Audiens Interactive

The Newsletter of
The British Association of Paediatricians in Audiology
Newsletter 52
Summer 2014

BAPA is registered as a charity, No.1142712

amplivox

Success with tympanometry

The Amplivox Otowave is ergonomically shaped to ensure tympanometry can be completed quickly, and with confidence and accuracy.

Intuitive to use, test results can be printed, saved in memory or exported electronically.

Designed for portability, the Otowave can be used for both clinic and mobile requirements.

- **Totally portable**
- **Intuitive use**
- **Large graphics display**
- **Programmable reflex test**
- **Optional portable printer and PC interface**
- **No external power or data cables**

Tel: +44 (0)1865 842411
E-mail: sales@amplivox.ltd.uk
www.amplivox.ltd.uk

World class solutions for audiological and occupational health requirements

AUDIENS EDITOR:
Dr. Anne Marsden
Email: anne.marsden@nhs.net

***BAPA SECRETARIAT**:*
Mrs. P Williams,
23, Stokesay Road,
Sale, Cheshire M33 6QN
Tel./answerphone: 0161 962 8915
Fax: 0161 291 9398
Email: pamelawilliams@onetel.com

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

Audiens is prepared for publication by:
Alan Batchelor
167, Chester Road,
Macclesfield, Cheshire. SK11 8QA
Tel. 01625 425087,
Email: alanbatchelor@hotmail.co.uk

Contents

AUDIENS

CONTENTS

Advertisers

.

The BAPA Executive is comprised of the Directors/Trustees, the regional representatives and the other members as listed.

Directors/Trustees

Kathleen Coats	*Chair*	
Gillian Painter	*Past Chair*	gill.painter@cmft.nhs.uk
Ken Abban	*Honorary Treasurer*	ababio@ic24.net
Veronica Hickson	*Honorary Secretary*	veronica.hickson@wales.nhs.uk
Adrian Dighe	*SIG Convenor to RCPCH*	Adrian.Dighe@sirona-cic.org.uk
Jane Lyons	*Rep to BACCH*	jane.lyons@nhs.net

Other members of the executive

Rosamund Aylett	*UKCoD Rep (co-opted)*	Rosamund.Aylett@esth.nhs.uk
Winifred Baddoo	*NE and Yorkshire Rep*	Winifred.baddoo@nhs.net
Anne Large	*Meetings Secretary*	ann.large@wwl.nhs.uk
Mahadeva Ganesh	*Midlands Rep*	m.ganesh@telfordpct.nhs.uk
Esther Harper	*Northern Ireland Rep*	esther.harper@westerntrust.hscni.net
Ruth Henderson	*Scottish Rep*	ruth.henderson@luht.scot.nhs.uk
Georgia Jackson	*S. East Rep*	georgia.jackson@royalberkshire.nhs.uk
Anne Marsden	*Audiens Editor*	anne.marsden@nhs.net
Shanker Rangan	*NW and N Wales Rep*	srangan@nhs.net
Claire Wilson	*SW and S Wales Rep*	claire.wilson4@wales.nhs.net

Contents

Editorial:

Dear All

For those members able to attend the January conference and AGM this year, I hope you agree that it was a highly successful event (some presentations are on the BAPA website). Themes (to be confirmed) for next year's meeting are OME, viral infections and hearing loss, and neuroplasticity of the auditory system.

One theme of the 2014 meeting was surgical and genetic aspects of cleft palate management. This edition of Audiens includes a thought provoking article on a study of parent and child perspectives of managing a hearing loss in this group of children.

The introduction of the BAPA audit prize was a welcome addition to the conference and it was encouraging to see students and trainees involved as well as BAPA members. There were no submissions for the BAPA prize this year. Please consider applying. It might be your involvement in, developing guidelines, service development, multidisciplinary working…..

An example of multidisciplinary working is shared in this edition by Jane Dalzell and colleagues in the development of care pathways.

One role of BAPA is to be involved in influencing the national developments in paediatric audiology. Ruth Henderson, outgoing Scotland rep, updates us on the development of Care Standards for microtia and meatal atresia. The final document is due to be launched very soon.

Dates for your diary:

- Submit your entry for the BAPA prize (regulations on the BAPA website) by 30 September 2014
- Submit your entry for the BAPA audit prize by 25 November 2014
- BAPA AGM and conference, London 30 January 2015

Anne Marsden *June 2014*

The executive committee has met on four occasions during the year to oversee the business of the association. We have continued to be able to meet at RCPCH and have the assistance of the BACCH secretariat with minute taking and maintaining the membership.

At the last AGM it was agreed that we would make more use of email communication with our members. This got off to a slow start for a variety of reasons, one of which was trying to verify the email addresses of all the members. In the autumn, the first electronic version of Audiens was circulated, not without a few problems because for many people the mailing went in to their spam. The regional representatives have been working hard to try to ensure that all their constituents received the mailing.

We have had a number of meetings this year to discuss loss of posts and lack of training opportunities in paediatric audiovestibular medicine. In April, Adrian Dighe and I had a meeting with the GMC. It was suggested that the problem of getting training in paediatric audiovestibular medicine might be addressed by accreditation which could feed in to credentialing which the GMC is piloting in a few subspecialties. Following this we wrote to Dr Hilary Cass, president of RCPCH. She expressed an interest in this route to training but suggested that we should wait until the Shape of Training consultation was released. This is a framework for future post-graduate medical training (see www.shapeoftraining.co.uk) and was published in October.

In December Adrian and I had a meeting with Cliona Ni Bhrolchain, representing Community Paediatrics from the college, Katherine Harrop-Griffiths and Tony Sirimanna to discuss the way forward. It was felt that it might be possible to combine training in community paediatrics with that in paediatric audiovestibular medicine within a three year period and this proposal is being put to RCPCH. To help to quantify the problem within paediatric audiology we are devising a census for members to complete on survey monkey which we would be grateful to all BAPA members and any non members who work in the field for completing.

Audiological scientists have been developing a curriculum for higher specialist training in audiological science and BAPA has been asked to comment on this on behalf of the RCPCH.

There have been meetings during the year on Commissioning of Paediatric Audiology Services; the general feeling is that the development of local networks is going to be the way forward for these services.

BAPA and BAAP continue to work together as the Audiovestibular Medical Federation. Adrian presented an audit on audiological assessments for cleft palate children in his service at the BAAP audit meeting in November. We are also contributing to the development of guidelines in a number of areas such as aetiological investigations, progressive hearing loss. I would again encourage you to attend the BAAP annual conference which will take place on 20th and 21st March 2014 at Latimer Place in Chesham.

We have provided comments to a number of consultations throughout the year; NICE "Looked-after children and young people – Review proposal of public health guidance". Ruth Henderson and I attended a meeting in Bradford where a start was made in establishing care pathways and standards for children with microtia.

BAPA jointly organised a session with BACCH, BAAF and the child protection interest group at the RCPCH conference in Glasgow in June with the title "Effective Interventions in Vulnerable Children". There were very few attenders from audiology and we have decided not to participate in this conference next year.

BACCH held its Annual Scientific meeting in October and Jane Lyons delivered a workshop on "Is this child not hearing or not listening?" The feedback from this was very positive.

