The Executive Committee, may, at its own discretion, award Honorary Life Membership to a full member who has made an outstanding contribution to the work of the Association. Nominations may be made by any BAPA member.

5. SUBSCRIPTION

5.1 All members shall pay an annual subscription fee as determined by the Executive Committee.

5.2 The subscription shall be paid on 1 May annually.

6. OFFICERS

6.1 The Officers of the Association shall be elected from full members of the Association by members at the Annual General Meeting.

6.2 The Officers of the Association who shall act without remuneration shall be:-

The Chairman of the Association

The Vice-Chairman of the Association

The Executive Secretary of the Association

The Treasurer of the Association

The Immediate Past-Chairman

6.3 The Officers shall be the Trustees of the Association

6.4 The term of office for all Officers shall be two years commencing at the end of the Annual General Meeting at which appointed.

6.5 The Vice-Chairman shall usually become Chairman on the expiry of the latter's term of office. A Vice-Chairman must have been a member of the Executive Committee for at least one year prior to election.

6.6 The Executive Secretary and the Treasurer may offer themselves for re-election for further terms of office up to a maximum tenure of 6 years but this does not preclude additional nominations.

6.7 Elections shall be at the Annual General Meeting.

6.8 In the event of an Officer's death or resignation the Executive Committee shall be empowered to elect a substitute who will hold office until the subsequent Annual General Meeting when the individual concerned will be eligible for election for a full term of office.

7. THE EXECUTIVE COMMITTEE

7.1 An Executive Committee shall be established comprising:

a) The Officers
b) The Meetings Secretary
c) The Editor of the newsletter
d) Regional Representatives
e) The Chair of the Development Group
f) Two Officers of the British Association of Audiovestibular Physicians
g) Representatives nominated by the Committee to sit on the committees of other professional organisations
h) Up to 3 co-opted members

7.2 All members of the Committee, with the exception of representatives of other organizations shall be entitled to vote.

7.3 The Meetings Secretary shall be elected and should serve for a period of two years, election taking place at the Annual

General Meeting. He or she would be eligible for re-election at the end of their term of office but this does not preclude additional nominations.

7.4 The Editor of the newsletter shall be elected and should serve for a period of two years, election taking place at the Annual General Meeting. He or she would be eligible for re-election at the end of their term of office but this does not preclude additional nominations.

7.5 The boundaries of each region and the number of representatives it may have shall be defined by the Executive Committee.

7.6 Regional Representatives shall be nominated and elected by the subscribing members working or domiciled in the relevant Region and may assist the Meetings Secretary in the organisation and holding of meetings in furtherance of the Associations aims within their Region.

7.7 Regional Representatives shall be elected for a term of two years and shall not ordinarily serve more than four consecutive years. A member shall be eligible for re-election as a Regional Representative one year after completing a term of office.

7.8 In the event of a serving Regional Representative resigning then the vacancy so created shall be filled by nomination from the Region affected.

7.9 The Executive Committee shall be responsible for the day to day functions of the Association.

7.10 The Executive Committee shall be empowered to prepare reports and to make representations to other bodies.

7.11 The Executive Committee shall be empowered to negotiate on behalf of the Association, and represent the Association in all matters.

7.12 The Executive Committee shall be empowered to appoint subcommittees to act on its behalf. Such subcommittees may be given the power to co-opt members provided that the number of such co-opted members does not exceed more than one-quarter of the total membership of each subcommittee. The proceedings and recommendations of the subcommittees shall be reported to and ratified by the Executive Committee.

8. THE EXECUTIVE COMMITTEE MEETINGS

8.1 The Executive Committee shall meet at regular intervals and in any case at least three times a year.

8.2 The meetings shall be called by the Chairman at his or her discretion, or when requested to do so by any other member of the Executive Committee.

8.3 All members of the Executive Committee shall be entitled to receive at least fourteen days written notice of such meetings.

