AUDIENS

BACDA

"20 years old

and

20 years on"

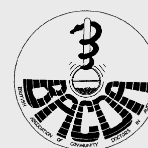
The Newsletter of
the British Association of Community Doctors
in
Audiology

APRIL 2006
No. 37

Siemens advert

REPEAT FROM PREVIOUS ISSUE

AUDIENS



The Newsletter of the British Association of Community Doctors in Audiology

BACDA is registered as a charity,

CONTENTS

Editorial .... *Page 4*

List of Officers .... *Page 4*

BACDA Study Day Reports: "20 Years Old and 20 Years On"

Chairman's report: *Ann MacKinnon* .... *Page 5*

Treasurer's Report *Dr. K Abban* .... *Page 6*

Reports from Regional Representatives .... *Page 9*

BACDA Development Group Report *Lesley Batchelor* .... *Page 12*

BACDA Study Day, Northern Meeting 2006 .... *Page 12*

From BACDA's new Chairman *Susan Rose* .... *Page 13*

PMETB Update regarding Paediatric Audiology *Elaine English* .... *Page 14*

BACDA Name Change .... *Page 14*

Newborn Hearing Screening around the Country (Part Two)

Elaine English .... *Page 18*

Anne Dooley, ... *Page 19*

Susan Rose .... *Page 23*

BACDA Prize Rules .... *Page 25*

Siemens News Release .... *Page 25*

Advertisers: *GN Resound Ltd* .... *Page 28*

Puretone .... *Page 27*

Otodynamics .... *Page 11*

Siemens .... *Page 2*

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Editorial

BACDA was formed in May 1985, so the January 2006 study day included the 20th annual general meeting (AGM), which was celebrated in style. Chris Hallett our first chairman cut the celebratory cake, which consisted of 5 cakes in the shape of the letters of BACDA. I always enjoy BACDA study days, and learn a lot, but the 20th AGM was exceptional. Not only was it good to see some old familiar faces, but there were the usual excellent presentations, which included the ground-breaking presentation on CMV. Dr. Mike Sharland from St. George's explained how he thought that CMV is a commoner cause of hearing loss than has previously been thought. He then described how it could be detected using the blood spot from the Guthrie test.

Dr. Hope Forsyth was the first speaker of the day. I was so surprised that she quoted from my latest editorial, as I didn't think anyone read it! She disputed my statement that I had been newsletter editor for only a little while, as it seems like forever. I am hoping to encourage some new blood in the near future!

The major item on the agenda for the AGM is a name change for BACDA, and there are more details about the reasons, and how the vote went, in this edition of Audiens. From a personal point of view, and from someone who is an old hand, I think this is timely and important, as we have to progress and develop.

There is very good news, which is well-timed for our 20th AGM, as BACDA is now a special interest group within the Royal College of Paediatrics and Child Health. This recognition is due in no small measure to the tireless efforts of Lesley Batchelor, and I am sure the BACDA membership will join me in offering my sincere thanks on their behalf. Thank you very much Lesley; I think you have gone a long way to helping secure the future of our small but important profession.

Jane Lyons

List of Officers

EXECUTIVE COMMITTEE MEMBERS

Chairman	*Dr. Susan Rose*	*susan.rose@sahs.nhs.uk*
Immediate Past Chairman	*Dr. Ann MacKinnon*	*ann.mackinnon@twht.scot.nhs.uk*
Vice Chairman	*Dr. Adrian Dighe*	*adrian.dighe@mspct.nhs.uk*
Honorary Secretary	*Dr. Veronica Hickson*	*veronica.hickson@gwent.wales.nhs.uk*
Treasurer	*Dr. Ken Abban*	*kwesi@doctors.org.uk*
Meetings Secretary	*Dr. Bernie Borgstein*	*bernie.borgstein@st-marys.nhs.uk*
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BAAP Representative	*Dr. Deirdre Lucas*	*deirdre.lucas@royalfree.nhs.uk*
BACCH Representative	*Dr. Susan Snashell*	*susans@enta.net*
	Vacant	

REGIONAL REPRESENTATIVES

Midlands	*Dr. Jeanette Nicholls*	*jeanette.nicholls@southbirmingham*
North West	*Dr. Annabel Dodds*	*annabel.dodds@elht.nhs.uk*
Scotland	*Dr. Ruth MacKay*	*ruth.mackay@tuht.scot.nhs.uk*
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South Wales	*Dr. Veronica Hickson*	*veronica.hickson@gwent.wales.nhs.uk*
Yorkshire	*Dr. Kathleen Coats*	*kathleen.coats@hdft.nhs.uk*
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Tel./answerphone: 0161 962 8915
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Email: bacda@boltblue.com

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

Reports from the BACDA Study Day and AGM "20 Years Old and 20 Years On" 27th January 2006

Chairman's Report

2005 has been an 'interesting' year for paediatric audiovestibular medicine, for BACDA and for myself. The BACDA Executive Committee and the Development Group have both been working very hard on behalf of the BACDA membership. The activities that they have been involved in have been many and varied, including study days, workshops, development of competencies for paediatric audiovestibular medicine with the Royal College of Paediatrics and Child Health, input to NDCS documents and of course formalising and strengthening our links with BAAP through the Audiovestibular Medical Federation. As you are aware there has been considerable discussion and debate regarding the future of BACDA and how best to ensure that we can effectively represent and support paediatricians working in this field in the future.

Workforce Issues and Training

BACDA are trying to gather up to date information about the current workforce and from this project future workforce requirements. As you are aware a Census was circulated to all members towards the end of 2005. It is disappointing that to date only just over a third of the membership has returned the census. Please return it immediately if you have not done so already. It is essential that we have as accurate information as possible in order to identify workforce planning needs and training requirements for the future.

There continues to be great concerns about the future of Paediatric Audiovestibular Medicine. Recent experiences would suggest that as individuals are retiring many are being replaced with either medical staff who have less of an expertise in audiology, often working fewer sessions in the specialty, or audiologists, if indeed they are replaced at all. The fact that there is no training programme for Paediatric Audiovestibular Medicine means that it is extremely difficult to attract good candidates to these positions when they do become available.

Much work is ongoing to try and address these matters and raise the profile of Paediatric Audiovestibular Medicine including -

- BACDA and BAAP working with the RCPCH to develop level 3 competencies for higher specialist training in paediatric audiovestibular medicine
- Input by BACDA to the Royal College of Physicians working party to consider the future of audiological medicine
- A submission to have BACDA recognised as a Special Interest Group within the RCPCH went to the College Council in November
- BACDA and BAAP will have representation at the Workforce Review Team Meeting in March when Paediatrics and Paediatric Specialties will be discussed

Audiovestibular Medical Federation

The Federation between BACDA and BAAP is now well established, with reciprocal representation on each others Executive Committees and increasing collaboration between the 2 organisations. It has been a great pleasure working with BAAP over the past 2 years and in particular working with Susan Snashall, Chairman of BAAP, with whom I have had closest involvement. Susan and/or Deirdre Lucas have managed to attend all the BACDA Executive meetings since the formation of the Federation. Their input and advice has been invaluable.

It is essential that BACDA and BAAP speak together with one unified voice in matters relating to medical audiology. I am sure that as time progresses the Federation will further evolve. It is important that we actively promote the role of the Federation among our non medical colleagues in audiology to ensure that we (the Federation) are appropriately consulted and involved in future developments relating to all aspects of audiology.

BACDA – Name Change?

As you are aware there has been considerable discussion over the past few months regarding BACDA's name. I am grateful to all members who have participated in the debate. As a result of these consultations a proposal to change BACDA's name will be made at the AGM. Suggested future names are "The British Association of Paediatricians in Audiovestibular Medicine" and "The United Kingdom Association of Audiovestibular Paediatricians".

Postgraduate Medical Education and Training Board

PMETB is now accepting completed applications from doctors seeking inclusion on the Specialist Register through article 14. There is however conflicting advice circulating about eligibility requirements and experience required. It would appear that many UK trained Staff and Associate Specialist doctors, currently leading audiology services and

acting as independent clinicians, who have postgraduate qualifications in audiology and extensive experience in the field, will be unsuccessful if they apply as they will be unable to demonstrate appropriate equivalent experience to that required for a CCT in General Paediatrics.

Doctors who have a specialist qualification or training from outside the UK are able to apply using an alternative route which requires them to demonstrate that they meet the standards required for an NHS consultant in a non-UK training specialty e.g. Paediatric Audiology. It is felt by many that article 14 is discriminatory against UK trained doctors. We have however been informed that it is bound by European Law and cannot be readily altered. BACDA will be writing to Professor Alan Craft, President of the Royal College of Paediatrics to seek clarification on this matter.

Development Group

I would like to thank the members of the Development Group and in particular Lesley Batchelor and Sarita Fonseca for all their hard work on behalf of BACDA. A separate report is available from the Development Group.

BACDA Study Days

Bernie Borgstein and Than Lwin are to be congratulated on organising 2 excellent study days. Although the June study day was a small gathering, mainly due to the date clashing with the NDCS conference, the content was excellent and very well received by those present.

Bernie has put together an excellent programme for today. I am grateful to her for organising things so well and for coping admirably with the additional complications of the 20th anniversary celebrations.

Audiens

I would like to thank Jane Lyons who has edited Audiens for many years and continues to produce it twice a year. This takes a considerable amount of work. She successfully persuades individuals to submit articles, with only a little arm twisting and occasionally bribery. If you have any possible articles for Audiens, letters or comments please contact Jane. All contributions will be gratefully received.