We were delighted to welcome Georgia Jackson onto the executive committee as regional representative for South East and Clare Wilson for South West/South Wales. The regions continue to hold local meetings with varied topics being discussed.

The 50th edition of Audiens was a fitting final edition from Jeanette Nicholls and Anne Marsden has taken on the role of editor producing the first electronic edition.

Lastly I would like to thank my fellow committee members for all their hard work and support over the year. They always promptly respond to requests for help and information making the work of the chair much easier. The two years of my chairmanship have passed very quickly and I wish Kathleen all the best for her tenure as chair.

Gill Painter

BAPA Chair

BRITISH ASSOCIATION OF PAEDIATRICIANS IN AUDIOLOGY

TREASURER'S REPORT

FINANCIAL YEAR ENDED 30 SEPTMBER 2013

It is my pleasure to present the BAPA Treasurer's Report for the year ending 30.09.2013 and to fulfil our obligation to the Companies House and Charity Commission as appropriate. The scrutiny of BAPA accounts by the accountants has been undertaken, our balance sheet is healthy and the report will also be made available in the Audiens Newsletter.

The Association, through its Directors, Trustees and Executive, continues to fulfil its planned activities and achieving a very small surplus thus steering away from trouble. We are a small organisation; and funding, in the main, is from Membership Subscriptions, Association Meetings, Exhibitions and Advertising in Audiens Newsletter. These are difficult times now as recruitment has fallen and the number of retired members has risen. We now have fewer Exhibitors and the number of Audiens advertisements has also fallen.

The balance sheet has not strengthened the way we would have liked. Investment income has dropped considerably over the last few years showing how hard the economic down-turn is biting. We, therefore, need prudence in our expenditure.

Our Net Balance Sheet is £36,000 and it shows that there are sufficient funds, enough to pursue our programmes for this year. The Company will continue to ensure that sufficient income is generated to meet its objectives in a professional, efficient and cost effective manner, in accordance with Companies House and Charity Commission's regulations and guidelines.

I would like to thank Mrs Pam Williams, our Secretarial Secretary and Isabelle Robinson, Secretary to the Executive, for their support for making it possible for our Association to function effectively.

Finally, I would also like to thank the Executive Committee Members, the Directors, Trustees and you the membership for helping to maintain the accounts in a healthy state of affairs.

KEN K. ABBAN

HONORARY BAPA TREASURER

18th January, 2014

Regional Representatives

Liaison between members in the area and reporting back to the Quarterly Executive meeting are the main duties of the Regional Representative. Organisation of local meetings is encouraged.

Reports from around the Regions

Report from Yorkshire and the North East.

Our BAPA group in Yorkshire and the North East consists of 22 members. We manage to meet 6 monthly in Doncaster with a group of 6-10 of us at any one meeting. Ideas for presentations and contributions are happily made from all the members of the group.

In this last year we have divided our half day meetings between peer reviewing cases and other presentations of interest. Both these areas stimulate interesting and helpful discussions.

Cytomegalovirus infection causing hearing loss is a huge area always discussed within and outside peer review. This is an area that we all feel needs more attention from the point of view of diagnosis (and possible universal neonatal screening), treatment of the infection, and management of deafness and the child as a whole. We have learnt a lot from different members of our group as practise around the country varies greatly.

Social care and deafness, and meeting the wider needs of the deaf child is also a concern. Presentations and on-going discussions have enlightened a lot of us on how added input, such as specialist health visitor involvement, might maximize the positive management of deaf children.

A presentation on Waardenburg's syndrome high-lighted the fact that we all seem to be picking up more cases of Waardenburg's syndrome than the literature suggests.

Winifred Baddoo (winifred.badoo@nhs.net)

Report from Scotland

BAPA Scotland continues to meet regularly, three times a year, at Perth Royal Infirmary, with an average attendance of 8 members

Our annual regional AGM was held at our meeting on 6th March 2013, with no changes to the current office bearers:

Chair: Ruth Henderson

Vice Chair: Christine Niven

Secretary: Martina Stones

Treasurer: Alison Schulga

The business component to our meetings covers a variety of topics and continues to review Newborn Hearing Screening across the country, with continued excellent coverage, but ongoing challenges with the IT transition from eSP Northgate to using SBR (Scottish Birth Record) as the system for recording screening data.

Quality assessment visits currently continue annually across Scottish Health Board areas.

Quality Standards for Transition in Audiology were launched in August 2013 by the paediatric subgroup of the Audiology Services Advisory Group (PASAG) and NDCS. Audiology services will be asked to "self-assess" against these standards and in future will be measured against them. It is hoped that good practice can be shared and improve this area of audiology care.

PASAG also continues to work on the implementation across Scotland of the "Local Record of Deaf Children" and collection / collation of a central database of patient information leaflets. Two members of BAPA Scotland sit on PASAG.

In the clinical component to our meetings we regularly have case discussions and peer review / support. At our November meeting we invited a paediatric ENT consultant to join us for an informal teaching session on middle ear problems, and all in attendance found this extremely useful.

We are in the planning stages of arranging a BAPA Scotland study day on balance disorders which will take place in Edinburgh on 7th November 2014.

The next BAPA Scotland meeting will be on 5th March 2014

Ruth Henderson (ruth.henderson@luht.scot.nhs.uk)

Report from South East

I took over as regional representative for the SE just a few months ago, so am still very much finding my feet, having attended just one BAPA executive meeting so far to find out what is involved. There have been no local BAPA events in the recent past, so this is a future goal for me. However, I am already part of a "clinical network" of paediatricians seeing children with hearing impairment in the Thames Valley area, and slightly further afield. We meet every few months to share interesting cases, updates and to hear a talk on a topic of interest. Through this network we have driven local guidelines for early testing of CMV and have collaborated on an audit of aetiological investigations which covers 5 centres and their sub-regions (prompted by the NHSP Quality Assurance process). It may be that this sort of set-up can be replicated across the region more widely, or we could extend one of our meetings to involve other BAPA members too.

One of my first tasks is to update my contacts list for SE members; I have been trying to track down members whose email addresses are now defunct and my next step is good old-fashioned snail mail. I plan to write to all those members whom I fear we are not accessing, to ensure that we our contact details are as up to date and accurate as possible. I should then be able to find out a bit more about what our members in the SE would like from BAPA and how we can achieve this.

I have never taken on a role like this before, so I am a little daunted but look forward to the challenge!

Georgia Jackson (Georgia.jackson@royalberkshire.nhs.uk)

Report from Midlands

The Regional Representative for the Midland region is Dr M Ganesh.

He can be contacted at m.ganesh@telfordpct.nhs.uk

Report from Northern Ireland

The Regional Representative for Northern Ireland is Dr Esther Harper.

She can be contacted at esther.harper@westerntrust.hscni.net

Report from South West and South Wales

The Regional Representative for South West and South Wales is Dr Claire Wilson.

She can be contacted at Claire.wilson4@wales.nhs.uk

Report from North West & North Wales

The Regional Representative for the North West & North Wales is Dr Shanker Rangan.

He can be contacted at srangan@nhs.net

Development of multidisciplinary care pathways and a service specification for paediatric audiology services in Cheshire.