8.4 The Executive Secretary shall keep minutes of proceedings and decisions made at all Executive Committee meetings; and he or she shall circulate copies of these minutes to all members of the Executive Committee.

8.5 A quorum shall be 2 officers and any 3 other Executive Committee members.

8.6 Voting shall be by a show of hands a simple majority being needed to carry the resolution. In the event of a tied vote the Chairman shall have an additional casting vote.

9. EDUCATIONAL MEETINGS

9.1 The Association shall hold at least one national educational meeting each year.

10. ANNUAL GENERAL MEETINGS

10.1 All paid up members of the Association shall be entitled to at least 21 days written notice prior to the Annual General Meeting and shall be entitled to attend. The notice shall specify the time and place of the meeting and the general nature of the business to be transacted.

10.2 The Chairman of the Annual General Meeting shall normally be the Chairman of the Association or the Vice-Chairman if the Chairman cannot be present.

10.3 A quorum shall be 30 full members.

10.4 All full members attending shall be entitled to vote.

10.5 Voting shall be by a show of hands a simple majority being needed to carry the resolution. In the event of a tied vote the Chairman shall have an additional casting vote.

10.6 The accidental omission to give notice of a meeting to, or the non-receipt of notice of a meeting by, any person entitled to receive notice shall not invalidate the proceedings of that meeting.

10.7 Minutes of the Annual General Meeting shall be taken by the Executive Secretary and these will be circulated to the members at least 21 days before the next Annual General Meeting.

10.8 The business to be transacted at the Annual General Meeting shall include:

a) Consideration of the Annual Report presented by the Chairman.

b) Consideration of Income and Expenditure Account and Balance Sheet presented by the Treasurer.

c) Election of Officers, Meetings Secretary and Editor of the Newsletter.

d) Presentation of reports by the Regional Representatives, the Chairs of any subgroups and Representatives on committees of other Professional organisations.

e) The awarding of the Annual Prize and any Honorary Life Memberships.

11. EXTRAORDINARY MEETINGS

11.1 Extraordinary Meetings of the Association other than an Extraordinary Meeting for dissolution may be convened by the Executive Committee at any time with at least 14 days notice to the membership.

11.2 Ten full paid up members of the Association may compel the Executive Committee to convene an Extraordinary Meeting other than an Extraordinary Meeting for dissolution within 28 days of a written request provided that written

request is signed by those members and is delivered to the Executive Secretary: and the time limit shall start from the first full working day after the receipt of the request.

11.3 A quorum shall be 30 full paid up members.

11.4 Voting shall be by a show of hands a simple majority being needed to carry the resolution. In the event of a tied vote the Chairman shall have an additional casting vote.

12. FINANCIAL ARRANGEMENTS

12.1 A bank account shall be held in the name of the Association and the signature of the Treasurer or one other elected officer shall be required on all cheques

12.2 The financial year shall run from December to November.

12.3 A statement of the accounts shall be published to the members at the Annual General Meeting.

12.4 The Treasurer shall arrange for the accounts to be audited annually.

13. ALTERATIONS TO THE CONSTITUTION

13.1 Alteration to this Constitution shall receive the assent of two-thirds of the members present and voting at an Annual or an Extraordinary Meeting. A resolution for the alteration of the Constitution must be received by the Secretary of the Association at least 21 days before the meeting at which the resolution is to be brought forward. At least 14 days notice of such a meeting must be given by the Secretary to the membership and must include notice of the alteration proposed: provided that no alteration to clause 3, clause 14 or this clause shall take effect until the approval in writing of the Charity Commissioners or other authority having charitable jurisdiction shall have been obtained; and no alteration shall be made which will have the effect of causing the Association to cease to be a charity in law.

14. DISSOLUTION OF THE ASSOCIATION

14.1 Dissolution can only be considered at an Annual General Meeting or an Extraordinary Meeting. This may be convened by the Executive Committee or by the Executive Secretary on receipt of a written request signed by ten full paid up members.