And finally

Serving as Chairperson for the last 2 years has been a challenging but very rewarding experience. I am extremely grateful to all the Executive Committee and Development Group members for their commitment and support throughout this time. Particular thanks go to Lesley Batchelor, Susan Rose and Elaine English who have provided me with so much help and guidance, to Veronica Hickson and Margaret Miles before her for keeping track of committee meetings and to Ken Abban for so ably managing the BACDA finances.
I would also like to extend my thanks to Pam Williams who provides excellent secretariat support to the organisation. Her input is invaluable in the smooth running of all aspects of BACDA business.

I wish Susan Rose all the best as she takes over as Chairperson and hope that I will be able to provide support and encouragement to her in her new role.

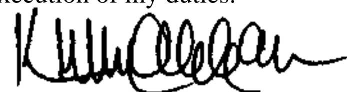
Ann J MacKinnon

Treasurer's Report January 2006
Financial Year Ended 30th November 2005

It gives me great pleasure in presenting the Treasurer's Report for the year. As you may be aware, there is a change of Accountants. Gregg Brothers & Co. have now transferred to, and incorporated with the well- established company of Hallidays Ltd., Chartered Accountants, Manchester.

The Chairman and The Executive Committee's continuing financial restraint on our overall expenditure ensures a success in keeping within our resources. Our forward progress also reflects the hard work put in by the Executive Committee.

The January Study Day gave us a surplus of £8797 (£5174 in 2004). The Study Day in June was also successful with a profit of £1680 (£2666 in 2004). The VRA Training course has yet again proved successful giving a surplus of £3758. Thanks to Dr. Sarita Fonseca who has worked so hard in organising the course. As you know expenditure is now high but a profit was registered. Sarita suggested future VRA courses be advertised in Audiens to enable a wider circulation and simplify organisational issues. I have no doubt that it will continue to be successful.
BACDA membership is still falling. It is important, therefore, that we continue to pursue our recruitment policy of bringing in new members as BACDA has much to offer them.
Our Net Assets show a balance sheet of £42981 (£31330 in 2004).
Finally I would like to thank the Chairman, the rest of the Executive Committee and the Trustees, whose advice simplified my task, and Mrs. Pam Williams whose invaluable dedication helped in the execution of my duties.



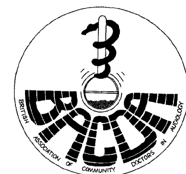
KEN K. ABBAN TREASURER
16 January 2006

BRITISH ASSOCIATION OF COMMUNITY DOCTORS IN AUDIOLOGY
Balance Sheet as at 30 November 2004

	2005		**2004**	
	£	**£**	**£**	**£**
Fixed Assets				
Computer and Printers at cost	2400.12		2400	
Deduct Depreciation to date	2390.12	10	2390	10
Office Equipment at cost	301.48		211	
Addition during the year			90	
			301	
Deduct Depreciation to date	221.48	80	211	90
Audiology Equipment at cost	112.69		112	
Deduct depreciation to date	27.69	85	17	95
		175		195
Current Assets				
Debtors	300		1100	
Prepaid expenses	869.50		811	
Cash at National Savings Bank	5870.59		5702	
Cash at bank: Deposit Account	33627.56		13284	
Cash at bank: Current Account	3553.67		13195	
Cash at bank: Area Branches	5457.29		4986	
Cash in hand	-			
	49678.61		39078	
Current Liabilities				
Creditors	200		1138	
Branches Accrued	5457.29		5600	
Accrued expenses	1215		1205	
	6872.29		7943	
Net Current Assets		42806.32		31135
Net Assets		42981.32		31330
Accumulated Fund				
Balance as at 30 November 2004	31329.95		22895	
Excess of income for the year	9705.88		8115	
Bank interest	512.19		320	
Transfer of Funds from South Wales Region	1433.30	42981.32		31.330

These accounts are approved, all records and information for their preparation having been made available and sibmission to the Inspector of Taxes is hereby authorised.
Dr. K ABBAN *Treasurer*
British association of Community Doctors in Audiology
Unaudited Financial accounts for Year ended 30th November 2005

Hallidays Limited, Chartered Accountants, Portland building, 127-129 Portland street, Manchester M1 4 PZ



Income and Expenditure Account for the year ended 30 November 2005

		2005		2004
	£	£	£	£
INCOME:				
Subscriptions		8520		8560
Clinical meetings: Delegates fees		14610		12050
Advertisements and exhibitors		3100		4610
Surplus on Visual Reinforcement Audiometry Course		3758.20		644
Membership and mailing lists				225
Other		709.26		20
		30697.46		26109

EXPENDITURE:				
Room hire and refreshments	4897.96		4245	
Meetings: Committee	4718.34		4369	
Research group	-		429	
Training group	-		521	
Other	2711.66		583	
Lecturers fees and expenses	915.20		1475	
Newsletters	3800		2242	
Advertising	-		90	
Postage	556.11		764	
Stationery	852.77		985	
Telephone and fax	156.29		197	
Secretarial	668.48		552	
Subscriptions	71		69	
Accountancy	1175		1175	
Bank charges	231.87		106	
Prize	100		100	
Web site registration	71.40		71	
General expenses	45.50		1	
Depreciation	20	20991.58	20	17994
Excess of Income		9705.88		8115
Bank interest received		512.19		320
Transfer of Funds from South Wales		1433.30		
		11651.37		8435

Analysed Income and Expenditure Account for the year ended 30 November 2005

	Clinical Meetings		**Newsletter**	**General**
	January	**June**		
	£	**£**	**£**	**£**
INCOME				
Subscriptions				8520
Clinical meetings: Delegates fees	12850	1760		
Advertisements			2300	
Exhibitors	800			
Surplus on Visual Reinforcement Audiometry Training Course				
Other				
	13650	1760	2300	
EXPENDITURE				
Room hire and refreshments	4716	182		
Meetings: Committee				
Other	915			
Lecturers fees and expenses	813	662		
Newsletter			3800	
Advertising				-
Postage				556
Stationery				852
Telephone and fax				156
Secretarial				668
Subscription				71
Accountancy				1175
Bank charges				231
Prize				100
Web site registration				71
General				45
Depreciation				20
Excess of Income (Expenditure)	**8019**	**1578**		

Reports from Regional Representatives

BACDA South East Region

Our annual regional meeting was held at RNTNE Hospital, London, on May 15th.
Dr. Ewa Raglan gave a very interesting talk on clinical assessment of balance disorders in babies and young children. Angela Harding, from Christopher's Place, a centre for children with speech and language difficulties, including those arising from hearing impairment, gave a stimulating and lively presentation on the work done there.

This year's meeting is yet to be finalised but will be held in London in the Summer.
Bernie, who has taken on the role of London meeting secretary, is standing down as regional representative. Nominations for a new representative are welcome.
Voting , if required will take place at the next regional meeting.

Rosamund Aylett, Bernie Borgstein
South East Representatives

BACDA South West Region

It had not proved possible to organise a regional meeting since last December.

Our numbers of paediatricians still involved in audiology in the South-West are getting smaller as colleagues are retiring. However, we have valued the opportunity to meet up with some of our colleagues from South Wales particularly to discuss "difficult" cases.

The next meeting is planned for Friday 10 February 2006.

Alison Hooper.
South West Representative

BACDA East Anglia Region

A small but select group met in May. We had interesting discussion about NHSP.
We have very few members even when holding joint audiology / BACDA meetings. Anybody interested in joining us is more than welcome.

The meeting planned for November did not take place, however, we hope to organise one in May 2006.

For details of meetings or for further information, please contact: Janmcc@doctors.org

Janice McCreadie
East Anglian Representative

BACDA Yorkshire Region

This is my 1st report as Yorkshire representative, I took over from Heather Lakin in March 2005.

To introduce myself, my name is Kathleen Coats and I work both in Harrogate NHS Trust and East Leeds PCT.
My contact email address is kathleen.coats@hdft.nhs.uk

We have had two successful meetings in 2005.

The first was a half day organised by Heather which was held in York in February. This was an extremely interesting look at Clinical Psychological Services and the "Deaf Child" or more usually "Adolescent". The incidence of mental health problems deaf children and adolescents is significantly greater than among the hearing population. We learnt about the problems for these young people expressing very complex emotional feelings to someone for whom sign language is not a mother tongue. Many prefer to use a video linkage through to a centre in London, where they can communicate with a deaf signer, rather than a face to face contact with someone who is not a natural signer. Unfortunately this linkage is not available nationwide and is of course expensive.

In June we had a full day course again held in York and organised by Dr. Lwin. Unfortunately there were several other meetings on the same day so attendance was less than expected. The meeting had as its overall theme the effects of early identification of hearing impairment on other agencies. Talks were given by Dr. Watkin (Whipps Cross) about multi-agency management. We also had two presentations about the "Early Support Programme" one by Sue Lewis (Mary Hare School) and one by our local Advisory Support Teachers who showed us the "Packs" that are given to the Families on diagnosis. This programme is a centrally funded mechanism to achieve better co-ordinated, multi-agency assessment and service provision for disabled children under 3 and their families. The pack included a monitoring protocol for deaf children and babies. We also learnt about the problems and challenges of fitting hearing aids to the very young. To remind us that all this theory relates to real children a parent spoke of her pathway through pain, resentment and slow acceptance when her daughter became profoundly deaf following pneumococcal meningitis.

