AUDIENS

The Newsletter of the
British Association of Paediatricians in Audiology

Issue No. 40

October 2007

OTODYNAMICS advert

AUDIENS

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Thanks to Pam Williams for her work in distributing Audiens

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Editorial

A warm welcome to this the first copy of Audiens since we officially became known as the British Association of Paediatricians in Audiology. A lot of effort has gone into the whole process of change from BACDA, with the new constitution and consideration of the new logo for BAPA; one that, no doubt, like our new name will take us well into the 21st century.

This is my first editorial since taking over from Jane Lyons, who I must thank for her informative e-mails on when and what to do to put the newsletter together. However, much of the work falls to Alan Batchelor who brings together all the articles that have been submitted ready for printing and so in this age of computers the process is certainly easier for me than it was when Jane started!

The comparison between our working environment and that of our colleagues in Africa is vividly reported by Lesley Batchelor following her visit to Kisiizi, Uganda in February this year. Kisiizi is a small 200 bed hospital which was established by the Rwanda Mission in 1958 and is now run as a non government organisation. It lies in the Kigezi highlands about 4,500ft above sea level. Patients come from as far as 80 miles away to be treated.

Uganda is a country where the life expectancy for men and women is still only 46 and 47 respectively (WHO 2007) whilst the average annual income only around US $310. We may rightly worry about the support difficulties for our hearing impaired children, but we should also reflect on the opportunities that are available here free to us by way of amplification and education which is not the case for a similar child in Uganda.

Back at home the introduction of the Newborn Hearing Screening Programme has enabled us to identify and habilitate children at a much earlier age and the Quality Assurance assessments which are underway are the subject of two articles. As Susan Rose mentions in her Chairman's Report with over one third of sites now visited many of us are in the throes of preparing for or reflecting after a visit. I would welcome letters from readers around Quality Assurance for future publication.

The London Study Days have enabled speakers to keep us informed of present research projects. Most recently the BEARS project (Dr Emily Pattison) and the year before, Dr. Simone Walters' work on CMV. It is with regret that we have been requested to include the notification regarding BEARS; I for one had been eagerly awaiting the outcome of this study.

Simone however won the European Society of Paediatric Infectious Diseases prize for best presentation in Porto this spring, for her project on the relationship between CMV viral load on the Guthrie card and SNHL. I hope that I extend from us all in BAPA many congratulations on her success. Her presentation had been up against over 1000 other abstracts and came with a prize of €500 for further CMV research.

Finally, one thing that will remain the same is the name of our newsletter. Audiens coming from the Latin, listening/ hearing and is as relevant now as ever.

Jeanette Nicholls, Newsletter Editor

A new logo for British Association of Paediatricians in Audiology (BAPA)

Following the decision to change the name of BACDA, it was inevitable that the logo would require alteration too. This provided an opportunity to update the image to reflect the core values of the new organisation. Of course in one sense not much has changed – for most of the membership paediatric audiology continues to be a part of our workload in community paediatrics. Yet in other senses, and I am sure members will have discerned this though Audiens, BACDA study days and other sources, there have been tremendous breakthroughs in the field of paediatric audiology, and our new organisation embraces these enthusiastically.

The brief given to our graphic designer was to produce a logo that reflected these core values. In addition we wanted something that gave the impression of a family centred holistic style of practice, was contemporary, and that would give impact whether in colour or black and white. We wished to avoid well used motifs from the past yet also have a logo with recognisable Audiological content. As you can imagine this was no easy task, and the executive spent some time viewing the first batch of images which I have to say I felt were of excellent quality. It proved really difficult to gain consensus, so I had a face to face brain-storming session with our designer in which I presented some concepts that I had developed, some sketches from executive committee members and comments from the executive in general. I included comments given to me following the 2007 AGM in London.

The result I feel is something stylish, certainly contemporary, professional in design yet holding to our values of practising holistic family inclusive audiology. This will hopefully be ratified at the next executive meeting on 17th September. Not everyone may agree but I think we have achieved a good result for our new organisation – and of course I hope many of you will come to like the logo even if it takes a while to become as familiar a part of BAPA as the Manchester rattle logo did for BACDA.

Adrian Dighe

BAPA
Chair's Report for Audiens

We are now officially BAPA–and I feel honoured to be writing the first Chairman's Report for the Organisation!

Much work has gone on behind the scenes by the Commitee to support the name change – and I would particularly like to thank Ken Abban, our Treasurer for negotiating both with the Charities Commission and the Bank to achieve such a seamless transfer. In addition Adrian Dighe has been working with a website designer and drawing on his own artistic talents to produce logo and website designs. At the time of writing this report a final decision has not yet been made but I hope you will approve of our ultimate choice. We plan to launch the new website at the AGM on 25th January 2008.

Study Days

BAPA (Scotland) Study Day
Early Days – Dilemmas and Decisions
Monday 5th November 2006,
Stirling Royal Infirmary

This Study Day is focussing on the challenges in early intervention following the Newborn Hearing Screen and should be of great relevance to the Membership. Stirling is a lovely city and easily accessible by public transport.

For further information please contact Ruth Mackay: ruth.mackay@nhs.net

The London Study Day and First Annual General Meeting of BAPA
Friday, 25th January 2008 at SOAS

We have our usual "slot" back on the last Friday of January. The Programme is enclosed and I hope it has something to interest everyone. At present we are still functioning without a Meetings Secretary and I, together with advice from the Committee and particular help from Keith Stewart, have put together what we consider an exciting and varied Programme. Please put it in your diary –and book early.