Andrea Curran, Jane Dalzell, Susan Donald, Liesel Warren (Cheshire CHSWG)

Contact: susandonald@nhs.net or andrea.curran@nhs.net

It is widely acknowledged that the service provision for children with permanent hearing loss is multidisciplinary. As a consequence of this, a process of ensuring the service is streamlined and well integrated is essential for both service providers and users. In the past, working groups were established involving professionals from key services to monitor and develop integrated service delivery. More recently, membership has widened to include service users and other agencies and these groups are described as Children's Hearing Service Working Groups (CHSWGs). An important function of a CHSWG is to acknowledge and address issues arising in children's hearing services as identified by both service users and providers. The CHSWG provides a means of highlighting such issues to the relevant commissioning bodies in order to further develop and improve multidisciplinary services1.

Since the introduction of the Newborn Hearing Screening Programme (NHSP) there has been a systematic development of national guidelines for hearing screening and paediatric audiology services (e.g. those provided by NHSP, National Deaf Children's Society (NDCS), Department of Health) commonly underpinned by Quality Assurance. Good practice guidance (e.g. NDCS Quality Standards, Modernising Children's Hearing Aid Services protocols and NHSP Recommended Procedures) recommends that every local service for deaf children should have a CHSWG that functions on both a strategic and operational level. In Cheshire, the CHSWG includes representatives from paediatric audiology and paediatrics, local commissioning groups, sensory support services (hearing impairment), speech and language therapy, parent representatives, social care and third sector organisations including local deaf children's society (DCS) groups and other voluntary organisations serving Central, East and West Cheshire. However, as yet, participation and attendance at meetings is voluntary. There is no formal ownership of the group and therefore a lack of overall accountability for the multidisciplinary service.

Based on the NHSP Quality Assurance recommendation that CHSWGs become more strategic rather than operational, Cheshire CHSWG has developed a blueprint for a multidisciplinary service for children with hearing impairment based on national guidance and with input from service users and other disciplines. Part of the rationale for this was to standardise a service spread over the large geographical area of Cheshire where historically three Audiology services had developed. Operationally these services were very different, yet overlapped in their involvement with other agencies.

A subgroup of the Cheshire CHSWG, consisting of NHS paediatric audiology based clinical scientists and paediatricians, was formed to work on developing the patient care pathways. The aim of these care pathways was to map out paediatric audiology and its interactions with other agencies or services for hearing impaired children across Cheshire. The care pathways contribute to the ongoing development of a service specification for paediatric audiology. The care pathways outline services for hearing impaired children, from birth to transition to the adult audiology services. They are divided into four categories: - birth- twelve months; twelve months – four years; school age children and transition to adult services. Where appropriate, pathways from the Map of Medicine have been integrated. In producing the care pathways local services were accounted for (for example voluntary organisations and local commissioning groups) but significant references were also made to guidelines and recommendations available nationally. These included (but were not limited to) those published by the NHSP, the NDCS, the British Academy of Audiology, the British Society of Audiology, the British Association of Paediatricians in Audiology and the Department of Health White Papers. These documents underpin all work carried out in paediatric audiology services.

The service specification is being developed using the NHS Standard Contract Document for 2012/2013 using five mandatory sections with subheadings as agreed locally.

Section 1 describes the evidence base for the description of this service model and includes the references supporting the care pathways. The reference list is not complete as new guidance and policy may determine modification to the existing pathways. It will therefore be important for there to be a good working relationship between the service provider and NHS GP Commissioning Groups.

Section 2 describes the aims and objectives of the service, the service description/care pathways and details the discharge process, requirements for families subject to child protection, acceptance and exclusion criteria and interdependencies with other services.

Section 3 outlines applicable service standards specifying Key Performance Indicators, a threshold and method of measurement and outcomes of any breach. This also describes the communication requirements of the service.

Section 4 of the service specification is to detail outcome measures used to monitor the service including feedback from the parent subgroup of CHSWG to ensure that outcome measures relevant to families are included. This group of parents represents all families who attend local audiology services, and is proactive in bringing feedback to CHSWG from parents who do not attend meetings. Parents felt that the objective measures commonly used as a service standard (for example NHSP Key Performance Indicators 1 & 2) were not meaningful to the family. One of the outcomes suggested by parents as a measure of an effective multidisciplinary service is that their deaf child "enjoys life, is happy and healthy". Parents have suggested introducing a routine questionnaire: 'How my child is feeling' with contributions from the child, parents, and practitioners including space for an action plan for immediate implementation. See Table 1.

Section 5 describes the need for the service to be delivered at locations convenient for service users, with suitable facilities meeting the relevant national standards.

The care pathways and ongoing development of the service specification highlight the complexity of the service we offer hearing impaired children; however it was felt important to document the involvement of other agencies in the multidisciplinary service in order to effectively advise commissioners. As Cheshire CHSWG becomes more strategic, it is anticipated that it will become acknowledged as a valid advisory group to the local commissioning bodies.

The care pathways and references can be viewed in the member's area of the BAA website www.baaudiology.org.

Figure 1 shows an example of part of a care pathway.

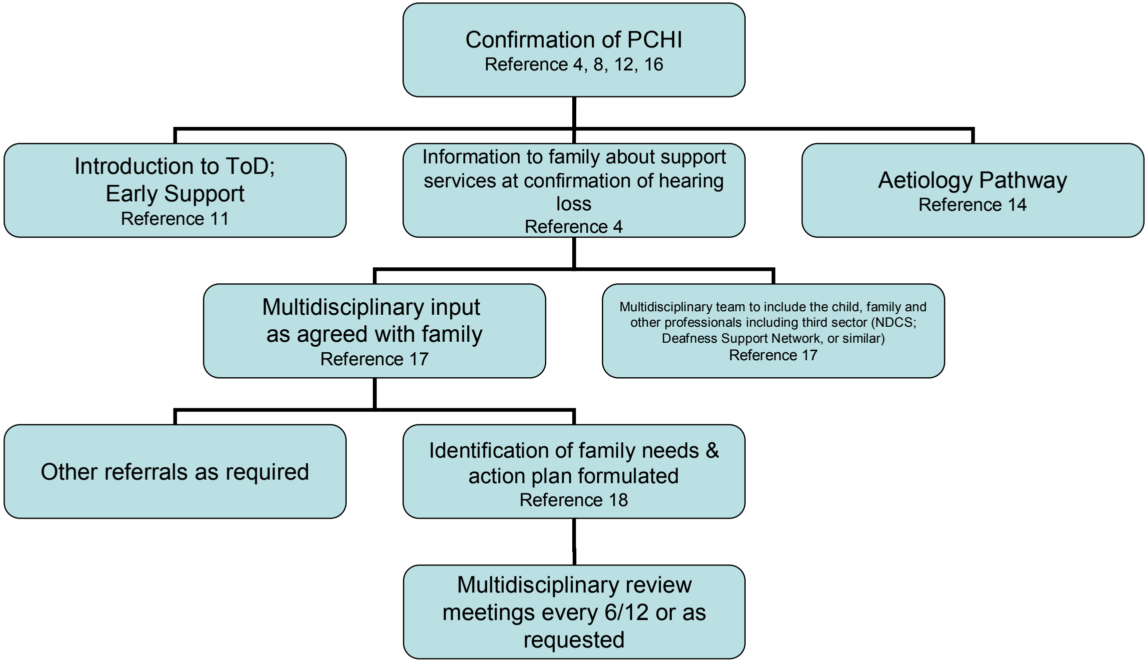
References

1. NHSP Children's Hearing Services Working Group (CHSWG) Guidance v1.1 (July 2010), MRC Hearing & Communication Group

Acknowledgement is also given to Dr Lesley Batchelor for her contribution to earlier versions of this work.