Please can I have emails of any Yorkshire members who may be reading this. I do have some already but by no means everyone's, and it is the easiest way of communicating.

Kathleen Coats
Yorkshire Area Representative

BACDA South Wales Region

The NBHSW (**N**ew **B**orn **H**earing **S**creening **W**ales) programme is now well up and running. Dr. Sally Minchom deserves congratulations for all the hard work that she has put in to the service as the Associate Director. Drs. Amanda Roberts, Elaine English and Meg Shepherd have also been very involved. A report on neonatal / new born screening was/is to feature in Audiens so I will not duplicate the detail here.

Within Wales we have been pleased to have Audiology Cymru which has allowed us to meet with other colleagues not only within our own profession but also those in other disciplines. If you know of any other doctors who would like to become members then please encourage them.
As I am now the Hon. Secretary I am actively looking for a replacement volunteer to be the representative - not only for South Wales but for the Principality in total. Any volunteers or suggestions for a named person then please get in touch.
Veronica.hickson@gwent.wales.nhs.uk

Veronica Hickson
South Wales Representative

BACDA Scottish Region

We eventually had 2 meetings in 2005. The February AGM and business meeting was cancelled at the last minute due to blizzard conditions.

In June we held our postponed AGM/Business meeting and in the afternoon we discussed the role of the Paediatrician in NHSP. This discussion was lead by Ann Mackinnon and Jackie Grigor as they had been involved with the pilot sites in Scotland. This discussion provided support for some of the members who feel marginalised by the way that NHSP has been introduced in their areas and are fighting to maintain a strong paediatric presence on the team. There was a good attendance at the meeting and we were pleased to welcome a colleague from BAAP. After the meeting we went for a meal to mark the retiral from work of two of our long standing members Jackie Grigor and Helen Milne. We still hope to access their good company and sensible advice.

We organised a Conference in October on Dual Sensory Impairment and had excellent talks from a range of speakers from paediatrics, ophthalmology, genetics, education and Sense. We had over 70 delegates from a spread of disciplines especially education. We received very positive feedback and these meetings are always a good opportunity to establish links.

Ruth Mackay
Scottish Representative

BACDA North Eastern Region

We had an informal meeting in January 05 to discuss the Federation Day and Dr. Jackson attended the meeting in London.

We have not had any education meetings in the North East this year but will be arranging one soon now that Dr. Sally Wade of Darlington has taken over from Jeanne Jackson as regional representative.

Neonatal screening is now up and running in most of the North East. There is a strategic audiology working group which covers Northumberland, North Tyneside, Gateshead, Sunderland and South Tyneside with some liaison between audiologists for Durham, Darlington and Cleveland.

I have enjoyed being the representative for the North East and look forward to a restful time as a granny to the new twins!

Jeanne Jackson
North East Representative

BACDA Midlands Region

We managed one regional meeting this year as due to illness of the speaker our Spring meeting, in April, became a Summer meeting, in July. That said a good number of members converged on my local clinic in Sutton Coldfield for a meeting on NHSP which was celebrating its first birthday in Birmingham, Sandwell and Solihull following the final roll out in April 2004. The talk itself left us with a number of questions which were discussed actively between members and our speaker Linda Truman (deputy co-ordinator).

After a break I presented a short prospective study on the outcome of the targeted follow up group from NHSP attending my clinic. It highlighted that in the local population extended family history of hearing loss was not relevant; whilst on further questioning family history was not always sensorineural.

Unfortunately the only two cases with a recognised family risk requiring review failed to attend (I'm sure that sounds familiar). There followed discussion on the need to ensure on going training and updating for our screeners. For some it was a taste of what was yet to come!

Pressures of work seem to weigh down on us all and so close to Christmas via e-mail (very useful means of communication for any who are not yet converted) we decided to cancel our second meeting of the year and look forward to our Spring 2006 meeting to be hosted by the BAHA team at Birmingham Children's Hospital on 29th March (pm only). A warm welcome is extended to any of our colleagues from further a field who would like to attend.

Jeanette Nicholls
Midlands Representative

There were no reports from:
BACDA Northern Ireland Region
BACDA North West Region

OTODYNAMICS ADVERT

Annual report of BACDA Development Group, January 2006

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

VRA Courses
These have been very successful but have probably run their course now. Thanks to Sarita for organising and doing all the clerical work, including chasing Trusts who haven't paid up.

Higher Specialist Training
The Level 3 competences are now complete and have been submitted to the college and to Gabriella Lang who is co-ordinating the 'Community' HST. Sorry we can't let you see them just yet. LB hopes to be able to attend the Sub Speciality Board at the college in November 2005.

Group members were: L Batchelor, B MacArdle, A Mackinnon, Michelle Dominic, S Fonseca who all worked with the college educational advisor, with occasional email advice from Sheila Shribman, RCPCH Registrar.

Special Interest group
Original overtures were made to the college in March. The submission should go before Council in November. LB will inform you of the outcome at AGM.

RCP Working Party (Prof. **Linda Luxon)**
The document is not yet finalised although the paediatric section (rather large) is. Thanks to Deirdre Lucas for inspiration, and Sheila Shribman for wisdom, diplomacy, tact and sheer determination. LB just did the writing...

Further courses
Will probably be 'Breaking the News/Sharing the News' in Bolton. To take place towards the end of the year. Please register any interest on the flyer in the pack.

Research/Audit
It is hoped to carry out a study of aetiology of unilateral sensorineural deafness. A research proposal has been written.
The group has made a commitment to become more active in BAAP audit, as part of our federation activity. Next meeting of BAAP audit - March 2006.

IT
The group has debated a proposal for PARS to produce a module for eSP.

BACDA Study Day
Northern Meeting, Friday, 30th June 2006

Postgraduate Centre, York District Hospital, Wigginton Road, York, YO31 8HE

PROVISIONAL PROGRAMME

(Speakers to be confirmed)

9.30 am	Registration, Coffee and Exhibition
9.55 am	Introduction and house-keeping
10 am	Non-organic Hearing Loss — Medical View Points
10.45 am	Non-organic Hearing Loss — Psychologist's View Points
11.30 am	Coffee, Exhibition, Posters
12 pm	Tinnitus in Children
12.45 pm	A Child's perspective of Tinnitus
1.10 pm	Lunch, Exhibition, Posters
2.20 pm	Hyperacusis
2.50 pm	Hyperacusis in Medical Conditions
3.50 pm	Panel discussion
4.10 pm	Close of Meeting

From the New Chairman

I have now been Chair for a full two weeks and am excited (if a little daunted!) by the many projects already under way. I am grateful to be supported by such a committed and enthusiastic group of people both on the Executive Committee and the Development Group. Ann, as Chair, has worked tirelessly for the organisation and has provided clear-headed leadership through challenging times. She deserves huge thanks from us all.

For those of you who attended the London Study Day in January I am sure you will agree it was an excellent day with diverse and fascinating presentations and much food for thought… as well as the 20th Birthday celebrations! The cake and coasters were inspired additions. Congratulations go to Bernie Borgstein for organising it all so brilliantly and for the many other people who contributed to the success of the day.

Few changes were made at the AGM to the Executive Committee and I am grateful that most of the Office Bearer's have agreed to continue in their current posts, despite the ever-increasing workload these entail. We are delighted, however, to welcome Adrian Dighe on board as Vice Chair. He will be well-known to most of you as a dynamic speaker and organiser of the VRA courses. Thanks go to Elaine English, for all her efforts on behalf of the Organisation both as Chair and Past-Chair. I am sure we will continue to seek her help particularly on PMETB issues, in which she has taken a special interest. Currently we have no BACCH representative, following the resignation of Robert Finch earlier in the year. His input was most valuable and BACCH are currently recruiting a successor.

As well as the knowledge I gained from the presentations, it was moving to hear Dr. Chris Hallett, the first BACDA Chair and Dr. Hope Forsyth, past Secretary, reflect on the changes in the field of paediatric audiology over the last 20 years and what BACDA has meant for them. The scientific and technical developments have been immense but committed practitioners have always strived to provide "family-friendly" services. Most of our membership works in relative professional isolation and the lack of recognised formal training programmes has been detrimental (although, hopefully, soon to be resolved). I have found BACDA invaluable in terms of provision of high quality education as well as professional support and friendship. Both speakers stressed that for an organisation to be successful it must keep in touch with its membership and change in order to meet its needs. I consider BACDA has managed this very well but to continue we do need to hear from you whether it be suggestions or complaints (or praise!).

I gather it is customary to tell you a little about myself, as incoming Chair. I am an Associate Specialist, working for an acute Trust (Surrey and Sussex Healthcare) which provides a service for the area around Gatwick. My beginnings, however, are in Scotland and, having trained in Aberdeen, I gradually drifted southwards. I completed a GP training scheme in Tunbridge Wells, never having contemplated or indeed been aware of the speciality of paediatric audiology. However, on moving to Tower Hamlets, I was fortunate to meet the late Dr. Sue Bellman, Consultant Audiological Physician at GOS and the Donald Winnicott Centre in Hackney. As those of you who knew her will realise, she was an inspirational person and that was the start, 17 years ago, of my interest and enthusiasm in the speciality.