14.2 The full membership shall receive at least 42 days written notice of the Annual General Meeting or the Extraordinary Meeting and the resolution to dissolve the Association shall be printed in the agenda which shall be circulated at the same time as the notice of the meeting.

14.3 Following discussion at the Annual General Meeting or the Extraordinary Meeting, Members shall have the opportunity to vote by postal ballot.

14.4 A majority of full paid up members shall be required to vote on the resolution.

14.5 The resolution shall only be carried if supported by three quarters of those members who have voted.

14.6 If any property remains after the satisfaction of all debts and liabilities such property shall not be paid to or distributed among the members of the Association but shall be given or transferred to such other charitable institution or institutions having objects similar to some or all of the objects of the Association as the Association may determine and if and in so far as effect cannot be given to this provision then to some other charitable purpose.

The copy dates for the next editions of Audiens are:
15th February 2007 and 15th August 2007.
Articles, letters or adverts etc. to the editor by those dates please. All submissions must at least be typewritten, and preferably on disc or by Email.

Advertising rates for Audiens

Colour, A4	Commercial	£300
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	Academic	£120
B & W, ½ page	Commercial	£90
	Academic	£60
Flyers for insertion with mailing	Commercial	£100
	Academic	£75

DRAFT PROGRAMME

BACDA

London Study Day

2nd February 2007
(Note Date)

ONE EAR OR TWO

Chair: Dr. Tim Williamson

9.30 Registration

Spatial Hearing in Babies
International Speaker to be confirmed

BEARS
Dr. Emily Pattison
MRC Hearing and Communication Group

Effects of Unilateral Hearing Loss in the Classroom and on Language
Speaker to be confirmed

Management of Unilateral Hearing Loss
Andrew Phillips

Afternoon

Chair: Dr. Elaine English

Bilateral vs Unilateral Cochlear Implantation
Speaker to be confirmed

The School Sweep Test – Study Findings
Heather Fortnum, Professor John Bamford & Team

16.45 - Close of meeting

The above is subject to minor changes.

Evaluation of the School Entry Hearing Screen

Heather Fortnum, on behalf of the research team*
Trent RDSU, Nottingham University, Nottingham

In 2005 we reported in Audiens that the Department of Heath funded Health Technology Assessment Programme (HTA) had commissioned a research team led by Professor John Bamford to evaluate the School Entry Hearing Screen. This 18 month study has recently finished and the final report is currently with the HTA awaiting review. We are very grateful to all BACDA members who were involved in completing questionnaires for the study or in advising us. We hope the findings will be of interest and useful to you.

The full report will be published as an HTA monograph in due course and will be available on the HTA website www.ncchta.org/ Details of the findings of the study will be presented at the BACDA study day in February 2007 but in summary:

Background:

Recent changes in childhood hearing screening policy (abandonment of the distraction test screen at eight months and the introduction of universal newborn screening) have implications for the population of children to be identified with hearing impairment at school entry. The research questions posed by this study were:

1. What is current practice for the School Entry Hearing Screen (SES) in the UK?
2. What is known about the accuracy of alternative screening tests and the effectiveness of interventions?
3. What is known about costs, and what is the likely cost-effectiveness of the SES?

Methods:

1. a) A national postal questionnaire survey to all leads for the SES in the UK, addressing current practice in terms of implementation, protocols, target population and performance data.
   b) Examination of primary data from cohort studies in one area of London.
2. A systematic review of alternative SES tests, test performance and impact on outcomes.
3. Review of published studies on costs, plus economic modelling of current and alternative programmes.