Figure 1. Example of a care pathway for paediatric audiology

Paediatric audiology care pathway 0-12 months
1. Child and family support



Confirmation of PCHI
Reference 4, 8, 12, 16

Introduction to ToD;
Early Support
Reference 11

Information to family about support services at confirmation of hearing loss
Reference 4

Aetiology Pathway
Reference 14

Multidisciplinary input as agreed with family
Reference 17

Multidisciplinary team to include the child, family and other professionals including third sector (NDCS; Deafness Support Network, or similar)
Reference 17

Other referrals as required

Identification of family needs & action plan formulated
Reference 18

Multidisciplinary review meetings every 6/12 or as requested

Table 1. Suggested service standards for paediatric audiology

Performance Indicator	**Threshold**	**Method of Measurement**	**Consequence of breach**	**Report Due**
KPI1 screen coverage	95%	NHSP Trends	Exception Report	4-monthly via CHSWG; Commissioners have access to NHSP Trends at any time
KPI2 NHSP referral to 1st attended audiology appointment	90%	NHSP Trends	Exception Report	4-monthly via CHSWG; Commissioners have access to NHSP Trends at any time
Time for Permanent Childhood Hearing Impairment in babies to be confirmed	80% by 6 months old 98% by 12 months old	NHSP National Report NHSP Trends	Exception Report	Commissioners have access to NHSP Trends at any time
For PCHI cases, referral to Education Services within 1 working days	100% unless declined by parents	Local audit (eSP)	Exception Report	Data from eSP as required
For PCHI cases, time from decision to aid to fitting the hearing aid(s) is ≤ 4 weeks	100% unless deliberately delayed for management reasons	NHSP National Report	Exception Report	Data from eSP as required
For PCHI cases, parents offered aetiological investigations within 6 months of confirmation of PCHI	100%	Regional audit	Exception Report	5-yearly or as decided by regional group (North West Paediatric Audiology Audit Group) due to small numbers of PCHI
Babies requiring targeted follow up from NHSP to be offered 1st assessment by corrected age 9 months	100%	NHSP National Report	Exception Report	Data from eSP as required

Audiology assessment of children with confirmed/suspected bacterial meningitis within 4 weeks of referral	100%	Local audit	Exception Report	1-2 year audit (depending on number of cases)
All other referrals –first appt offered to be seen within 6 weeks of referral	100%	DMO1 Trust IT system	Exception Report	Manager’s monthly reports
Children with OME and associated hearing loss offered review to monitor persistence of hearing loss within 3 months	100% unless deliberately delayed for management reasons	Sample local audit	Exception Report	1-2 year audit of sample cases
Parents want their deaf child to enjoy life, be happy and healthy.	100%	Routine questionnaire : ‘How my child is feeling’	Exception Report	NDCS survey using questionnaire 5 yearly showing credible emotional health linked data for individual children informing their monitoring and progress
Increased parental feedback to service interventions.	100%	Parental feedback invited re service interventions while agreeing individual management plan. Parents invited to CHSWG meetings.	Exception Report	Ongoing evaluation of individual managements plans and use of listening questionnaires giving parents an increased range of mechanisms to generate parent and user feedback
Parent expertise is sought to support a child’s learning and development.	100%	A ‘Valuing Parents’ principles paper is established and applied by way of ‘sign-up’ across all local agencies supporting deaf children and young people.	Exception Report	NDCS survey using ‘Valuing parents’ questionnaire 5 yearly showing that parents are true partners and valued

Attendance of representative at regional CHSWG meetings to be held at least three times per year	67%	CHSWG meeting minutes and attendance list	N/A	Recorded in CHSWG meeting minutes
Levels of satisfaction with the service.	80% satisfied, or very satisfied	Service user feedback via survey	Exception Report	Every 3 years
Number of Paediatric Audiology staff who have completed Safeguarding Children training, including Domestic Abuse training (at Level 3).	100%	Trust electronic staff register Number of staff attending relevant training	Exception Report	Trust training record
DNA rate for first appointments.	≤ 20%	No. of first appointment DNAs	Exception Report	Recorded by hospital patient management system
DNA rate for follow up appointments.	≤ 30%	No. of follow up appointment DNAs	Exception Report	Recorded by hospital patient management system

Those service standards in RED are qualitative and dependent on the cooperation of service users and families for evaluation.

Multidisciplinary care pathways for paediatric audiology services in Cheshire

Countess of Chester Hospital NHS
NHS Foundation Trust

East Cheshire NHS
NHS Trust

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Andrea Curran, Jane Dalzell, Susan Donald, Liesel Warren
Cheshire CHSWG subgroup