As for the year ahead, it is clearly going to be a busy one! I don't plan to repeat the information so clearly outlined in Ann's report for the AGM. The immediate issue to resolve is the name. It is to be changed. That much was agreed at the AGM in January. It is clear from the discussions at the AGM that no name will please everyone. I believe when choosing we have to try to envisage the next 20 years and not our current situation. I hope Dr. Eva Raglan's comprehensive presentation at the BACDA Study Day will have convinced people that vestibular dysfunction in children is, at present, under-recognised and as paediatricians we should be aiming to improve our knowledge and skills in this area. The Development Group is currently buzzing with ideas to address this…more anon!

In addition, there is the information from the Census to collate and use to inform workforce planning and training requirements for the future. There is much to be done in pursuing the aims of the Audiovestibular Medical Federation and our next meeting is on 28th February. We are greatly indebted to the enthusiasm and efforts of Susan Snashall and Deirdre Lucas in keeping the momentum going. In addition, on the 22nd of February, Lesley Batchelor, as RCPCH representative and I, as BACDA representative will be attending a Scoping Workshop on Cochlear Implants organised by NICE. This is the first time BACDA has been invited to such a forum and is an important sign of recognition of our Organisation.

So much to be done and so little time in which to do it! All this brings to mind the Chinese curse "May you live in interesting times". However a brief glance at previous Chairs' reports in "Audiens" shows that "change" has always been the main theme and as previously mentioned this is necessary for our continuing success.

Susan Rose
Chair, BACDA
12th Feb 2006

PMETB Update regarding Paediatric Audiology

At the AGM I reported back briefly from the SASG Conference held in Cardiff on 25th November 2005.

The format for the day was presentations in the morning from Mohib Khan (Chair SAS Committee), James Johnson (Chairman of BMA Council), Awani Choudhary (Deputy Chair SAS Committee) and Alan Craft (Chair, Academy of Medical Royal Colleges and President RCPCH). The afternoon consisted of parallel sessions on Appraisal, PMETB and Terms and Conditions.

Alan Craft led the PMETB workshop. He explained the current routes to the Specialist Register, either by CCT or the "Equivalence Route" – acquiring a "Statement of Eligibility for Specialist Registration" under Article 14(4) or 14(5) of The General and Specialist Medical Practice (Education, Training and Qualifications) Order ("the Order"). He explained that "outside the UK" as stated in Article 14(5) does not include Ireland, Isle of Man or Jersey.

He then took UK trained doctors working in Paediatric Audiology as an example of one group of doctors who are excluded under current legislation of applying to PMETB under either category. Since Paediatric Audiology is not a recognised UK specialty we cannot apply, whereas those who have some training from outside the UK where it is a recognised specialty *can* apply. It will require a change in the law before we are eligible, so please do not waste your money by applying. I did ask Alan Craft to ensure that all staff in the College are aware of this information because I know that people have had differing advice on contacting the RCPCH.

Following the BACDA Executive Committee meeting where we discussed seeking legal advice under European Law, I contacted the SASG Committee to ask their advice and I enclose a copy of their response. I shall keep the membership informed as best I can as and when I receive more information. Please feel free to contact me in the meantime if you think I may be of further help (elaine.english@bromor-tr.wales.nhs.uk).

Elaine English

Dear Elaine,

Natalie Breeze has passed to me your comments regarding PMETB and Article 14(5) of The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 ("the Order").

The Committee are reviewing a number of issues which have arisen as a result of the Order and PMETB. At present the Committee is dealing with these issues via two main channels of redress. First and foremost, the Committee is engaging with PMETB directly to lobby them to change those parts of the Order which we believe detrimentally effects our members. Secondly the Committee has instructed a leading QC to provide a legal analysis of what (if any) legal action may be taken on behalf of our members. The Committee expects an update from the Legal Department in the near future and will advise you in due course.

In the meantime however I have passed on your details to the Legal Department as they are compiling a dossier of examples of how Article 14(5) has effected our members to pass on to the Q.C. Please be assured however, that any identifying personal data will be removed before your information is passed on (unless you advise us otherwise).

You are of course free to pursue legal advice privately as I understand there are time limits to pursuing a claim, but on balance I believe it is better to wait for the outcome from BMA sought legal analysis.

We will be letting members know of legal advice in the very near future, if however, you require any further information, please do not hesitate to contact me.

Regards,

Joni Jabbal
Executive Officer
Staff & Associate Specialists Committee
Direct Line: 020 7383 6040

Disclaimer
The views expressed in this newsletter are not necessarily the views held by the British Association of Community Doctors in Audiology

BACDA Name Change

For those of you who were unable to attend the AGM in January 2006, I will give a brief update. A written proposal was put to the membership present, firstly to agree to a name change and if this was agreed to then vote for one of two options namely, British Association of Paediatricians in Audiovestibular Medicine (BAPAM) or United Kingdom Association of Audiovestibular Paediatricians (UKAAP). These names were proposed by the Executive Committee, having previously sought the membership's comments and suggestions (few had been forthcoming at that stage).

Before the vote took place at the AGM, however, discussion was opened up and it rapidly became clear that there were strong feelings both for and against the proposed names. A vote was subsequently taken on whether or not to go ahead with a name change and the outcome was a resounding "YES".

However, it was obvious that membership wanted both more time to consider the name and an opportunity to add other names to the vote. It was agreed, therefore, that any comments or suggestions received would be published in the next Audiens and that a voting slip and SAE would be enclosed. This we have done. Please take time to read the following letters and comments. Ratification of the new name will take place at the AGM in January 2007.

Here is your opportunity to make your vote count.
Please complete and return your voting slip in the sae now!

Susan Rose
February 2006

Reproduced below are some of the comments from BACDA members during the discussion about the name change, at the AGM:

- A 'Good Organisation' will change as needs of members change
- 'Community Doctor' title should be changed to paediatrician
- Working practices have changed , with some members carrying out 3rd tier paediatric work full time, whereas others carry out 2nd tier for 1-2 sessions
- We need to promote members effectively and improve profile and credibility
- Audiovestibular medicine is important as was covered in Ewa's talk. She showed how the wobbly child may have a vestibular and not developmental problem, and we should be prepared to develop our expertise in this area
- We need to do the 'medicine' in the Audiology service
- We did fill a gap in service when BACDA started. In future audiologists (previously technicians, scientists etc.) will be trained in paediatric testing. We need to carry out the related medicine.
- 'Excellent proposal' Sarita Fonseca
- Jane Lyons said that she suggested the original name but now saw the need to move on
- Community label had become a problem in the last few years at times. It is possible to practice Audiology in both the hospital and community
- Community is important as things are being devolved. Community is what we are.
- The tide is changing – we should ride it or sink. As regards the community approach to child health a lot of the profession has missed the point. We don't want to lose sight of the fact that we are not 'medicalising the normal child'. In the past 'consultant' implied hospital. We are already going down this road. The initial concept was of 'home based' family centred now. Should we keep 'community' in the title?
- Joanne Harries from Bath is a consultant and feels like a community paediatrician
- Alison Hooper said community reflects child in the family, the home and school/nursery.
- Paediatrics/ paediatrician automatically now means community. 'Hospital paeds' is moving to faster discharge etc.
- Melanie Parker is concerned about label of 'vestibular' when we often are not doing this. Response – but who will be the grass roots and what will they be doing in another 10 years?
- Audiovestibular paediatrician is an aspirational title. Would he feel a charlatan to call himself an audiovestibular paediatrician?
- Is the title for public / professionals? The organisation is for professionals but the work is for the child.
- Community may exclude some who do not work in community but would otherwise be in BACDA / BAAP
- Would a title of audiovestibular frighten off those who feel they could not meet the expectation of the title. Not everyone in a speciality works in all areas.
- The original members of BACDA did not all think they knew all about audiology, as one reason to join was to learn. Same should hold for vestibular part of new title.
- BAPA – British Association of Paediatricians in Audiology
- I'm not an audiovestibular paediatrician but in an organisation that includes that I would take a history and do basic examination and refer on.
- Only 20 years ago audiology was a basic science. We want a new name to last the next 20 years.
- Lesley reported that following discussions with the RCP it was desirable to take the speciality forward to a subspecialty and to have own training and future.

Community was outdated. The flavour of the workforce discussions was that all audiology would be back to the community and possibly in the independent sector.

- We see patients and take a history and carry out an examination. We may refer the vestibular cases on. If we are changing the title then we should ensure 'medicine ' or "paediatric" is included to ensure the 'doctor' part is recognised.
- It is the right time after 20 years to change the name.
- We have been thinking about it for a long time now and it has been public with request for members' comments. The vote to change was unanimous. The exec will look at the constitution and bring to the AGM next year for ratification.
- No new name will satisfy all members. The committee came up with 2 favourites. – BAPAM & UKAAP but opened out for other suggestions.
- It was mentioned that there is already a BAPAM (British Association of Performing Arts in Medicine)
- Suggestion to remove one 'A' from UKAAP so that we are not 'you carp' but UKAP
- Other suggestions included AUKAP association of UK Audiovestibular Paediatricians, AVPUK Audiovestibular Paediatricians UK, BAPH&B British Association of Paediatricians in Hearing & Balance

Following on from comments at the AGM are letters and emails that have been received by the committee.