Plans are in the pipeline for a Vestibular Training Course (probably a two day course) and for a Breaking the News Course – please look out for further details in due course.

Audiens

For most of BACDA's life Jane Lyons has been the Editor of Audiens and the Membership owe her a huge debt of gratitude for her years of hard work on our behalf. I consider the Newsletter to be very important to the Organisation and it has remained informative and accessible. Jeanette Nicholls has now taken over as Editor and will be carrying on the good work. Please consider sending her articles, letters and reviews of meetings you have attended. jeanette.nicholls@sbpct.nhs.uk

BAPA Research Award

The Committee considered it appropriate to introduce a new award both to mark the Association's name change and to promote audit and research. Please see the article on P.17 for further details. This is an exciting opportunity for you either working alone or with colleagues to produce an original piece of work – so please start thinking!

Consultation

I attended the 18 Week Pathway Consensus Event on 26th April 07 as the BAPA representative with Lesley Batchelor attending as the RCPCH representative. Three pathways were under discussion – Reduced Hearing – Adult; Reduced Hearing- Child (glue ear) and Recurrent Sore Throat. A brief overview of each pathway was given to the whole audience. Before attending group discussion on one pathway only, there was then an opportunity for informal discussion and to write post-it notes on the other two pathways. I attended the Reduced hearing/Glue Ear pathway discussion chaired by Deirdre Lucas who, together with Mark Haggard, has done the bulk of the work on this pathway. Considerable debate ensued – not least about the title of the pathway –which remains problematic. At the time of writing this report, the pathway on the website has not yet been updated.

Sarita Fonseca attended the NICE Scoping workshop on ventilation tubes on 22nd March as the BAPA representative. Both she and I subsequently submitted comments on the scope following consultation with Committee members. The Report is due out in November 2007.

Audiovestibular Medical Federation

The value of the Federation and the close co-operation between Paediatricians and Physicians has become particularly important in relation to training issues. Lesley Batchelor, as Convenor of the Special Interest Group within the RCPCH, has been working with Deirdre Lucas and Linda Luxon to promote training for Paediatricians in Audiovestibular Medicine. Susan Snashall ended her Presidency of BAAP in April 2007. She was instrumental in the establishment of the Federation and on behalf of BAPA I would like to express our thanks and our best wishes for her retirement. We are delighted to welcome Deirdre Lucas as the incoming President and John Irwin as Vice President of BAAP.

AUDIENS

I am in the process of preparing for our NHSP Quality Assurance Visit …and so time seems in short supply! It is, I suspect, common to feel somewhat threatened by the QA process – although the more mature attitude should, no doubt be for it to be helpful for shortcomings in one's service to be highlighted to and subsequently addressed by managers and commissioners. I am, however, finding that the latter change with such amazing frequency that it is hard to maintain an up-to-date contact list. Following on from the contributions of Keith Stewart and Nicky Bulmer in this edition it would be interesting to hear of members' experiences and so please write in with your thoughts to the editor.

Susan Rose, BAPA Chair

(August 2007)

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If your contact details have changed, please let BAPA know by sending your details to Ann Mackinnon

"One Ear or Two"
BACDA Study Day 2nd February 2007
Dr. Bernie Borgstein, Meeting Secretary

My second and final Study Day as the South Meetings Secretary proved to be one to remember and, whilst attempting to iron out the problems that arose on the day, I was relieved that I had already tendered my resignation!

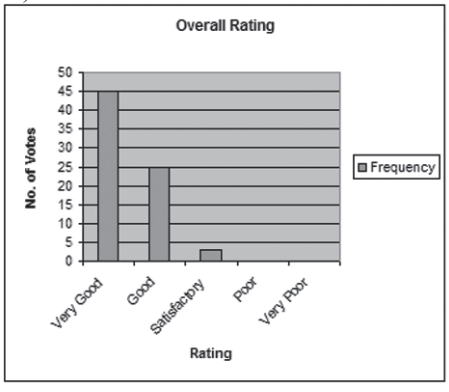
- On my arrival at 8 am some of the exhibitors had no access to power for their exhibits. SOAS staff sought out extension leads which restored the peace.
- Professor Summerfield had had to withdraw at very short notice. There was frantic discussion between the executive as to who could replace him and we were extremely grateful to Deirdre Lucas for standing in at the eleventh hour. (The feedback for her presentation was excellent. Thank you, Deirdre.)
- Andy Phillip arrived without his presentation having previously e-mailed it to Pam Williams assumed that it would have been downloaded onto the SOAS PC. Once located Pam, who was some distance away from home, headed back to e mail the presentation to SOAS. Fortunately it arrived by the time that Andy's presentation was due. Thank you, Pam.
- The last problem was the non appearance of Sarah Munro for her talk until the minute it was due to start.

After this I am pleased to say that the day ran smoothly although it took me the whole weekend to recover.

There were 120 delegates and 91 evaluation forms were returned – a 75% response rate. Thank you to all who returned forms (5 Consultants, 23 Associate Specialists, 22 Staff Grades, 2 SCMOs, 1 CMO, and 38 did not specify).

Below is a summary of the feedback.

(The figures in the 2 graphs do not add up to 91 because not all parts of the feedback forms were filled in by everyone.)