Results:

1. The evidence from the national survey of current practice is that
   a. the school entry hearing screen is in place in most areas of England, Wales and Scotland; just over 10% of respondents have abandoned the screen; others are awaiting guidance in the light of the national implementation of newborn hearing screening
   b. coverage of the SES is variable, but is often >90% for children in state schools
   c. referral rates are variable, with a median of about 8%
   d. the test used for the screen is the pure tone sweep test but with wide variation in implementation, with differing frequencies, pass criteria, and retest protocols; written examples of protocols were often poor and ambiguous
   e. there is no national approach to data collection, audit and quality assurance and variable approaches at local level
   f. the screen is performed in less than ideal test conditions
   g. resources are often limited and this has an impact upon the quality of the screen.

2. The evidence from the primary cohort studies is that
   a. the prevalence of permanent childhood hearing loss continues to increase through infancy
   b. of the 3.47/1000 children with a permanent hearing impairment at school screen age, 1.89/1000 required identification after the newborn screen
   c. the introduction of newborn hearing screening is likely to reduce significantly the yield of SES for permanent bilateral and unilateral hearing impairments; yield had fallen from about 1.11/1000 before newborn screening to about 0.34/1000 for cohorts that had had newborn screening, of which only 0.07/1000 were unilateral impairments
   d. just under 20% of permanent moderate or greater bilateral, mild bilateral, and unilateral impairments, known to services as six-year-olds or older, remained to be identified around the time of school entry.

3. The evidence from the systematic review of the alternative tests and of the effectiveness of interventions is that
   a. no good quality published comparative trials of alternative screens or tests for school entry hearing screening were identified
   b. studies concerned with the relative accuracy of alternative tests are difficult to compare and often flawed by differing referral criteria and case definitions; with full pure tone audiometry as the reference test, the pure tone sweep test appears to have high sensitivity and high specificity for minimal, mild and greater hearing impairments, better than alternative tests for which evidence was identified

c. there is insufficient evidence to draw any conclusions about possible harm of the screen
d. there were no published studies identified which examined the possible effects of school entry hearing screening on longer term outcomes.

4. The evidence from the cost-effectiveness study is that
   a. no good quality published economic evaluations of school entry screening were identified
   b. a universal school entry screen based on pure tone sweep tests was associated with higher costs and slightly higher QALY's when compared to no screen and to other screen alternatives; the incremental cost-effectiveness ratio (ICER) for such a screen is around £2500 per QALY gained; the range of expected costs, QALY's and net benefits was broad, indicating a considerable degree of uncertainty
   c. targeted screening could be more cost-effective than universal school entry screening
   d. lack of primary data and the wide limits for variables in the modelling mean that any conclusions must be considered indicative and exploratory only

5. a national screening programme for permanent hearing impairment at school entry meets all but three of the criteria for a screening programme, but at least six criteria are not met for screening for temporary hearing impairment

Conclusions:
The lack of a good quality evidence-base to drive change in this area remains a serious problem.

**Research Team:*
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Jenny Smith, University of Birmingham
George Vamvakas, University of Manchester
Linda Davies, University of Manchester
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Pete Watkin, Whipps Cross Hospital, London
Sarita Fonseca, St. George's Hospital, London
Adrian Davis, University of Manchester
Sally Hind, MRC Institute of Hearing Research, Nottingham

International Association of Physicians in Audiology March 2006 Conference, Mexico City A personal account

On the morning of my daughter's 16th birthday (she has yet to forgive me for going) five of us met at Manchester airport. We were excited about our jaunt across the Atlantic, and tried not to giggle like schoolgirls, including Wendy's husband, for the 2006 IAPA Conference was to be held in Mexico. Apart from myself the five of us travelling together were Gill Painter, Lesley Batchelor, Wendy Floate and her husband Chandran. In Mexico City we met up other members of BAAP and BACDA who had travelled from London. Matthew Varghese, Dolores Umapathy and her husband also travelled from Manchester, but separately from us five.

We flew out on Saturday; the IAPA conference was in conjunction with the Pan-American Society of Audiology, and was scheduled to start on Monday, finishing on Wednesday lunchtime. As were staying for a week we had planned to take in some sightseeing. However the translation from Spanish to English did not encompass all sessions, so we did more sightseeing than expected.