From: Bath and North East Somerset Primary Care Trust
To: Dr. Jane Lyons, Audiens Newsletter Editor

Dear Jane
Re: Change of name for BACDA

We are writing following the BACDA AGM on 27 January 2006 at which the change of name for BACDA was discussed. At the meeting it was suggested that if members had any suggestions or comments that we should write to you. We thought we would write to put forward the opinions of 'ordinary members'.

We both work as Staff Grade Community Paediatricians and do 2 or 3 'Second Tier' Hearing Clinics a week. This involves seeing children with neurodevelopmental or physical problems to exclude glue ear, or advise on management if glue ear is found. We rarely see children with sensorineural hearing loss.

In her talk at the BACDA meeting Dr. Hope Forsyth said that BACDA had been formed 20 years ago to represent SCMO's and CMC's who were setting up audiology clinics in the community. There have been a lot of advances over the last 20 years and SNHL and complex needs work is done in tertiary audiology clinics.
The two suggested names of United Kingdom Association of Audiovestibular Paediatricians UKAAP and British Association of Paediatricians in Audiovestibular Medicine BAPAM would represent doctors working in the Tertiary Service. However a new Staff Grade Community Paediatrician or Registrar working in a second tier clinic might not think that either of those names applied to him/her.

In order to encourage membership it would be helpful if the new name felt inclusive rather than exclusive. Omitting 'Community' and adding 'Vestibular' might give the impression that the organisation only welcomes doctors working in tertiary clinics. It is possible that there will be fewer doctors working in second tier clinics in future. But it would still be useful to include them in the organisation as some of them may be encouraged to do further training and undertake tertiary level work.

At the AGM one view expressed was that it would be better to have a name at the beginning of the alphabet, which seems sensible. This rules out UKAAP. We would like to suggest some alternative names for consideration:
British Association of Community Paediatricians in Audiology — BACPA
British Association of Community Paediatricians in Audiovestibular Medicine — BACPAM
British Association of Paediatricians in Audiology and Vestibular Medicine — BAPAVM (or BAPVAM?)
(separating audiology and vestibular medicine gives the impression that one does not need to be a specialist in both to be a member). A compromise suggestion that was made at the AGM was *British Association of Paediatricians in Audiology* — BAPA.

Of the two names put forward by the Executive Committee we favour BAPAM. We hope that these comments and suggestions are helpful contributions to the debate about the new name for BACDA.
Yours sincerely
Dr. Joanna Harries, Staff Grade Community Paediatrician,
Dr. Diana Green, Staff Grade Community Paediatrician

From: Y Delyn, LLangan, Bridgend
To: Dr. Jane Lyons

Dear Colleague,
I am writing regarding the change in name proposed for B.A.C.D.A, most recently at the A.G.M. in London on the 27th January 2006.

I feel that the names suggested do not reflect the make-up or workload of the doctors who belong to B.A.C.D.A In particular, I feel that the retaining of the title Community in the name is vital. The use of Community is not harking back to the past, as was put forward at the AGM. In fact, anyone who has been involved with looking at government proposals for the future of the NHS will know that the term 'Community' is paramount in the future planning. An example of such a report is that of the Wanless Commission findings and proposals. Likewise, "Design for Life" - a 10 year study looking to implementation of Wanless in relation to Community/Primary Care Services. Moreover,

Community does not refer, again as was implied, to working in a less than ideal setting providing a make shift service. It implies the idea of working within the Community i.e. the people of the area - engaging other agencies and disciplines thereby providing a broad brush approach and holistic overview of the needs of the children of the area.

Secondly, the term "audio vestibular" medicine. I have never undertaken any vestibular investigations during my 25 years working in Audiology. Vestibular problems in childhood are, as stated by the speaker during the annual meeting in January 2006, quite an unusual presenting problem. This being the case, and the obvious complexity related to differential diagnosis of these children, I feel that vestibular assessment should be part of a tertiary lead service referral. I therefore feel to promote myself as having experience in this area would be a false representation to the parents leading to unachievable expectations and possible harmful conclusions. To describe myself as having only an expertise in audiology is not to denigrate or belittle my abilities. In fact, it provides an honest assessment of my strengths and abilities to diagnose and support the child and family in relation to their identified needs.

On the basis of these comments by proposed new title (if one is really needed) is: *British Association of Community Paediatricians in Audiology.*

Yours sincerely,
Dr. Sue Rees, Associate Specialist (Community Child Health)

P.S. B.A.C.C.H. - does not seem to have a problem!

A NEW NAME FOR BACDA
Issues:
1 Some doctors working feel that the inclusion of "vestibular" is raising expectations of what they could provide. They also feel that the word "community" clearly describes their field of work and distinguishes them from hospital based doctors. This group might therefore want "community" included and "vestibular" excluded in the new title.

2 Others feel that vestibular medicine is an area of work that we need to be seen to be involved in. They might also feel that the word "community" is inappropriate for them because they are not based in the community and it suggests the type of service from the days when BACDA first started. These doctors might therefore want "vestibular" included and "community" excluded in the new title – the very opposite of the first group of doctors.
Resolution.
Clearly we can't keep everyone happy all the time. "BACDA" as we know and love it, includes doctors who provide a range of services, and no one group should feel excluded.

We therefore propose:
1. Removing all contentious words
2. Keeping the title short and snappy

So what do we all have in common? Well, we are all doctors, working in paediatrics, in the field of audiology

We propose:
British Association of Paediatricians in Audiology

And all we've done is to substitute "Paediatricians" for "Community Doctors" – not such a difficult change after all! How does BAPA sound to you?

Wanda Neary
Tim Williamson

How about Association of *British Paediatricians in Audiovestibular Medicine*, ABPAM?
If we don't need the British then APAM is snappier, but either way we'd be near the top of any list. Sue Shah

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From: 3 Park House, East Street, FAVERSHAM ME13 8AU
31st January 2006
To: The Editor, Audiens

Madam
Re: **Change of Name: BACDA**

The proposed modernisation of our craft organisation's name offers a timely opportunity to consider all aspects.
- It is important that we remain "British" to include our Northern Island members.
- There seems to be a desire to drop "community" from the name and to add "paediatrician" and "vestibular".
- "Paediatricians" and "audio-vestibular" will speak to our colleagues, but are not "family friendly".
- Either "Doctors" or "Paediatricians" but not both should be in the title.

Hence, I offer two alternatives:

1. *British Association of Child-health Doctors in Hearing and Balance* — (BACDHB or BACDHaB)
2. *Association of British Audio-vestibular Paediatricians* — (ABAP)
Yours, etc.

Keith Stewart, (Associate Specialist & BACDA Member)

Newborn Hearing Screening around the Country Part 2

In order to follow the implementation of newborn hearing screening Audiens has been publishing reports from members around the UK. Last edition we had a report from a phase 1 site, a phase 4 site and from Scotland. This edition includes the final 3 reports, one from Wales, one from Northern Ireland, and another from the fourth phase but this time a community site.

Newborn Hearing Screening in Wales
Elaine English, Divisional Coordinator NBHSW, Mid and West Wales

Newborn hearing screening has been fully implemented in Wales since October 2004. Newborn Hearing Screening Wales (NBHSW) is managed in a screening division with 3 other screening programmes Breast Test Wales, Cervical Screening Wales and Antenatal Screening Wales, thereby providing models for effective and efficient management of All Wales screening programmes. The Director of Screening Services has overall responsibility for all four programmes.

In mid 2002, Sally Minchom was appointed as Associate Director, followed by three Divisional Coordinators, one for each of the established divisions or areas within Wales, namely Meg Shepherd (North Wales), Amanda Roberts (South East Wales) and Elaine English (Mid and West Wales). Our initial challenge was to roll out the programme across Wales in 12 months between March 2003 and March 2004, but it became evident during 2003 that even for a team of wonder-women this was going to prove difficult! The Welsh Assembly Government agreed to an additional 6 months.

An option appraisal of equipment (OAE and AABR) was undertaken. An IT module was developed by Health Solutions Wales that linked in to and was populated by the Child Health 2000 system used by all Trusts in Wales.

Programme Managers and Divisional Administration Support were appointed for each Division as roll out progressed. As new sites came on board, teams of screeners were appointed and undertook a 5 week training programme.

The first sites to start screening were North East Wales Trust and Conwy and Denbighshire in March 2003 followed by North West Wales in July 2003, completing roll out in North Wales. Swansea and Bromorgannwg started screening in October 2003, Bro Taf in December 2003, Powys in March 2004, Gwent in May 2004 and finally Pembrokeshire, Carmarthenshire and Ceredigion in October 2004.

All screeners in Wales work to the same protocols and procedures and the same service model applies throughout the country. This has been challenging to implement because of the diversity of the country geographically, with large cities with high birth rates in the south and very rural communities with low birth rates in the mid and west. The service model is a community based programme with screening in hospital where possible. That being said, one of our standards is to achieve >75% of well babies screened within the first week – a target which is achieved on an All Wales basis (79.1%) but is not achieved in our rural counties of Powys and Ceredigion where there is no hospital based screening.

Powys presented a unique challenge being the largest but least densely populated county in Wales, with no District General Hospital. Therefore the most effective way of delivering the screen has been to train 7 community midwives who also perform newborn examinations.

Our service model differs from that in England which has again presented some issues along the border. The aim of NBHSW is to identify babies with significant hearing impairment of sufficient severity to cause or potentially cause a disability without the introduction of habilitation in infancy. While our screeners always test both ears, a one ear clear response is accepted as a "pass" although parents are given the option of another test should they wish, either before the baby is 6 weeks or at 8 months. However, high risk babies are highly recommended to proceed to assessment following a one ear clear response. The other main difference in the service model is that high risk babies in Wales are screened with AABR only.