January 2014

Contents

Contents

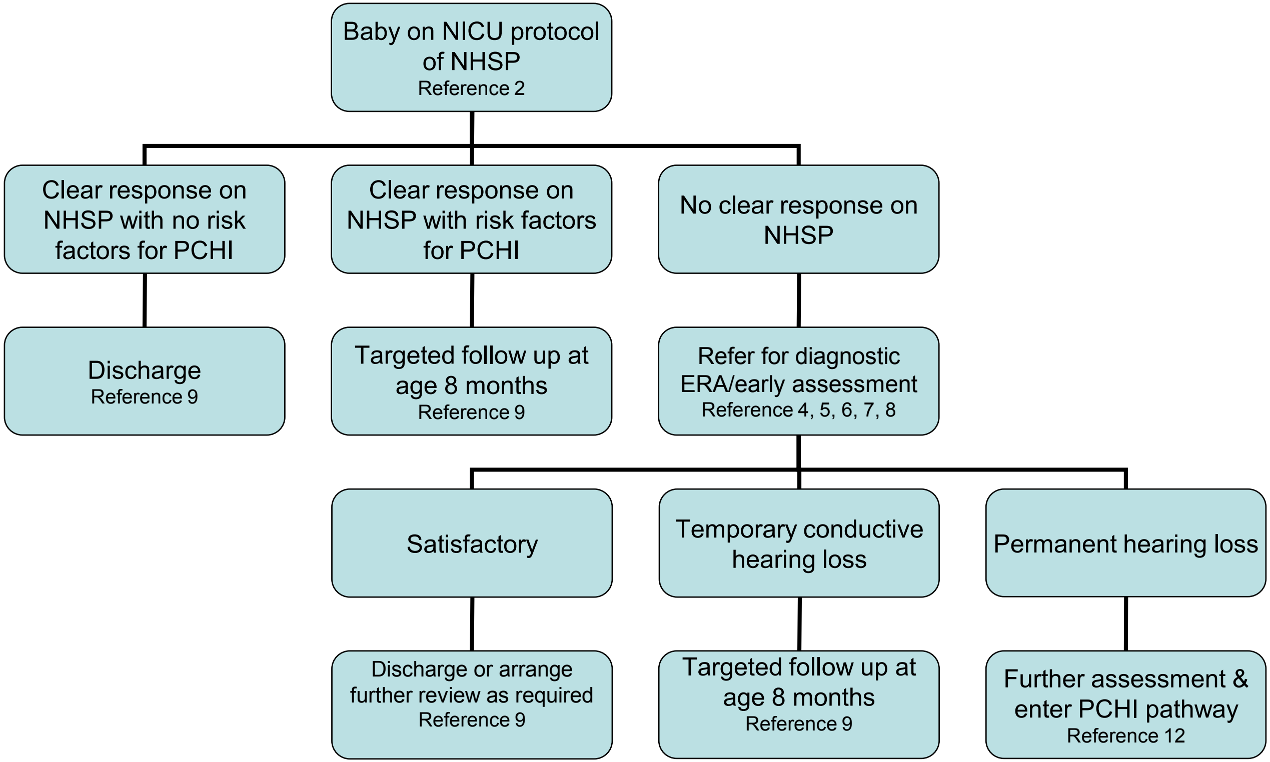
0-12 months care pathways

Initial Assessment: 0-12 months
1. Missed newborn hearing screen

Missed/did not attend appointments for Newborn Hearing Screening Programme

Discharged
Reference 1

Initial Assessment: 0-12 months
2. NHSP NICU protocol



Baby on NICU protocol of NHSP
Reference 2

Clear response on NHSP with no risk factors for PCHI

Clear response on NHSP with risk factors for PCHI

No clear response on NHSP

Discharge
Reference 9

Targeted follow up at age 8 months
Reference 9

Refer for diagnostic ERA/early assessment
Reference 4, 5, 6, 7, 8

Satisfactory

Temporary conductive hearing loss

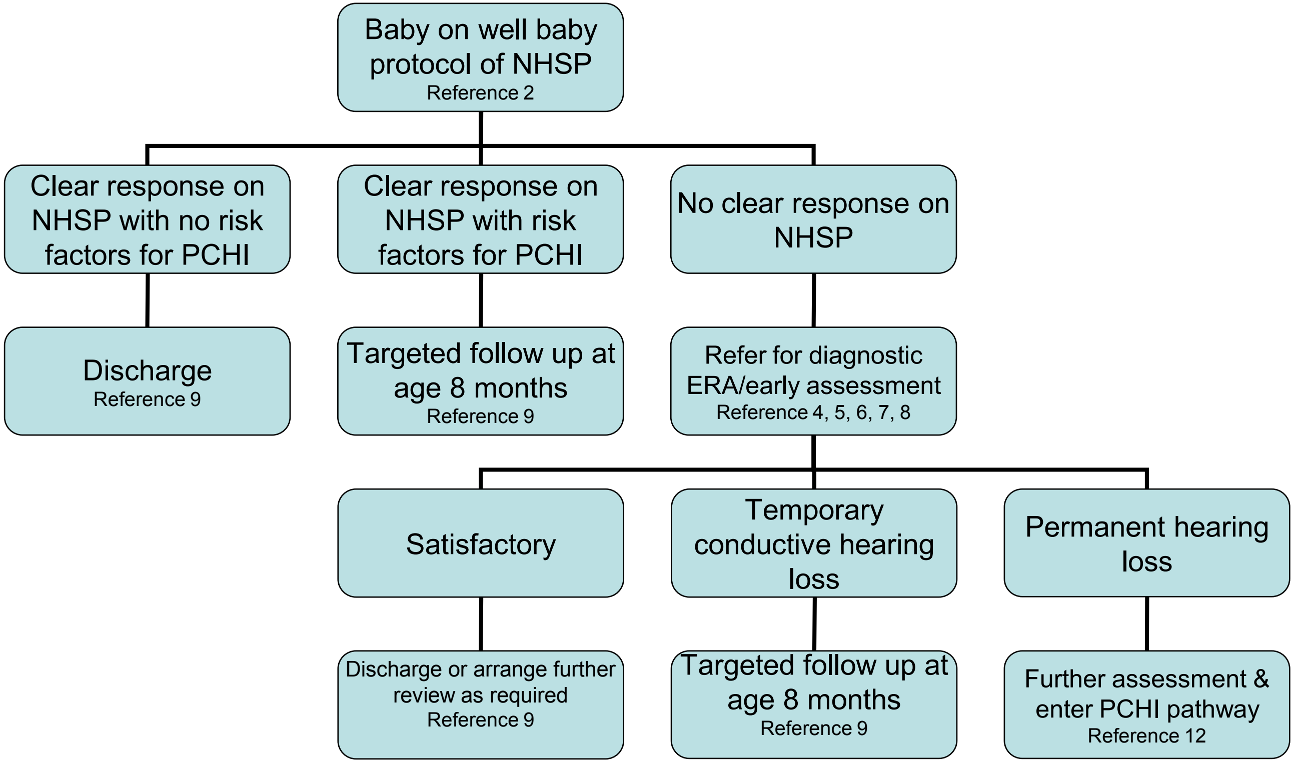
Permanent hearing loss

Discharge or arrange further review as required
Reference 9

Targeted follow up at age 8 months
Reference 9

Further assessment & enter PCHI pathway
Reference 12

Initial Assessment: 0-12 months
3. NHSP well baby protocol



Baby on well baby protocol of NHSP
Reference 2

Clear response on NHSP with no risk factors for PCHI

Discharge
Reference 9