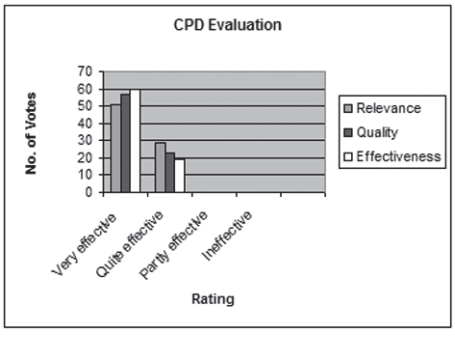


General comments

Overall comments for the day were very positive, a sample of them are listed.

- Excellent meeting, good in all aspects
- Good lunch!
- One of the best meetings here
- Fantastic meeting. Thank you Bernie
- Very important topic
- Extremely interesting & very relevant
- A very worthwhile day – very motivating
- Very interesting, well timed, informative, thought provoking overall
- Found the course very interesting, focussed and stimulating. Good lunch as well
- An excellent day as usual as I have come to expect from BACDA (BAPA). These days tend to be so much better than other study/training days. Interesting and highly relevant.
- All presentations were very clear and interesting & concise, very relevant to the way forward in paediatric audiology
- Really good meeting. Will have to rethink approach to unilateral hearing loss
- Thanks for a well organised study day
- Good venue. Lovely lunch & service. Congratulations to chairs on keeping to time. Thank you for an excellent day.
- Surprisingly stimulating. Speakers clear & fluent. Excellent organisation
- Very impressed with all speakers today
- This study day was the most relevant to our service
- Sarah Creeke gave the best presentation I have ever heard
- Excellent meeting. Enjoyed all speakers. Seating at lunch better!
- Good planning meeting organiser

Any comments for change will be considered for the coming year.



Suggestions for future courses

- Auditory neuropathy
- What about a presentation when report (school sweep) is published? My only concern is my PCT will remove reception screen before this report is out.
- Surgical intervention. Possible community and hospital based audiology services – ideas and practicalities
- BAHA – indications – current research
- Aids for unilateral hearing loss
- Feedback from Quality Assurance visits for NHSP and audiology services
- Planning medical support and input for paediatric audiology services.
- Continue to invite interesting speakers to cover updates in paediatric audiology
- Vestibular diagnosis & management/ training
- Case studies in aetiological investigations and final recommendation/protocol
- Anyone interested/could speak on e.g. MRI findings/neurological deficits with unilateral hearing losses
- Practical implications of middle ear problems on pre5 & school age children with
  - View from teachers – primary & secondary
  - View from child (possibly now a teenager/young adult) who has had (still has) middle ear problems
- Further VRA courses please
- Aetiological investigation for unilateral hearing loss – need guidelines. Gentamicin – how long to follow in clinic if have received toxic doses of aminoglycoside during the neonatal period
- Management of mild, moderate SNHL w.r.t. amplification or not in particular. Agree with need to cover vestibular material – complex though it is. Particularly the examination of children from birth onwards. Practical training would be wonderful

I would like to thank all the speakers and of course the chairs, Tim and Elaine, whose timekeeping was impeccable

I am honoured to have served as the South Meetings Secretary for the past 2 years and am very sorry to leave. Unfortunately service commitments have had to take priority.

NHSP Quality Assurance Visits –The Assessors View

Keith Stewart, Associate Specialist, Community Paediatrics, East Kent and a Quality Assurance Consultant (Audiological Medicine), NHSP for England

"There's more than one way to skin a cat". Quality Assurance (QA) visits that have taken place to Newborn Hearing Screening sites have amply demonstrated the different ways that effective screening programmes have tackled the Newborn Hearing Screening Programme (NHSP) Best Practice Guidelines (BPG). The QA programme aims to ensure:

> *high quality, effective and efficient screening services*
> *high quality, effective and efficient assessment and diagnostic services*
> *high quality, effective and appropriate child & family support & FU services*
> *a robust evaluative culture of service provision.*
> *To foster integrated, family friendly, multi-disciplinary service provision*
> *Copyright 2005 MRC*

and to ensure national (minimum) quality standards and encourage improvement. At the beginning of the QA programme, and despite working within a uniform template for the report of the visit, different teams produced reports with quite different emphasis and feel to them. The latest reports have undergone a transformation and they could now have all been written by the same person. It was a surprise to me that the Quality Assurance Board had focused on uniformity of report when the QA team members met for the second time in January, 2007. On reflection, though, QA is about a level playing-field and the BPG recommend the same requirements of each NHSP site. When I applied to become a Quality Assurance Consultant, I had not expected the process to be so formal, but the whole process of the NHS programme is structured from the top down and from the bottom up, with the MRC Institute of Hearing Research in Manchester at the centre of the process. The command structure is detailed in Table 1.

At the first meeting of (nearly) all the QA consultants at the Old Trafford cricket ground in November 2006, I was struck by the experience and authority of my colleagues. There were new faces and old friends. The task for the QA programme was daunting: There are 122 sites in England and two Ministry of Defence sites, one in Germany and one in Cyprus (I hope to be on the visiting team for that one!). The plan was to complete the QA visiting programme in 18 months.