Sally has just produced the Annual Report which reports on screening figures from the first completed year of screening across Wales.

Screening
Coverage rates are excellent with screening being offered to 99.8% of eligible babies and 99% being screened. 100% of high risk babies are completing the screening programme and in all Trusts more than 90% of well babies are completing screening within 4 weeks.

Assessment
An expected number of babies are being referred for assessment (1.2%) and the percentage of babies referred for assessment who are found to have normal hearing as a proportion of all babies screened is 0.6%, well within the 3% target. 82% of babies referred for assessment are completing the assessment process by three months of age.

Following assessment
0.96 per 1000 babies screened has permanent significant bilateral hearing loss (defined as > 40dBnHL) requiring hearing aids to be fitted where appropriate.

3.5 per 1000 babies screened have a mild/moderate or worse hearing loss (defined as > 35dBnHL in one or both ears) requiring audiological follow up.

Habilitation
Services for children with hearing loss have improved in Wales. A network of Professional Leads (Lead Paediatricians in Community Audiology services) and Audiologists has been established and every Trust now has a CHSWG. Coordinated multi-agency working has improved in all areas.

For the period 1st April 2004 until 31st March 2005, the mean age of hearing aid fitting was 5.7 months with 57% fitted within 4 weeks of confirmation of the hearing loss.

The age of identification of hearing loss in Wales prior to newborn hearing screening was 22 months in Trusts where figures were recorded. Between 1st April 2004 and 31st March 2005 the mean age of confirmed hearing loss in children was 4.8 months.

It has been a fantastic experience being involved in the implementation, development and delivery of the programme. The results we have achieved are testament to the hard work of all involved and do make us feel it is all worthwhile. An ongoing reward will be seeing the benefits for babies identified from the screen and their families.

Implementation of Newborn Hearing Screening in Northern Ireland
Dr. Anne Dooley

Background

The National Screening Committee has recommended the introduction of a universal newborn hearing screening (UNHS) across the UK, to detect children with significant irreversible hearing loss in the newborn period.
A number of pilot sites, including the Royal Jubilee Maternity Hospital, Belfast, were established to develop programme models and inform the roll out of the screening programme. Subsequently, the Department of Health, Social Services and Public Safety (DHSSPS) issued a circular "Priorities for Action 2003/04" which stated:

"*During 2003/04, Boards and Trusts should extend neonatal hearing screening with a view to achieving testing of all newborn babies by March 2005"*

A workshop was organised for the 30th May 2003 to facilitate the development of an implementation plan for Northern Ireland and to help inform Health and Social Services Boards and those involved in the detection and management of children with a hearing impairment. Prof. Adrian Davis agreed to come over to Northern Ireland and share with us the experiences of the Newborn Hearing Screening Programme in England. There was also feed back from the hospital based pilot which had been established in the Royal Jubilee Maternity Hospital in September 2002 and from the Western Health and Social Services Board where newborn screening had been in place in Altnagelvin Hospital since June 1999.

A number of workshops were facilitated, one from each Health and Social Services Board, to discuss the main issues which needed to be addressed at regional and local levels and the development of an implementation plan for their Board area.

A number of important points were highlighted particularly the need for partnership and effective communication. All boards supported a "Big Bang" approach rather than incremental implementation. They supported a hospital-based model but recognised the need for a follow up in the community, in cases of domino delivery and early discharge. They recognised the need to operate to national protocols and standards, and to have clear lines of accountability. They requested a coordinated approach to the purchase of equipment. There was a strong preference for using the Child Health System, as an effective population based system to monitor the programme and quality assurance, rather than a stand-alone system.

To take this forward, a Regional Hearing Screening Steering Group was established in November 2003 at Departmental level:

- To oversee the implementation of the neonatal hearing screening programme across Northern Ireland including the development of a regional quality assurance framework.
- To ensure that the Northern Ireland programme operates to National standards.
- To agree the dataset required to support monitoring and quality assurance of the programme.
- To advise on standards for treatment and support services for children identified through the screening programme and ensure that they are brought to the attention of relevant organisations.

Three subgroups were convened to support the work of the steering group:

1. The Regional Newborn Hearing Screening Implementation Project Team. The role of this group was to lead and coordinate the implementation of the programme across Northern Ireland.
2. The Support Services Sub-Group. This group is undertaking a review of existing support services and will report back on recommended model(s) of support services. Work is ongoing to develop agreed regional protocols for investigation, follow-up and habilitation and provision of support services.
3. The Equipment and Training Sub-Group. This group was established to address equipment needs and to

procure automated otoacoustic emission and automated auditory brainstem response screening equipment on a province wide basis. It has recently reconvened to address visual reinforcement equipment needs.

Local Multidisciplinary Planning and Implementation Groups for Newborn Hearing Screening were established in each Board area.
It soon became apparent that the target date of March 2005 was not achievable if we were to follow the "Big Bang" approach, as some Boards were able to move ahead more quickly than others. A moratorium on spending held up the appointment of new staff. A new date was set for the 1st October 2005.
The NHS Implementation Project Team circulated a letter to organisations providing Newborn Hearing Screening services identifying the necessary actions that they were required to undertake to effect the universal programme within their Trusts.

Underpinning Principles
- The NHSP will be universal and accessible to all newborns with Northern Ireland.
- The NHSP will be child and family friendly and will take account of the needs and wishes of parents at all times.
- The service will operate to regional and national standards, and in line with national protocols.

Target Population
The service will have responsibility for screening the following groups:
1 Live born babies born in (or transferred after birth to) Hospitals within each Board area. This includes babies born to non-board residents.
2 Board resident babies who missed screening for whatever reason- including home births and those born in (or transferred after birth to) hospitals outside the Board's area and who have not been screened prior to hospital discharge

Screening Model
The screening service is hospital based in the maternity units and aims to screen as many babies as possible before discharge from hospital. Babies in the community who have missed screening will be offered an outpatient appointment at the nearest hospital of their choice. The aim is to have all babies screened for hearing loss by 4 weeks of age. The Regional Steering Group has recommended that a hospital-based service should be available at least 6 days per week (including bank holidays).

Screening is provided and managed via the Audiology Services. Screeners were specifically recruited and trained either as dedicated screeners or at Assistant Technical Officer (ATO) grade. The need to recruit screeners who will work flexibly was recognised. Administration is part of the screeners' responsibilities in some Board areas. All screeners have been appointed and are in post. All have been trained in newborn hearing screening and in use of the Child Health System.

The national protocols for the screening test have been adopted. There are 3 protocols for NHS in Northern Ireland (Well Baby Protocol, SCBU Baby Protocol, Early Discharge Baby Protocol) along with the formal risk assessment process for (PCHI), with follow up at 8 months of those identified to be at risk.

Funding
Funding allocated to and ring fenced for the development of the screening programme was divided between each Board area and subsequently each Trust area on the basis of birth population. Funding allocated in 2003/04 was used to purchase the required equipment. The regional project managers' posts were funded by the DHSSPS. For the financial year 2004/05 the funding allocation (£450,000) was to have been used to implement the programme. The department held £50,000 for the project management. However, due to delays in the implementation of the programme in some Board areas much of the allocated funding was recalled. For the financial year 2005/06 the funding allocation was used to implement the programme (staffing, training, leaflets, consumables etc.) and any slippage in year will be used for activities associated with the implementation and coordination of the programme such as training and IT development.

Service Model
The service model has been agreed in all four Board areas. Two regional project managers were appointed on a part-time basis (2 days a week each) from the 1st July 2004 to the 28th February 2006. A local Newborn Hearing Screening Co-ordinator was appointed and trained for each Board area. Two were appointed for the Eastern Board (see Fig. 1)

Each Board area commenced screening on a pilot basis once staff was in place and appropriately trained. These pilots did not provide universal screening or "mop up" arrangements, the emphasis being on ensuring quality not quantity and slowly working towards screening all babies born in the hospital. All sites were up and running on a pilot basis prior to the 1st October when screening became universal. Following that date it became the responsibility of the N. Ireland programme to ensure that newborn hearing screening was offered to all infants resident in N. Ireland between birth and 6 months of age, including resident infants who were inpatients in hospitals outside N. Ireland.

Information Systems and Flows
The Project Team developed a business needs option appraisal looking at IT solutions, which was then brought to the regional steering group. It was decided to develop Child Health System (CHS) software to collect all of the eSP data set. Therefore the CHS was enhanced by the addition of a hearing module, which provides a population-based system to support the operational delivery and quality management of the programme. Funding for development of this system

Figure 1

Board area	Provider	Responsible for screening		Local coordinator
		Live births/inpatients in	Residents in	
Eastern Board	Royal Trust	Royal Jubilee Lagan Valley Hospital	North, West South Belfast and Lisburn	Sharon Brown
	Ulster Trust	Ulster Hospital	North Down, Ards, East Belfast, Castlereagh, Down	Alison Megarity
	Mater Trust	Mater Hospital	NA	Jim Cassidy *line manager of staff only*
Northern Board	United Trust	Antrim Hospital Mid-Ulster Hospital Causeway Hospital	Northern Board area	Angela McKeown
Southern Board	Craigavon Trust Newry & Mourne Trust	Craigavon Hospital Daisy Hill Hospital	Southern Board area	Wendy Webb
Western Board	Altnagelvin Trust Sperrin Lakeland Trust	Altnagelvin Hospital Erne Hospital	Western Board area	Wendy Edwards

was identified by DHSSPS.