Clear response on NHSP with risk factors for PCHI

Targeted follow up at age 8 months
Reference 9

No clear response on NHSP

Refer for diagnostic ERA/early assessment
Reference 4, 5, 6, 7, 8

Satisfactory

Discharge or arrange further review as required
Reference 9

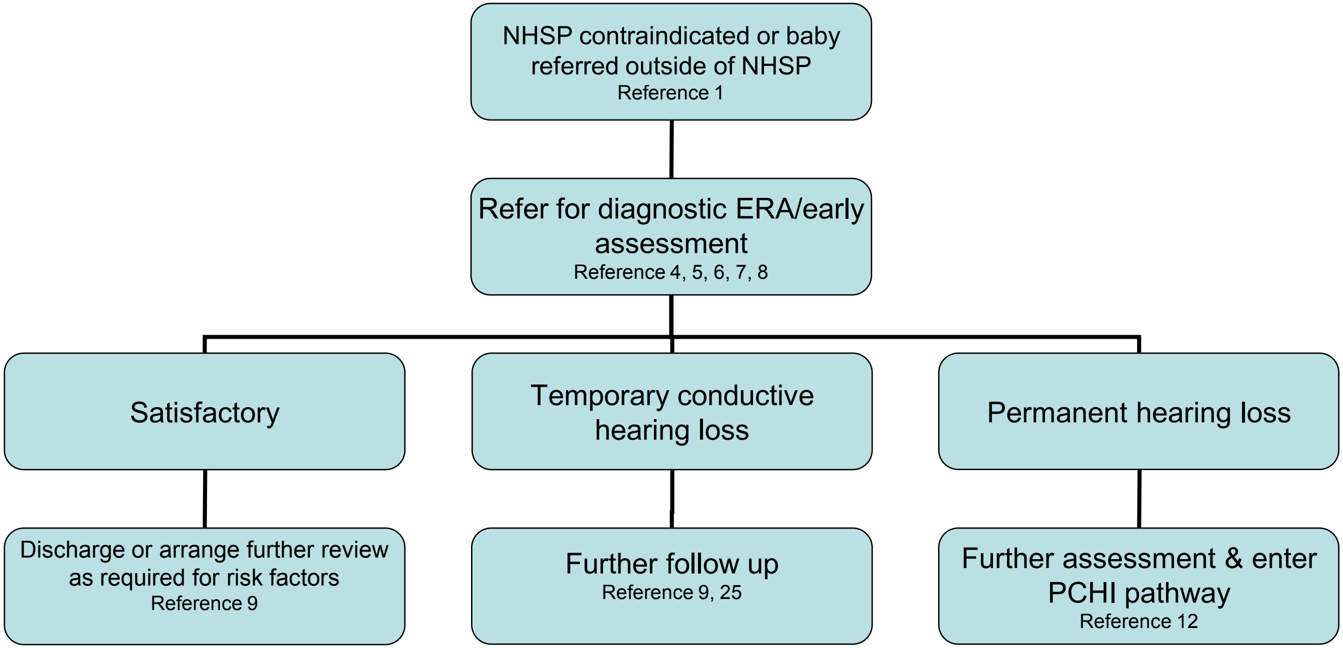
Temporary conductive hearing loss

Targeted follow up at age 8 months
Reference 9

Permanent hearing loss

Further assessment & enter PCHI pathway
Reference 12

Initial Assessment: 0-12 months
4. NHSP contraindicated or referred outside of NHSP



NHSP contraindicated or baby referred outside of NHSP
Reference 1

Refer for diagnostic ERA/early assessment
Reference 4, 5, 6, 7, 8

Satisfactory

Discharge or arrange further review as required for risk factors
Reference 9

Temporary conductive hearing loss

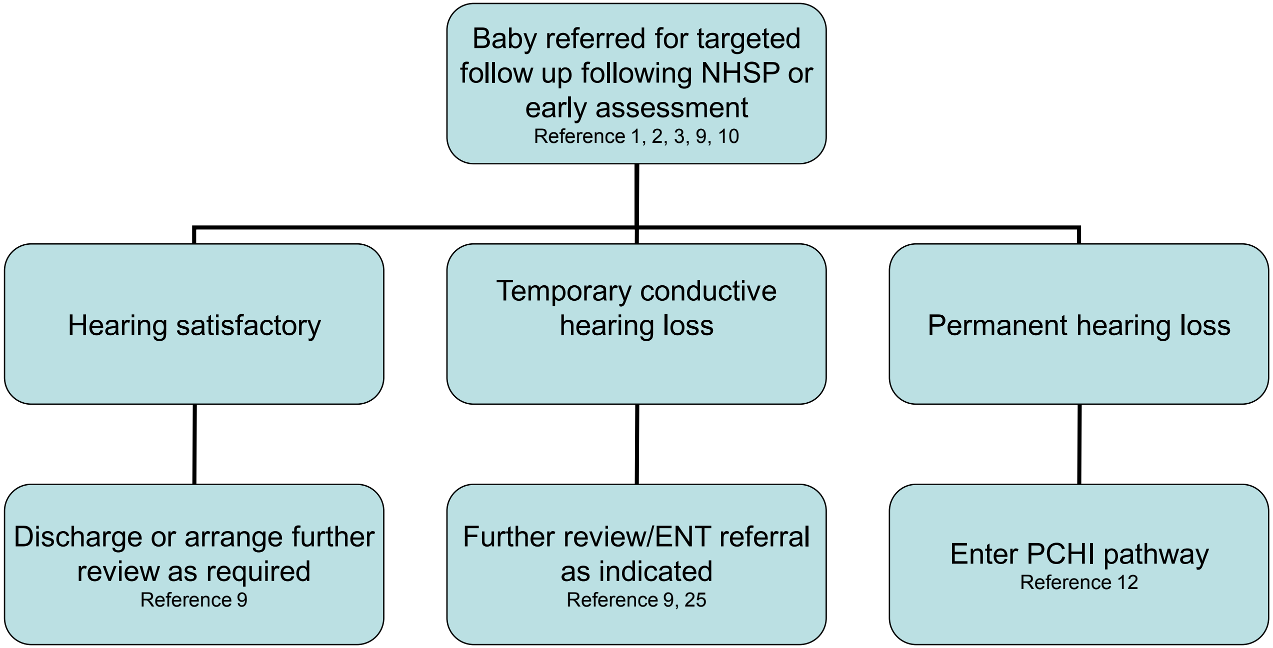
Further follow up
Reference 9, 25

Permanent hearing loss

Further assessment & enter PCHI pathway
Reference 12

Contents

Initial Assessment: 0-12 months
5. NHSP targeted follow up



Baby referred for targeted follow up following NHSP or early assessment
Reference 1, 2, 3, 9, 10