Just walking round Mexico City centre, the Centro Historico, and looking up at the architecture was an experience in itself, particularly as the weather was pleasantly warm, and not too hot, rather like an English summer. Most of the buildings date from the Spanish conquest and are very grand and even ornate in style. As Mexico City is built on a swamp many of the large stone buildings such as cathedrals and churches are subsiding. When walking round inside them the floors and walls are often sloping unevenly so it can feel quite disorientating as you walk uphill to the main door or downhill to the chancel. The Aztecs overcame this problem by progressively adding floor levels, which is easily seen in the Temple Mayor behind the cathedral in Revolution Square. Although the Aztec ruins in Mexico City have been plundered by the Spanish for stone, they are still very impressive.

Our first official outing, which was part of the conference, was a visit to the Folklore ballet. This was a colourful and vivacious performance, but I was somewhat disappointed that it drew mainly on the Spanish flamenco tradition, with little allusion to the earlier Aztec culture. We did happen to see them performing their traditional dance on one day, in Revolution Square.

I mentioned that Mexico City was originally built on a swamp, most of which has now disappeared. Some of this however can still be seen at Xochimilco to the South East of the city. It is easily reached by the ridiculously cheap and efficient metro. Xochimilco is a system of waterways and artificial islands, which were originally built for cultivation. Nowadays the tiny islands are chiefly pretty homes, both small and lavish, with carefully tended gardens.

Close to the city centre is Chapultepec Park, a vast green open space. Like all the parks we saw it is full of people, who throng there for every holiday and weekend and even at the end of the day. It is here that the ubiquitous fountains and statues are most evident, including the series of whimsical cows. The golden cow is at the entrance to the anthropological museum, which is built on a grand scale. It is extremely well set out taking the visitor through each

stage of habitation and civilisation in Mexico. I could have spent several days there and not got bored at all.

One day we made the trip out to the ancient city of Teotihuacana. It is more than 2,000 years old and at its height 200,000 people lived here. It was abandoned suddenly, became covered in silt and only rediscovered when Europeans came to Mexico. It is here that you can climb up the famous Sun and Moon pyramids, which made me pant in the rarefied atmosphere at 7000 or so feet, but it's worth the effort for the spectacular view over their ruined city.