The operational software development for CHS is completed and in place in all Board systems, with all sites using CHS to capture screening results and identify infants for mop-up and referral. CHS Bureau Offices are regularly reporting activity relating to cross boundary flow.

There have been some problems with the Quality Management Reports Specification, which will require some further development in software and has meant amendment to report design.

The Personal Child Health Record (PCHR or 'red book'), previously issued at First Visit by Health Visitors, is now being issued at time of birth by Midwives. This record acts as the vehicle for recording and sharing NHS consent status and results with parents and relevant professionals, in hospital and community settings.

The revised edition of the PCHR, containing the new NHS Screening page in quadruplicate copy for Screeners, GPs and Health Visitors, as well as hearing and speech and language checklists are now in use across N Ireland. Loose-leaf copies of the screening page are available to screeners for follow-up screening or use where the PCHR is not available.

Risk Assessment documentation, based on national guidance, has been developed for use by NHS screeners, Health Visitors, neonatal and audiology services and is now available from NHS Co-ordinators and CHS System Managers.

Equipment

Equipment requirements to support screening were identified and detailed standard specifications have been agreed for screening equipment as well as equipment and minor capital work required for CHS access for screening staff. Funding has been provided by the DHSSPS and CHS access has been established in maternity units for Screeners and Co-ordinators.

The equipment subgroup met with representatives of a number of companies looking at the advantages and disadvantages of various pieces of equipment. There was a unanimous decision to purchase Echoport IL0288USB-I supplied by Otodynamics and Algo 3i supplied by Natus. The manufacturers provided training in use of the equipment.

Health Visiting Services

Health Visiting Services continue to have an important role in the surveillance of childhood hearing impairment. The Newborn Hearing Screening Programme includes ongoing surveillance in relation to infants / children with risk factors for permanent childhood hearing impairment (PCHI).

The newborn risk assessment protocol for late onset acquired permanent childhood hearing impairment (PCHI) will be undertaken for infants born from 1st October 2005. Health Visitors will need to maintain their assessment skills regarding communication ability as part of a child's overall developmental assessment. In line with 'Hall 4' guidance prompt referral to second tier audiology services is required when parental concern regarding hearing is identified.

Audiology Services

A number of developments have taken place within

audiology services to accommodate prompt assessment of 'screen positive' referrals. These developments have included a system of prioritisation, a facility for screeners to be given appointments to parents by telephone, the implementation of a protocol for the management of non-attendees and feedback of the outcome of attendance / non attendance to GPs, health visitors, the CHS and local NHS Coordinators. This feedback includes details of all children diagnosed with PCHI, regardless of age and the source of referral.

Training and Communications
A training strategy and a communications strategy have been developed. Lindsay Kimm and staff from the NHSP Implementation Team provided initial coordinator training and trained identified staff in providing screener training. Detailed professional guidance has been developed for all staff involved in delivering the NHS programme and has been used in training. The training of midwives, neonatal, paediatric and audiology staff in hospitals is completed.

Training for community-based staff (health visiting and CHS staff), co-ordinated and delivered by NHS Co-ordinators and CHS System Managers, is also completed.

Information and awareness raising activity has taken place via DHSSPS circulars to organisations across the HPSS, as well as statutory and voluntary services involved in supporting children with PCHI and General Practitioners.

Current situation
Universal newborn hearing screening has been in place just over 3 months and appears to be working well. Operational reports are working well ensuring all babies are being captured for screening. The enthusiasm and determination of the Local coordinators knows no bounds. We are awaiting the software updates to allow the production of quality management reports. We will then review the quality management structure and processes, focusing on framework, roles and responsibilities, reporting frequency, breakdown and analysis of reports, risk management and critical incident reporting. We currently have no formal performance statistics available for N. Ireland. In our Southern Board area during the months of October and November 97.8% of newborns were screened, but only 90.51% were screened before discharge from hospital. 3.2 % were referred for further assessment but no hearing losses were identified. These figures do not meet the standards for the Northern Ireland Newborn Hearing Programme and we are reviewing our processes to improve upon them.

Information leaflets produced specifically for N. Ireland in conjunction with the NDCS are now available.

The aim of this programme is to reduce the morbidity caused by permanent childhood hearing impairment (PCHI) by achieving early diagnosis and treatment through population screening.We appear from initial reports to be identifying those children, through screening, who require further assessment of their hearing status. However the process of confirmation and treatment remains problematic as limited staffing levels in audiology make it difficult to accommodate prompt assessment of 'screen positive' referrals. Many audiology departments have identified learning needs regarding their skills in dealing with young babies and their families through the diagnostic process and delivery of early intervention. Many board areas lack a coordinated approach in the provision of early intervention.

The subgroups have now stood down with the regional group taking on their role. The work of the regional steering group continues to help advise on standards for treatment and support services for children identified through the screening programme and ensure that they are brought to the attention of relevant organisations.

A regional audit of support services is currently underway.
Distraction testing will not be offered to any infant born on or after 1st October 2005.

Arrangements for the 8-month follow up of babies identified through the screening process as requiring further audiological assessment i.e. those infants who meet the risk criteria, miss screening for any reason or have incomplete screening, are not yet in place. Locations for additional Visual Reinforcement Audiometry equipment (VRA) required to provide follow up at 8 months have yet to be finalised. Training needs will have to be identified and provided for regarding the 8-month assessment.

The Regional Steering Group has endorsed the proposal that the 8-month audiological assessment (VRA) should be provided through existing community-based audiology services. Each Area Implementation Group is to identify specific locations for service delivery. The Regional Equipment Subgroup is dealing with the detailed equipment specification.

The Future
Implementation of newborn hearing screening in N. Ireland has involved over 2 years of concerted effort by the steering groups and implementation teams who did all the process mapping, produced the care pathways, protocols, professional guidance, worked with (Electronic Data Systems Ltd.) EDS to produce the newborn hearing module for the CHS and continue to oversee performance measures and quality standards. The DHSSPS provided ring-fenced money and coordinated support throughout this process.

The National Deaf Children's Society (NDCS) in association with the regional project managers have been providing multidisciplinary training at Board and Trust level for all professionals involved in ensuring early intervention is coordinated and meets the needs of the families. We hope these will continue, developing multidisciplinary working to ensure services are family friendly. We aim to learn from the strategic development of the Early Support Programme

in England and consider how this could be taken forward in a N. Ireland context. Developing a set of standards for early intervention, auditing services against those standards, identifying the shortfall and then bidding for funding. The NDCS Quality Standards in Paediatric Audiology and in Early Years will underpin all the standards.

The NDCS is also supporting Trusts in setting up local Children's Hearing Services Working Groups.

We plan to identify a lead professional (local paediatric coordinator/lead) at each Board with responsibility for the coordination and delivery of ongoing multidisciplinary management and follow-up of children with hearing impairment.

A clinical database of "true cases" needs to be set up possibly using the special needs module of the CHS.

As part of ongoing surveillance, national protocols require that infants who are assessed to be at risk of late onset permanent childhood hearing impairment (PCHI), or those who, for whatever reason, miss or fail to complete screening, should be offered a VRA or age appropriate hearing test at 8 months. It is hoped a scoping exercise will be carried out to inform and support implementation.

Experiences of a Fourth Wave Community Site
Dr Susan Rose

I see from past notes that I organised the first meeting to discuss Newborn Hearing Screening in March 2000 and, as all of you who have been involved with drawing up business plans for NHSP will know, it can seem a lengthy and complex business. Identifying all the key players to join the steering group was the first major hurdle. I was fortunate, early on in the process, to meet a manager for Children's Services in one of the local PCTs with a background in health visiting who was as enthusiastic as I, to introduce community-based screening. She, effectively, took on the role of Project Manager until the appointment of our Local Co-ordinator.

Our site, later to be named East Surrey and West Sussex, forms an area around Gatwick Airport, stretching from its border with Croydon in the north almost to the coast in the south. It is a mixed area socio-economically, part-rural but with rapidly-expanding conurbations. It consists of 3 PCT's (East Surrey, Crawley and Horsham & Chanctonbury) and has a birth rate of 5000 (approx). Being a community site, our borders were dictated by the PCTs but none of you will be surprised to hear these do not follow the boundaries of other relevant services, namely Education, Social Services, Speech and Language Services nor indeed our own Audiology Service. The steering group became huge but somehow never seemed cumbersome and agreement was reached on how to move forward. We were particularly helped in the planning process by Dr. Rob Low, Consultant Clinical Scientist (Audiology) at Brighton who is Team Leader of a successful 1st Wave Community Site. He also provides our diagnostic ABR service, holding weekly clinics alternating between our Trust's two main hospitals and has carried out home assessments for a few babies.

Funding for our site was agreed at the end of 2003 by the National Team. The next most crucial step was to appoint our Local Co-ordinator, who was previously a health visitor team leader with ideal experience for the post. She started in April 2004 and a hectic 6 months of planning ensued .Training the 102 health visitors was completed within the space of 4 weeks largely due to her energy and efficiency. Our Audiologist and I pre-screened the babies and helped with the practical training sessions and we were all exhausted by the end of it!