Hearing satisfactory

Discharge or arrange further review as required
Reference 9

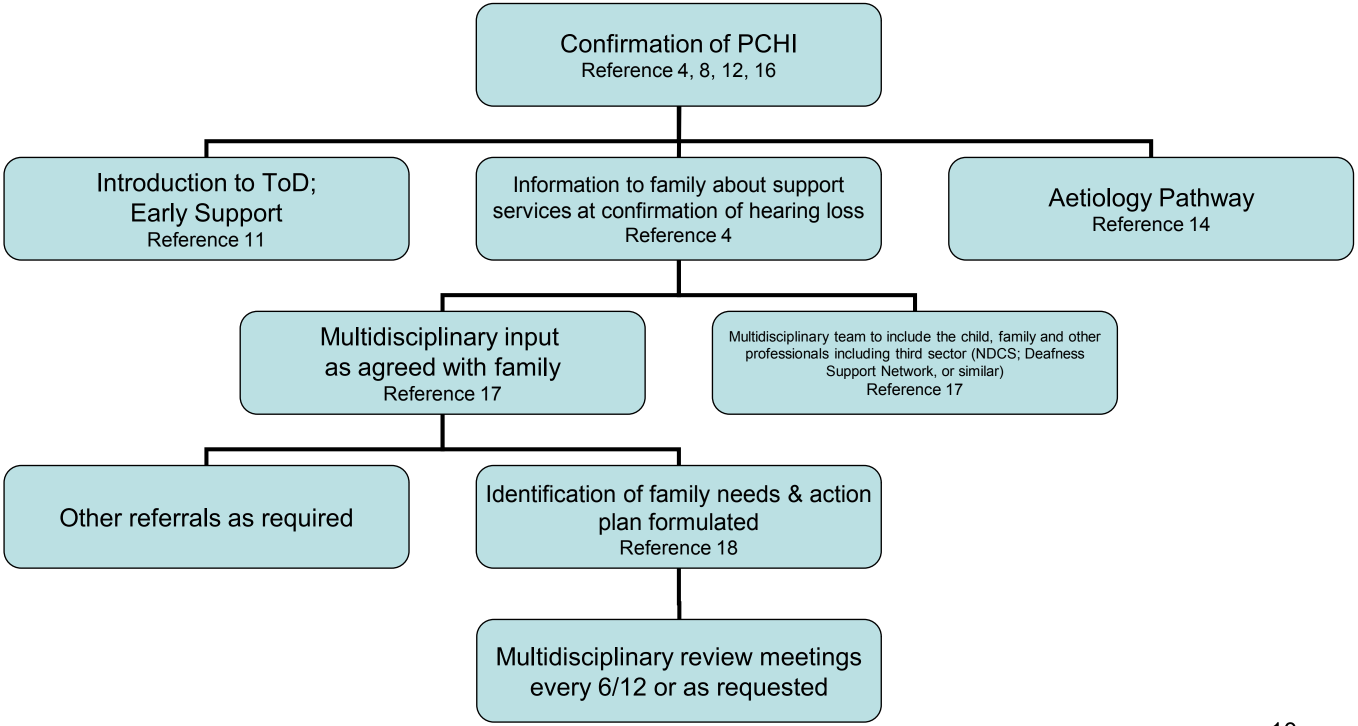
Temporary conductive hearing loss

Further review/ENT referral as indicated
Reference 9, 25

Permanent hearing loss

Enter PCHI pathway
Reference 12

Paediatric audiology care pathway 0-12 months
1. Child and family support



Confirmation of PCHI
Reference 4, 8, 12, 16

Introduction to ToD;
Early Support
Reference 11

Information to family about support services at confirmation of hearing loss
Reference 4

Aetiology Pathway
Reference 14

Multidisciplinary input as agreed with family
Reference 17

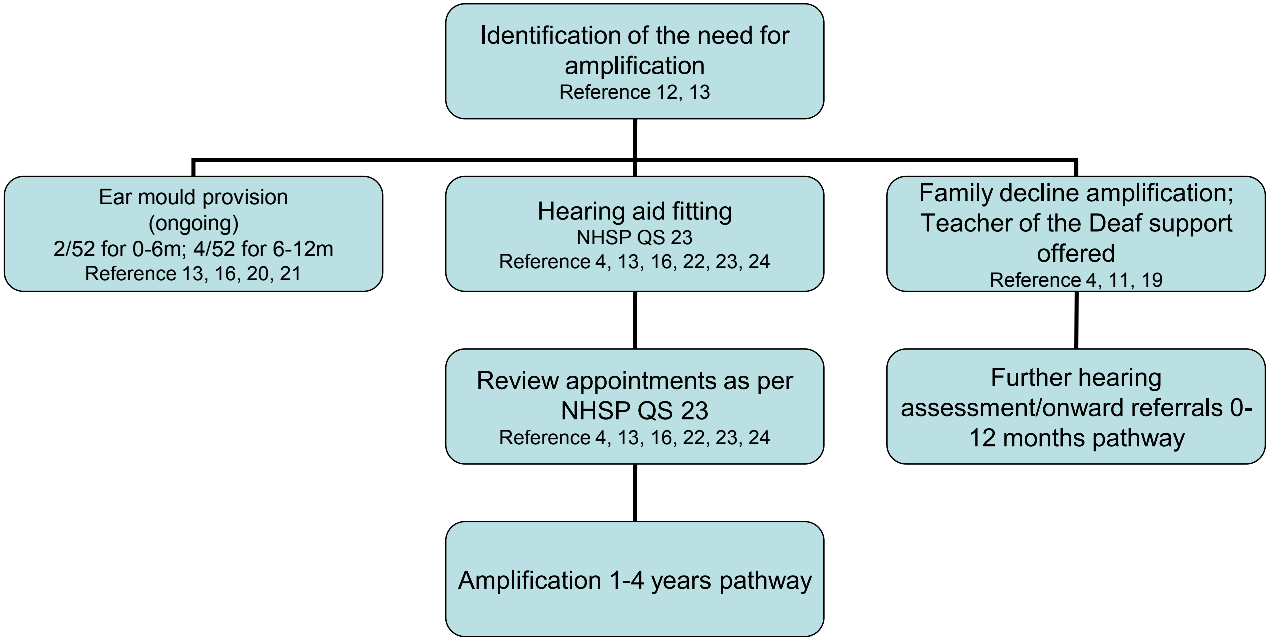
Multidisciplinary team to include the child, family and other professionals including third sector (NDCS; Deafness Support Network, or similar)
Reference 17

Other referrals as required

Identification of family needs & action plan formulated
Reference 18

Multidisciplinary review meetings every 6/12 or as requested

Paediatric audiology care pathway 0-12 months
2. Amplification



Identification of the need for amplification
Reference 12, 13

Ear mould provision (ongoing)
2/52 for 0-6m; 4/52 for 6-12m
Reference 13, 16, 20, 21

Hearing aid fitting
NHSP QS 23
Reference 4, 13, 16, 22, 23, 24

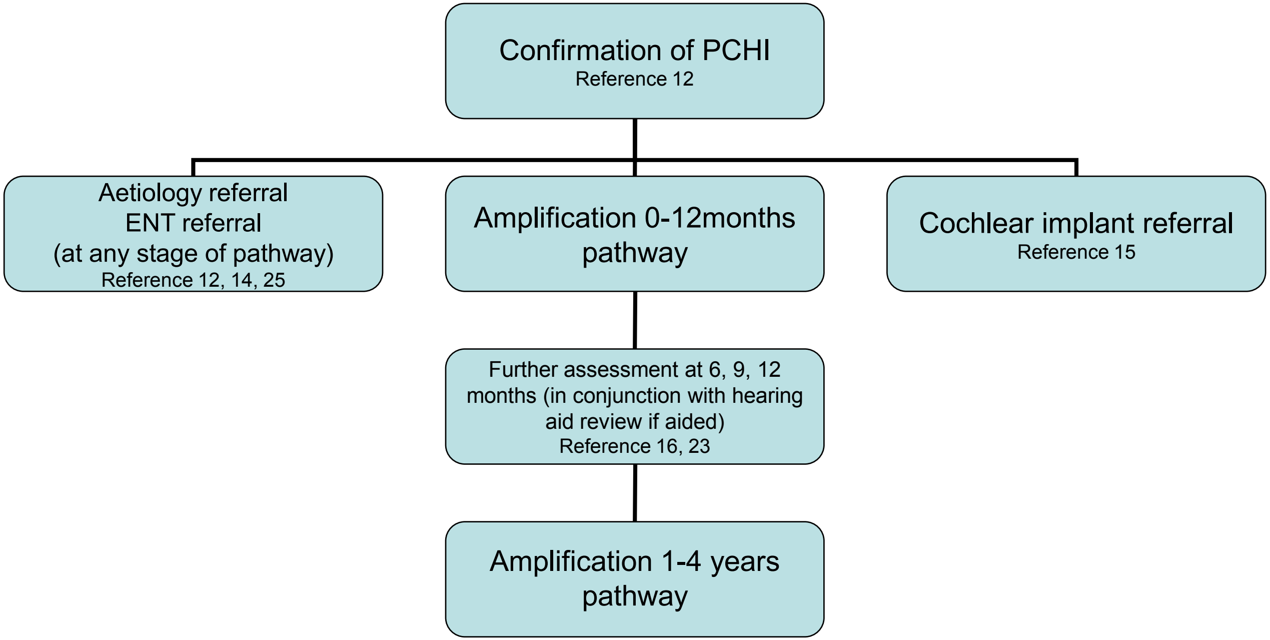
Family decline amplification; Teacher of the Deaf support offered
Reference 4, 11, 19