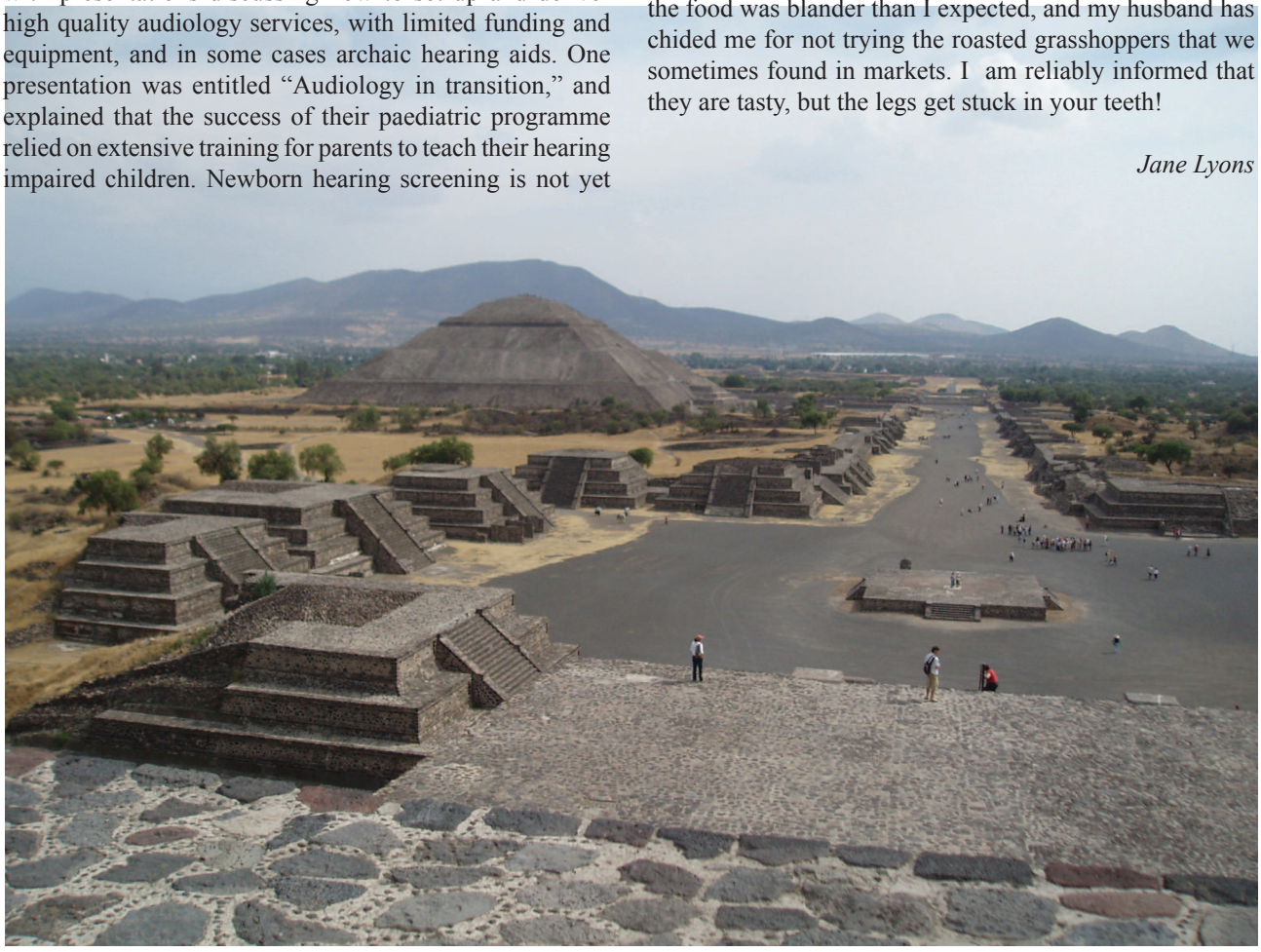
The conference itself had very much a Latin American feel, with presentations discussing how to set up and deliver high quality audiology services, with limited funding and equipment, and in some cases archaic hearing aids. One presentation was entitled "Audiology in transition," and explained that the success of their paediatric programme relied on extensive training for parents to teach their hearing impaired children. Newborn hearing screening is not yet universal in most countries, and various speakers from South American countries were discussing how to set up a national programme. Screening protocols, follow up and management were discussed.

One session was devoted to central auditory processing with Katz the keynote speaker and setting the context. Several speakers spoke about how to categorise auditory processing problems, the different diagnostic tests and treatments, which include auditory training, compensatory strategies and environmental modification.

For me one of the most interesting presentations was on partial ear canal occlusion due to wax. The suggested prevalence was 5% in children and adults, and 20% in elderly, increasing to 35% in those with developmental delay (though this high incidence wasn't explained). The trend is for a high frequency loss until 90% occlusion, before the low frequencies are affected. Having removed what seemed to be huge quantities of wax in 2 children this week (instantly curing their conductive hearing losses), this is definitely food for thought.

I really enjoyed Mexico City and would strongly recommend anyone to visit. However I am not entirely sure that Lesley and Wendy would agree, as they were both ill for 2 days. Lesley blames it on a tortilla, and never wants to see one again. I enjoyed the food including the chocolate sauce called mole, which is like a thick, dark and spicy gravy. Generally the food was blander than I expected, and my husband has chided me for not trying the roasted grasshoppers that we sometimes found in markets. I am reliably informed that they are tasty, but the legs get stuck in your teeth!

Jane Lyons



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