As well as enthusiastic support for the Programme from health visitors and their managers, the NICU staff were, from the outset, very keen to be involved in screening. Five of them (SRNs and Nursery Nurses) have been trained and they have maintained a very good service, screening virtually all babies prior to discharge, even during their busiest periods.

The South East of England has been, in general, slow to introduce NHSP and at the time we went live only two of our neighbouring sites, namely Portsmouth and Croydon on our extreme borders were up and running. Both are hospital-based sites. Border-issues have complicated data entry and our initial cover figures seemed disappointing. However a site visit from the National IT team proved helpful and our data entry clerks are now on top of these problems. Subsequently, the rest of our neighbouring sites have gone live, all of them community sites which simplifies the border issues and means that we will be able to share training in the future.

We held the Launch of our Newborn Hearing Screening Programme on the 26th of January 2005 to coincide with the opening of our new paediatric audiology facilities at East Surrey Hospital (two high quality sound-proofed rooms very generously funded by the League of Friends). It was well-attended by colleagues from Sensory Support, Social Services, the local NDCS Group, Acute and Community Paediatricians, Managers from the acute Trust and the PCTs, as well as those directly involved in the NHSP. The Launch was reported in 5 local papers, as well as the local radio and TV stations, with a local celebrity to cut the ribbon. All those involved in both projects heaved a huge sigh of relief when it was over…but, of course, this was just the beginning!

What have been the main positive experiences?

1. Early diagnosis and support for deaf infants and their families.

In our first year, four infants with bilateral sensorineural hearing loss, two with auditory neuropathy and two with

unilateral hearing loss have been diagnosed. Of these eight babies, four were well babies, three stayed over 48 hours on NICU (although one would not have been screened by our previous more-stringent criteria for targeted screening) and one, had clear responses on her NHSP but contracted meningitis at three weeks of age. She is profoundly deaf and undergoing cochlear implant assessment. Of the other three babies with bilateral loss, one is profoundly deaf and two have moderate losses. All had early input from support services and two were aided before 4 months of age. The parents of one baby with a moderate loss decided against early aiding but subsequently accepted aiding when behavioural testing demonstrated his high frequency hearing loss. Both babies with auditory neuropathy were NICU babies and one is now being considered for aiding.

2. Team Work

The intensive process of planning and implementation has resulted in close liaison and co-operation within our own NHSP team and with colleagues in Sensory Support, Social Services and Speech and Language Therapy. In addition to the Audiology Working Group, a monthly multi-agency meeting is held in West Sussex to share information on infants with newly-diagnosed hearing loss. There are, of course, resourcing difficulties, but there have been many positive spin-offs for all services.

3. Enthusiasm of Staff

One generally expects resistance to change but instead I have encountered interest and enthusiasm from most staff. This is, perhaps, particularly surprising when, for many of them, the introduction of NHSP has resulted in additional workload. This is particularly true of the health visitors who had to continue with the HVDT for a year. The feedback at recent review days is relief at discontinuation of the latter and a sense of increased respect for their role by some parents because of the "high tech." nature of the screen.

4. Positive feedback from parents

We have not conducted a parental survey but anecdotally have received positive feedback from parents at different stages in the screening process as well as from the parents whose babies have a diagnosed hearing loss.
The mother of one of the profoundly deaf babies has volunteered to attend our staff review days with her baby and has given a moving account of "their story". Her baby had no risk factors for deafness and has always been a delightfully alert and responsive baby. The diagnosis at 6 weeks of age came as a huge shock to the family. She is an experienced mother and is convinced that she would not have been aware of her child's deafness for many months. She stresses the importance of the early diagnosis in allowing them to find effective ways to communicate.

What have been the main problems?

1. Increased workload

I have made mention of this previously and so will not dwell on it. However, the lack of additional funding for the diagnostic and support services has placed significant strain on them.

2. Change of Local Co-ordinator

After nine months of battling round the M25 to work each day, our first LC resigned. The post is crucial to the smooth-running of the programme and we had only been screening for a few months. It was an anxious time but we were fortunate to recruit another very experienced health visitor and she quickly found her feet.

3. Quality control issues

With so many staff involved in screening (some of whom carry out very few screens), problems can arise. Awareness by the LC of unusual referral patterns as well as frequent down-loading of data from the echo-check machines to cross-check with the forms is necessary.

4. IT issues and data entry

I realise that there have been significant improvements in the eSP system as a result of the experiences of the early sites. Nonetheless, it remains time-consuming and we struggle to keep up with all the data entry.

5. Parental distress

To my knowledge, we have had one very distressed parent. Her baby had unclear responses on AOAE 1 and 2 and on AABR but subsequently was found to have satisfactory thresholds on diagnostic ABR. Although she was fast-tracked at each stage of assessment, her mother found the few days wait unbearable. This is, I suppose, bound to happen from time to time but it was important for all involved to review how each stage had been managed. On the whole, I think health visitors are well-placed to anticipate particularly anxious parents and can sometimes avoid such situations developing.

All in all, it has been an eventful year. I have enjoyed most of it and learned a huge amount …..But, oh, so much more to do!

Susan Rose,
February 2006

The BACDA Prize Rules

1 The award is entitled the BACDA Annual Award.
2 Only full BACDA members will be eligible to submit work for consideration.
3 Work is to be submitted by September 30th, for consideration by the panel. If the panel agrees to make an award this will be presented at the Annual General Meeting in January. If the recipient is unable to attend the meeting the award will be presented in absentia.
4 The award will be a book token. The first presentation was in January 1993. The value of the award is currently £200.
5 The panel of three assessors will comprise, two members of the BACDA committee nominated by the committee and one non-BACDA member of academic or other recognised standing in the field of audiology. This person will also be nominated by the committee.
6 The work to be considered for the award should be related to community audiology, but any subject concerned with audiology will be considered. The presentation may be a research project, a clear audit process, an article for teaching or informing other professionals or affected individuals and their families, a literature search or something similar.
7 The work should be presented with an upper limit of 7,500 words. It may summarise work presented in a longer form elsewhere. Submitted work may be published or unpublished. Work should be presented on A4 paper, typed, double spaced with margins on both sides, referencing should be in the Vancouver style. The author's name should be on a separate detachable front sheet and entries should be signed.
8 The entries are to be submitted to the chairman who will pass them on to the panel to be judged anonymously.
9 Members of the award panel are ineligible to submit work for consideration.
10 Work submitted should be wholly or predominantly the work of the author; any help should be declared.
11 Work may be submitted by individuals or groups (where two or more BACDA members work together).
12 The award will be made at the discretion of the panel.
13 BACDA will be free to publish any submitted work in the newsletter. The winner will be asked to submit an abstract for publication in Audiens.

The closing date for this year's BACDA Prize is September 30th and entries are invited from BACDA Members.

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SIEMENS News Release

International Binaural Symposium 2005

Event examines 25 years of research and technology in binaural hearing

Leading figures in the world of audiology met at a recent high-level conference in Manchester (UK) to consider the latest research into binaural hearing and its scientific, clinical, social and economic implications.

The International Binaural Symposium 2005 (29-3l Oct.), organised by the Medical Research Council's Hearing and Communications Group, marked the 25th anniversary of the release of the influential report, Binaural Hearing and Amplification Vols. 1 & 2 (Libby, E.R., 1980).

The event attracted around 200 delegates from Asia, Africa, Australia, North America and Europe, demonstrating the importance of binaural issues around the globe. There are some 560 million people with bilateral hearing impairment in the world, a number that is expected to grow to around 703 million by the year 2015.

The dissertations of over 25 scientists and academics at the symposium offered a comprehensive and unique account of the advances made in research and technology in binaural hearing over in the past 25 years. Their papers will be peer reviewed and published in 2006 in a journal and a synopsis will be available from the MRC Hearing and Communication Group. (Tel: +44 (0) 161 275 8570.)

Presentations at the symposium covered topics from psycho-acoustic considerations and public health policy on bilateral fitting to signal processing of binaural devices and bilateral v unilateral fitting strategies.

The vast majority of speakers agreed that bilateral amplification can offer huge benefits, especially in difficult environments like understanding speech in competing speech noise, the so called 'cocktail party effect'. Bilateral amplification also helps to localise sound sources and to make following conversations in rapidly changing environments less tiring.

"The symposium also highlighted the need for improved and harmonised scientific methods to evaluate the benefit of bilateral amplification and advanced signal processing features in hearing aids," said Prof. Adrian Davis of the MRC's Hearing and Communication Group. "Traditional, laboratory-based methods often do not adequately reflect the challenging environments of today's work places and social life. Further research is urgently needed to show the benefits of personalised support from the exciting new generation of hearing aids that are being made possible by miniaturisation, by new approaches to making aids more comfortable and by demonstrating the benefits of hearing instrument technology there and then in an initial appointment."

The MRC's Hearing and Communication Group was formed at the University of Manchester in 2004. It is part of the Audiology and Deafness Research Group, one of Europe's foremost centres of excellence in hearing research. Professor Davis, a leading researcher in the area of hearing impairment, heads the team.

The International Binaural Symposium was sponsored by Siemens Hearing Instruments (UK) and Siemens Audiologische Technik, Germany.

More information on the event is available from Naomi Stocks of the MRC naomi.stocks@mrchear.man.ac.uk.

The copy dates for the next editions of Audiens are:
15th August 2006 and 15th February 2007.
Articles, letters or adverts etc. to the editor by those dates please. All submissions must at least be

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