Visiting teams are formed on a one off basis and usually contain an audiologist and/or medic, educationalist, local NHSP co-ordinator or screener, national co-ordinator and, particularly if the QA visit is to a community based site, a health visitor. There are about 35 QA Consultants and National Co-ordinators in all and a visiting team will consist of at least four members (including a Team Leader for the visit), depending on the size of the site. Each team has to

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CHAIN OF COMMAND: Newborn Hearing Screening Programme (England)

NATIONAL:	Department of Health Committees and Sub-committees
	Foetal Maternal Child Health Grp, SHAs & DoH
	National Screening Committee
	NHSP Steering Group
	NHSP Quality Assurance Board
	Programme Centre MRC Manchester
LOCAL	
	SHA, PCT, Acute Hospital Trust, Local Education and Social Services
	Team Leader
	Local Co-ordinator
	Screeners
	Audiologists, Audiological Physicians, ENT Consultants, Paediatricians
	Community Services, Doctors, Health Visitors, Speech and Language Therapists
	Local Authority Teachers of the Deaf and Social Services (Deaf Services) Early Years Support

TABLE 1

come together (usually the night before the visit) and form a cohesive, professional group. One should not be surprised how well this happens as we all have a common purpose, but the degree of support within the group is truly wonderful. Whilst the visiting team may feel daunted, the visited may be shaking in their boots. Remember, you have the home advantage; several visiting teams have ended at the wrong end of a bridle path from the hospital, thanks to the wonders of sat-nav. The visit should not be overwhelming. The National Co-ordinator who keeps an eye on your site, and whom you should know, will already have indicated any areas where the site is not coming up to scratch, so there should be no nasty surprises on the day. The particular part of your local programme for which you hold responsibility will be observed by your peer from the visiting team: it is a two way process. The QA team will support you if there are deficiencies that have not been addressed, despite your prompting to those that control the purse-strings or logistical processes. You will also be helped to look at any sticking points to find a workable solution to allow your part of the local programme to comply with the national BPG. Be entirely honest in all your replies and try not to spin, either positively or negatively. The visiting QA Consultants are extremely well briefed and incisive. Comments from individuals at the sites I have visited indicate that the QA Team's feedback has been balanced, supportive and fair.

There are always positive things happening at every site and even in the best run site, there will be something that could be improved. The main focus for the wider family of the site being visited will be the "feedback meeting" in the afternoon that concludes the visit. By the start of this meeting, the QA team will have composed its draft report. Each visiting team member will feedback on the part of the programme for which (s)he has responsibility and the team leader for the visit will reflect on the excellent and not so good within the site and report the various recommendations and their "action levels". There has been more discussion about action levels than any other part of the QA process and this is the area that has been exposed to the greatest effort to reach equity between reports. The level refers to the severity of the problem (Table 2) but also to the urgency with which it must be addressed and, as a general guide, level 1 would require immediate action; level 2 should be addressed within six months and level three within 18 months. Most "action levels" will refer to the 26 quality standards that underpin the process, and where the quality standard has "not been met", or "almost met". There are also System and Capacity guidelines that are considered within the report and these often warrant "action levels".

CLASSIFICATION OF RECOMMENDATIONS

Level 1: recommendations of this category have been made because there is a serious concern about this aspect of the service provision.

Level 2: recommendations of this category are considered to be fundamental to the quality of the service

Level 3: recommendations in this category will usually refer to issues with longer-term implications for the sustainability of the services (copyright MRC 2006)

TABLE 2

The report for the site that has been visited is written and delivered to the Programme Centre in Manchester within a couple of days, during which time, emails will have been flying back and forth between the visit team leader and members, to clarify points and make sure that the report is as accurate as possible. The stakeholders at the site will receive a draft report for comment and the final report is usually delivered within three months. This will be sent to the NHSP Quality Assurance Board and on up the chain of command. Likewise, recommended action may well come down from on high to the SHA, acute trust and PCT, and local team

leaders may use the report to support bids for resources, etc. The Programme Centre will keep a close watch on local activity in the light of the recommended actions within the report, especially the Level 1 and 2 ones.

The QA process is constantly evolving within its own best practice criteria and the site visit is now known as the NHSP Risk Assessment and Quality Assurance Support Visit. The future of the programme is in the hands of the Department of Health. If funding continues, it is likely that a further round of visits will commence when the first round finishes. There are rumours that local sites may amalgamate; if this happens, a greater uniformity of NHSP can be anticipated. There may, in fact, be only one way to skin that cat, in the future.

To find out more about the QA process, go to the NHSP website: www.hearing.screening.nhs.uk and click on "Health Professionals"

Comments, criticisms and enquiries may be sent to: keith.kpas@lineone.net but letters to Audiens will reach a wider audience.

The views expressed in this article are those of the author and may not entirely reflect those of the members of the Newborn Hearing Screening Programme Centre, MRC, Manchester.

2nd July 2007

Feedback from a recently assessed site
Nicky Bulmer, Associate Specialist Community Paediatrics and Team Leader NHSP, Wolverhampton

In February 2007, Wolverhampton hosted a visit from the NHSP Quality Assurance Team. We are a Phase 3 site, offering a Community-based screen, with a birth rate of approximately 3500 per annum. We have achieved consistently high coverage since the Screen was introduced. We recently moved into a purpose-built Children's Centre.

We made preparations as requested by the NHSP team – it was easy enough to provide the required information for the contacts of colleagues closely involved, but identifying some of the strategic leads and making sure that other supporters were not omitted proved interesting! Referral pathways, CHSWG minutes, and ASP and DEESP (formerly PASI and DESI) were submitted online. We agreed on the case histories to discuss and approached some of our parents to see if they would be willing to speak to the Team on the day (parents preferred telephone consultation rather than coming into the Centre to meet the Team face-to-face). Volunteers from the Health Visitor screeners and GPs were also sought.

Preparations complete, the chosen day arrived. I wasn't sure exactly what the Quality Assurance Team had in mind – only one had made contact a few days prior, so that at least we were able to arrange a schedule for some of those who needed to be involved and not have them on stand-by all day. We arrived early but not before the first of our visitors, and the other three arrived soon after. We left them with refreshments to discuss the format. The Team then split up to look in some detail at various aspects of the service.

The Neonatal Intensive Care Unit can sometimes be seen as a weakness in Community sites – a different Trust detached from Audiology and Community services. We were keen to show the robust and family-friendly way the NICU screen was managed. Most of the screens are undertaken by a dedicated Screening Nurse with her colleagues providing cover when necessary. We were pleased to hear that one member of the Team would be spending some time on the Neonatal Unit, and also visiting the Community Midwives. GPs and Health Visitors were spoken to on the telephone and their involvement with and knowledge of NHSP discussed.

The Team Leader for Sensory Inclusion, also Chair of the CHSWG, had a lengthy session – thank goodness we had kept comprehensive minutes and produced an annual report to demonstrate that our CHSWG was well-represented and effective. The Specialist Speech & Language Therapist and Social Worker for Sensory Impairment were also interviewed regarding their level of involvement with the newly-diagnosed infants during their early years.

The Local Coordinator spent the morning with her counterpart pouring over eSP data on the computer and also the team's admin support.

The Audiology suite was visited and it was observed that the sound treatment in our brand-new facilities was inadequate! This is an issue that we had raised as soon as we started using the facilities but has still to be resolved. The audiologist was able to demonstrate the diagnostic equipment available for the testing of infants referred to audiology by the screen. The chosen case histories were discussed.

Historically, threshold ABR has never been undertaken in Audiology – this service was developed in the EEG Department at the hospital. Whilst preparing the business plan for NHSP, we recognised the need to secure funding for ABR equipment and high frequency tympanometry.

Two Audiologists attended the Harrogate course as part of the preparation; new equipment was purchased and commissioned and the Audiologists had started to assess the unilateral ABR referrals from the Well Baby Pathway. Bilateral referrals and babies from the Neonatal Unit were

still being assessed at the Hospital. We were very aware that these arrangements would not meet the NHSP Standards so were not surprised that this was the only significant criticism raised later in the day.

We had a convivial lunch together and agreed to cancel the "optional "session as we did not have any real issues to take up with the managers. We are fortunate to reside in a zone of tranquility – one PCT, one Hospital Trust and one Children's Service for Education and Social Care. The PCT had been fully supportive of the Screening Programme from the outset.

And so for the "feedback" session. Not quite sure who or what to expect! We had informed all the stakeholders well in advance of the day. We decided that we were doing our best with the human resources available and the emphasis on 'family friendly' but were not sure how it would measure up. The Chief Executive of the PCT, Directors of Public Health & Care Services, Clinical Director for Community Paediatrics, Consultant Neonatologist, Health Visitor Manager and Head of Special Needs & Disability were all present to hear our fate.

Feedback was very positive – the Team were very impressed by our new building. They complimented us on our multi-disciplinary working, which was well-established before NHSP was introduced and strengthened by co-location of the services. Comments from parents confirmed that we had developed a seamless service and feedback about the CHSWG was also positive. We were pleased that there were no surprise criticisms of the service. A number of suggestions were made which we have taken on board and are now addressing. The transfer of the ABR service to the new Centre so that ABR, diagnostic OAEs and high frequency tympanometry can be undertaken at the same time has already occurred. Undertaking sedation procedures may take a little longer to organise, but is now in the Community Nurses' business plan. We hope that the sound treatment issues will soon be resolved by the Trust. We hope we can persuade the Social Worker for Sensory Impairment to undertake a BSL signing course to fulfil another recommendation, so that leaves us with the last significant suggestion – to think harder about the early management of moderate losses. I think this calls for a local audit of outcomes for those with 50dBHL to 60dBHL losses on initial ABR that have been identified so far and some feedback from parents about whether they would have liked aiding earlier if indeed it was needed later. We are very aware that this is not a soft option for parents.

Overall, we found the visit a positive experience. It was pleasing to see that we were on the right track. The recommendations made by the QA Team assisted us in the development of an action plan and have already been a spur for change. Although we did not have any big issues to take up with the Primary Care Trust, it is good to know that the NHSP Team are very supportive and determined to maintain the high standards the Local Teams signed up to.

July 2007

A World of Difference

Dr Lesley Batchelor
Consultant Community Paediatrician (Audiology), Macclesfield

I visited Uganda in February with a paediatrician colleague (Ian), an ENT surgeon (Mike) and a psychiatrist (Christine)!

TB, malnourished children, Typhoid, chronic osteomyelitis…..had we gone through a time warp and found ourselves in the 1880s? No! This was indeed 2007 but we were far from home, visiting Kisiizi, a remote mission hospital in South West Uganda about 400km from the capital, Kampala, Yet amongst all the poverty we found some great riches – respect for the elderly; a recognition that spritual life is important as well as the physical; a sense of community supporting one another.

Medically we saw how much could be done with very basic facilities – no microbiological culture or sensitivity reporting, limited biochemistry, oxygen from concentrators, intravenous fluids prepared on site. Drugs such as chloramphenicol are valuable where alternatives such as cephalosporins are too expensive. Falciparum Malaria is a huge problem and can affect staff as well as patients.

Patients carry their own A5 papers for outpatient visits and this is used for medical notes, lab requests and prescriptions – very efficient!

We were impressed by many of the dedicated and skilled Ugandan staff supported by a few ex-pat workers. The range of surgery is impressive with good outcomes. 'Hope Ministries' visit HIV patients and their families with holistic care. There is an excellent antiretroviral clinic.

visiting short-term doctors and medical students. Ugandan nurses act as interpreters as most patients only speak Rukiga (say *Roochigga*). Kisiizi also has a Community Based Health Care programme, a cost-sharing health insurance scheme, voluntary counselling and testing for HIV, a comprehensive nurse training school, a Rehabilitation unit, ophthalmic and dental facilities, other workshops and a Primary School.

Ian soon settled into the routine of life in Uganda whereas it

During our stay we were privileged to see the patients move from the old maternity department to a new ward block with improved facilities. This building, like many other capital expenses and equipment has been given by churches and supporters in the UK and Ireland.

The idea for the trip arose from Ian's time at Kisiizi Hospital where he was Medical Superintendent in the 1980s. Kisiizi Hospital is an NGO under the umbrella of the Church of Uganda. It is situated in the hills of south-west Uganda about 20 miles 'off road'. Located next to a spectacular waterfall, the hospital benefits from a 60KW hydroelectric generator providing electricity to the hospital and surrounding campus. The hospital was founded in 1958 on the site of an old flax factory, and has been expanding ever since. There are currently six wards; Maternity, Children's, Surgical, Medical, Infectious Diseases & Psychiatric. There are two main operating theatres and a minor theatre, laboratory, X-ray and ultrasound facilities. An Outpatient clinic doubles as a Casualty department. Some patients travel great distances over the hills (often by stretcher borne by 2 walkers) to get to the hospital. Inpatients have a relative to attend to their basic needs. A relatives' hostel is provided to accommodate them. The medical team comprises around 5 doctors, 3 clinical officers (3 years medical training but no basic science background), physiotherapist and occupational therapist, took the rest of the team a little longer! Every day began with a service in the chapel. Ian preached on several occasions. We were kept busy observing and becoming involved in activity at Kisiizi, participating in Ward Rounds, Outpatients and Community visits as well as some teaching and even physically moving the maternity ward to new premises. Mike wasn't able to operate as there were no usable ENT instruments. Those instruments, which had been donated from the UK and kept in a dusty biscuit tin, were outdated or broken. This was just one example of a whole culture shock – well-meaning folk from the UK donating out-of-date equipment in the hope that there will be someone to mend it – well – there just isn't. We saw this time and again. Countries like Uganda need new, up to date and serviceable gear. That was a lesson for me.

Christine and I were particularly interested in the work of Hope Ministries. With them we were able to make a visit on foot to a small village up in the hills where the community is involved in the support of a young family left destitute by the death of their parents, by building a new house.

As far as audiology goes I was presented with 6 children of various ages who were thought to be hearing impaired. Guymark had very kindly lent me their new hand held freefield warbler, which was all I had, as Kisiizi doesn't

have an audiometer. Testing was done in an echoey hall which serves as ophthalmology OPD. The Clinical Officer (eyes) spent the entire time making loud mobile phone call! Despite this I managed to identify 2 moderate sensory losses, a monaural (I think) 2 normals and a profound loss. This was Dorothy aged 4 who I think you met on the cover of the last issue. She had recovered from meningitis 6 months previously and was still very ataxic. She is supported by her great uncle who told me that it will be unlikely that he can find the 170,000 Ugandan shillings (about £50) per term for her to attend Deaf School.

On a lighter note, we were able to take time out to make trips to various beauty spots, sample the Ugandan roads (sorry, potholes) and observe the spectacular bird life. We were entertained to some traditional meals – often served outside in a Banda (round hut with no walls – just a thatched roof) and involving roast goat. I soon acquired a taste for Matoke, slowly roasted or steamed green bananas.

The first part of the 2 week visit was spent in Kampala. One of Ian's ex-colleagues from Kisiizi now heads the ENT department at Mulago Hospital in Kampala, the main Teaching Hospital in the country. I spent several days teaching in the ENT department, while Mike taught operating techniques and shared his experiences of Ear Camps in other countries. Part of our reason for the trip was to explore the possibility of running 'ear camps' in remote parts on Uganda, along the lines of the ones Mike runs in Nepal.

The Audiology department at Mulago Hospital is interesting. There is a test room, some 4m x 2m, which has ever-open windows onto an outside corridor or thoroughfare through Surgical OPD. The ambient noise was some where in the region of 75dBA. In the corner of the room is a very small sound-treated booth (well, there were a few tiles on one of the walls and a hole in the other). Unfortunately there was little space for the tester or patient as the one and only working and very large audiometer had to be housed in there because the electric socket on the outer side was hanging out of the wall, and had been for several years. There was no facility for testing anyone under the age of 4 or 5 years. There was one broken wooden toy. There wasn't room to do a distraction test although I was assured it was done. The patients wait 3-4 hours for audiometry. When they finally reach the front of the queue they are given a dog-eared audiogram form, which has to be taken 5 floors downstairs to the photocopier where the patient pays for a copy before they can be tested. Most losses I saw were conductive, due to CSOM. This is very common. Of course there are sensorineural losses – often due to meningitis.

There is also an 'earmould lab' where acrylic earmoulds are made in-house using a saucepan, jug and microwave. The Canadian Rotary visit every year for several weeks to support this and to bring all the materials and equipment needed. At the time I was there, the stocks were down to half a tub of impression material and some very second hand looking wax. There was also a defunct ENG recorder, 2 dead computers (no live ones at all) and a skip full of a huge GSI10 Audiometer and various accessories, donated by UK hospitals, none of which could be induced to perform.

One of the saddest things I saw in this department was a young classroom assistant from a rural School for the Deaf who had travelled many miles from the country to try to get a hearing aid, as she wanted to train as a teacher. She had missed her appointment that morning through the vagaries of Ugandan public transport. She had a profound sensorineural loss, with a little island of useful hearing at 65dB at 250 and 500Hz. The only aids available were a few sad and very second hand BE34s. The audiologist (there are two with BAAT in Mulago) decided it was worth a try. They did impressions, sent her to buy her own batteries, gave her money for a nights lodging at the University Hostel and directions to get to the recruiting office to register for a course to become a Teacher of the Deaf. She will have to return to the department for the fitting.

Mike had a few frustrations, like waiting 3 hours for an anaesthetist. On our final morning at Mulago, he was due to perform a tympanoplasty on a young girl who was clearly about 36 weeks pregnant, so it was to be done under local anaesthetic. As we stood in the theatre foyer (well – the place where you change into a pair of grubby wellies), the barefoot patient was being verbally consented, when suddenly someone came rushing in to announce that she had a Hb of 4! We decided not to go ahead.

Later that morning we were due to travel to Kisiizi, but as yet we had no idea how – we had been advised not to take the public bus. At coffee (very milky, spicy tea served in a Thermos) we were introduced to the 'Head of Burns and Plastic Surgery Unit'. It was he who (at a price) provided a 4 wheel drive jeep and driver. It seems that even the head of plastic surgery has to make ends meet somehow, and his method was to run a car hire business. I think he also had a few other businesses as well, as he offered to show me around the orphanage next door……..

Our visit finished with a Christian Medical Fellowship meeting in the grounds of Makerere University, under a shady tree, where once again we were shown generous hospitality. We won't forget our experiences and we look forward to taking some ideas forward on subsequent visits.

For more information and pictures visit the Friends of Kisiizi website:

www.kisiizi.supanet.com

Review of Midlands BACDA seminar: 10th May 2007
"The Local Practicalities of Investigating Childhood Deafness"

Audiology Perspective -
Jayne Harper, Hearing Services Centre, City Hospital, Birmingham.

In Birmingham, there are strong links between audiology, medical and educational services, which are committed to providing services underpinned by a family-friendly approach. As an audiologist, it is important when dealing with families of hearing-impaired children, to understand the other implications of a diagnosis of hearing loss, and although audiologists are not a regular addition to BACDA meetings, it was suggested by the midlands rep that this particular seminar might be of interest.

The morning session concentrated on looking at particular aspects of aetiological investigation, and the importance of considering deafness not just as a diagnosis in itself, but investigating the cause with regards to co-morbid conditions, the need for genetic counselling and the possible implications for family members. The afternoon session gave delegates a chance to discuss issues relating to their local NHSP service, and also looked at several case studies, bringing up some interesting discussion around approaches to investigation and treatment.

The seminar was very useful, as in my opinion, a multidisciplinary approach is invaluable in providing an informed, joined-up service for families we see. Occasions such as this give an opportunity to look at issues from a wider perspective, and provide a forum for improving the quality of the services we provide for families.

ENT Perspective –
Victoria Possamai, SpR, West Midlands Deanery.

ENT was well represented at the seminar with a selection of West Midlands consultants and specialist registrars attending.

In assessing children with hearing impairment a multi-specialty approach is essential. However as ENT surgeons we inevitably tend to focus on the narrow area of ENT pathology. Having worked in several departments locally, it is clear that there is no consensus regarding requests for inter-disciplinary expert opinions or specific investigations. It was therefore valuable to gain an understanding of what our colleagues in other specialties do, the different perspectives they bring, and to hear directly from them about what constitutes appropriate referral. The presentation of a large series of children assessed in Wolverhampton illustrated the frequency with which specialist assessment and investigation resulted in a diagnosis.

Uncertainty lies in whether making a "diagnosis" for which there is no active treatment or change in management is in itself beneficial. It was interesting to hear very different perspectives on this. For example, the paediatricians view that explanation and reassurance of the parents is beneficial, contrasted with the concerns from radiology regarding the justification for scanning in such circumstances due to risks involved in the sedation or general anaesthetic needed in this age group.

The discussion was enlightening, and answered many of my questions. The simple opportunity to put faces to names and meet other members of the multidisciplinary team was rewarding.

Paediatric Perspective –
Monira Mali, Associate Specialist, Stoke.

The aim of the seminar was a follow on form the NHSP meetings in Manchester and London looking at the local practicalities of investigating childhood deafness.

The day was very well organised with excellent presentations by Community Paediatricians, a Paediatric Radiologist and a Clinical Geneticist, focusing on the investigations into childhood deafness and understanding the various causes, the genetic implications and valuable use of imaging.

The National guidelines for medical investigation of bilateral severe to profound hearing impairment identified by the Newborn Hearing Screening Programme were presented and further discussions on implementation of some of the tests followed. It was evident that local variations exist due to the size of the population, availability of resources and specialist skills.

The seminar reminded us of the various congenital infections that can cause deafness; Toxoplasmosis, Rubella, CMV and Herpes Simplex virus and their mode of transmission, clinical manifestations, detection and treatment and most importantly the need for prevention.

Radiological investigations would help to identify and manage co-existing medical conditions such as neurofibromatosis, vestibular hypoplasia, Ushers syndrome, Pendred syndrome, etc and aid decisions for cochlear implantation and genetic counselling. Practicalities of conducting CT and MRI and their pros and cons were discussed in detail.

The genetics of SNHL were made clear to the participants in terms of gene nomenclature, the disorders and new technologies. It was good to hear that the geneticists and the laboratory staff were happy to discuss cases and advise.

Following the identification of a child with permanent hearing loss it is vital that a referral is made for a full ophthalmology assessment. A good source of information on this subject is: "Vision Care for deaf children and young people" produced by NDCS and SENSE

All participants would agree that the day was very useful and the difficult diagnostic cases presented were interesting and gave us food for thought. Well done to the organiser and the presenters!

Postscript

Dr Mahadeva Ganesh, Associate Specialist, Mansfield, has agreed to take over the role of Midland's rep, after an initial period co-leading with Jeanette Nicholls

Our next meeting is Thursday afternoon, 8th November, Birmingham Women's Hospital Education Centre. This follows on from the first Midland's Multidisciplinary Deafness Group meeting which will be discussing a variety of cases in the morning. Lunch will be available for those attending all day.

BEARS – EARLY CLOSURE ANNOUNCEMENT

Babies Early Amplification Research Study

The BEARS project, looking at the management of babies with unilateral (and mild) permanent hearing loss, is closing early following recruitment problems.

We should like to thank all clinicians and parents who have got involved and given us their views. Letters are going out to all sites and participating families.

To make best use of the data and knowledge gleaned over the duration of the study, we shall shortly be sending a questionnaire to all paediatric Audiology services asking about their current practice and views of best practice for unilateral and mild permanent hearing loss. We shall also be gathering more detail from participating families and sites.

If you get one of these questionnaires please please fill it in – it will help with any future research in this area and to understand the difficulties in doing research in the NHS. This will help us gather information on the following areas:

1 Costs and impact to families of intervention for baby's unilateral hearing loss

2 Clinicians' views on best practice in intervention for childhood unilateral hearing loss and mild hearing loss identified by newborn hearing screening.

3 Parental and family experience of providing amplification or not through hearing aids in babies with unilateral hearing loss

4 Characteristics of children with unilateral hearing impairment identified by newborn hearing screening.

5 Challenges in taking this type of research forward. For example, how the perceived importance of a research topic affects willingness to participate, the implications of bureaucratic delay and difficulties in involving parents and clinicians in sensitive RCTs

We will post the latest information on the MRChear website. (www.mrchear.info/cms/Resources.aspx?Action=Folder&ResourceID=3)

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The BAPA Research Award Rules.

1. The award is named the BAPA Annual Prize
2. Any BAPA member (Full, Associate or Retired) will be eligible for the award apart from members of the Panel (see below)
3. The award will be given for work that promotes the aims of BAPA, which are:
   (a) The promotion of standards in both training and professional qualifications of paediatricians working in audiovestibular medicine and to contribute to the training of other professionals working in related disciplines.
   (b) The promotion of multidisciplinary working for the benefit of children and their families.
   (c) The promotion of multidisciplinary working by maintaining and developing links with other professional bodies.
   (d) The holding of meetings, lectures and discussions in various regions and the publication at regular intervals of a newsletter for members.
4. This work can be in the form of:
   (a) a report or publication
   (b) a presentation to an educational or audit meeting
   (c) an outstanding contribution to service development and/or multi-disciplinary working.
5. Candidates can themselves apply for the Award by submitting a report or presentation. Alternatively candidates can be proposed by any full member of BAPA by submission of a citation.
6. The Awards Panel will comprise three assessors, two of whom are BAPA members (one of whom is a committee member) and one non-BAPA member who is actively involved in children's hearing services. The Panel will be nominated annually by the Committee.
7. Submissions should be sent to the Secretariat or Chairman by 30th September each year for consideration by the Panel. If the Panel agrees to make an award this will be presented at the next BAPA Annual General Meeting. If the recipient is unable to attend, the award will be presented in absentia.
8. The award will be in the form of tokens of the recipient's choosing. The value of the award is currently £250.

The copy dates for the next editions of Audiens are:

15th February 2008 and 15th August 2008.

Articles, letters or adverts etc. to the editor by those dates please.

All submissions must at least be typewritten, and preferably on disc or by Email.

BAPA Study Day and first AGM

Friday 25th January 2008
School of Oriental and African Studies
University of London
Russell Square

Provisional Programme

9.30	Registration	
	Chair, Dr. Sarita Fonseca	
9.55	Introduction and Housekeeping	
10.00	The Global Impact of Hearing Impairment	*Dr. Ian Mackenzie*
10 40	Pneumococcal Vaccine and its Impact on Hearing Impairment	*Dr. Mahein Hussain*
11.20	Coffee	
11.45	Cytomegalovirus – a Parent's Perspective	*Carmen Burton*
12.15	Is SNHL a new feature of the Metabolic Syndrome	*Dr. Marie Louise Andersson*
12.55	Lunch and exhibits	
13.45 - 14.30	**BAPA AGM**	
	Chair Dr. Ann Mackinnon	
14.30	Management of OME	*Mr. Peter Robb*
15.10	Audiological Medicine in the Dark Room	*Dr. Kate Broome* *Dr. Dolores Umapathy*
15.50	Neonatal Splintage of Ear Deformities	*Mr. David Gault*
16.30	**CLOSE OF MEETING**	

Change of address or other changes? If any of your details have changed, please let BAPA know by sending your details to Ann Mackinnon : ann.mackinnon@tuht.scot.nhs.uk

Please be sure to let her have the following:

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