Review appointments as per NHSP QS 23
Reference 4, 13, 16, 22, 23, 24

Further hearing assessment/onward referrals 0-12 months pathway

Amplification 1-4 years pathway

Paediatric audiology care pathway 0-12 months
3. Further hearing assessment/onward referrals



Confirmation of PCHI
Reference 12

Aetiology referral
ENT referral
(at any stage of pathway)
Reference 12, 14, 25

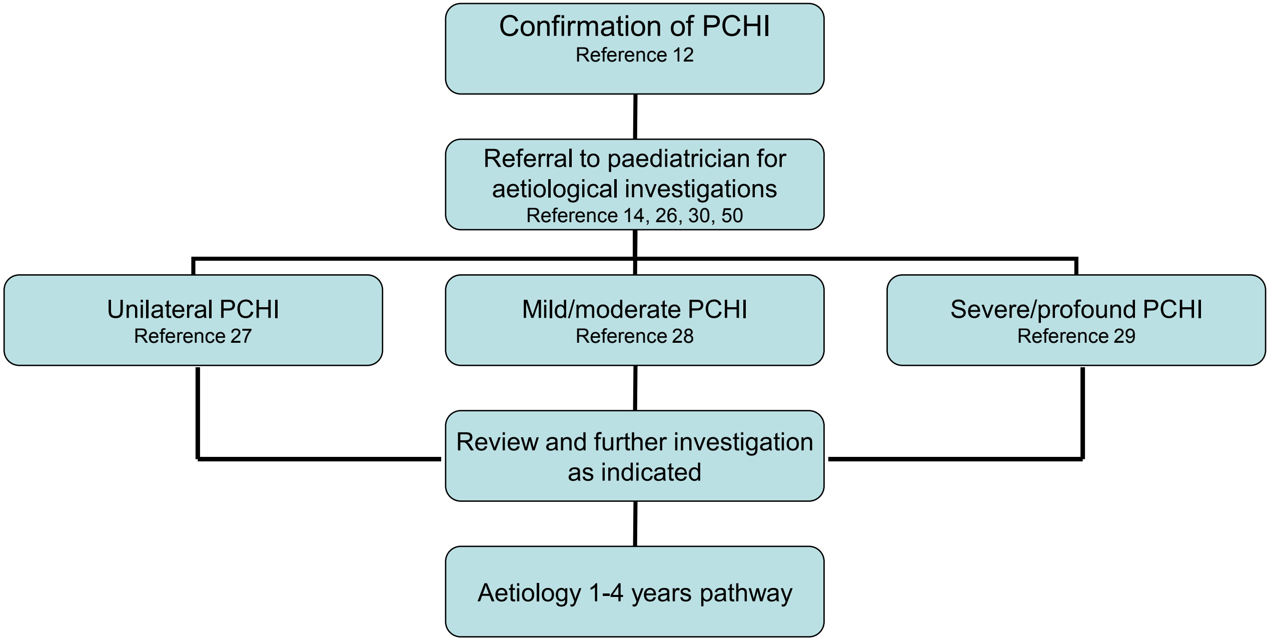
Amplification 0-12months pathway

Cochlear implant referral
Reference 15

Further assessment at 6, 9, 12 months (in conjunction with hearing aid review if aided)
Reference 16, 23

Amplification 1-4 years pathway

Paediatric audiology care pathway 0-12 months
4. Aetiology



Confirmation of PCHI
Reference 12

Referral to paediatrician for aetiological investigations
Reference 14, 26, 30, 50

Unilateral PCHI
Reference 27

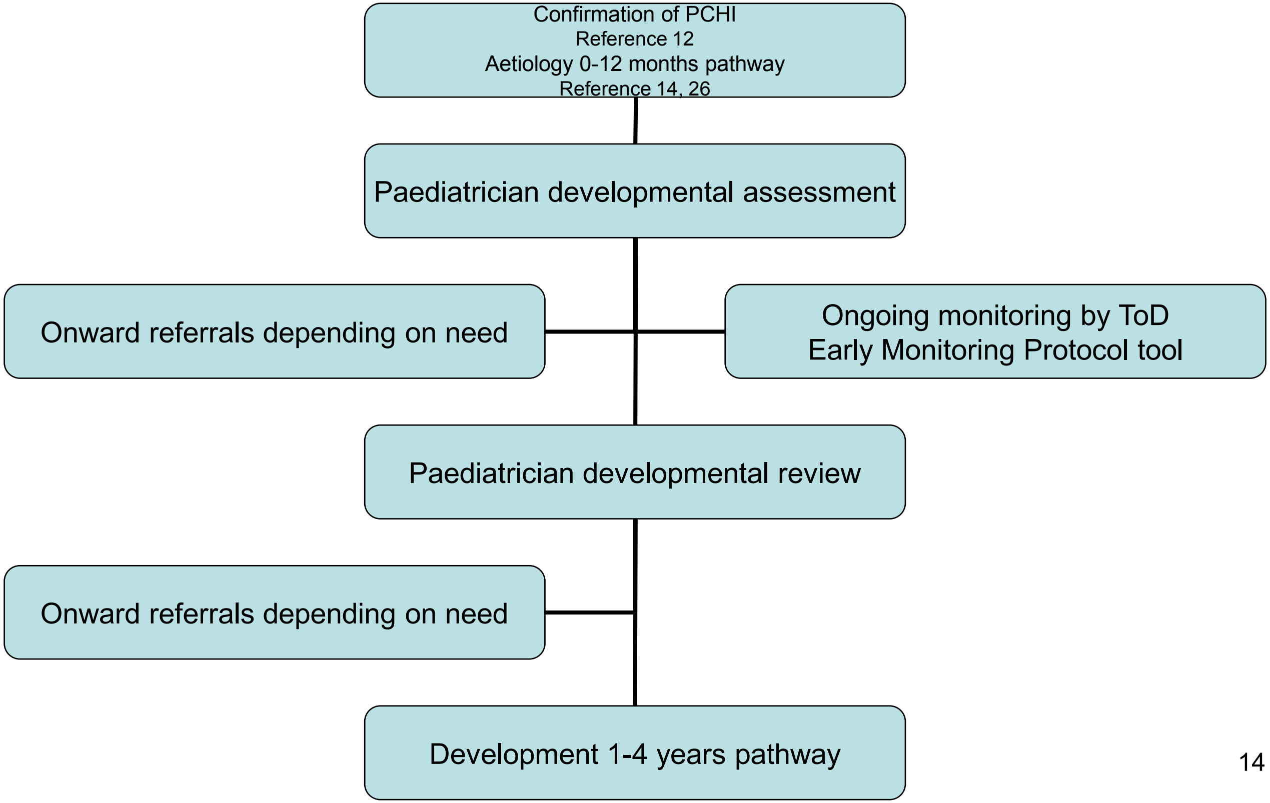
Mild/moderate PCHI
Reference 28

Severe/profound PCHI
Reference 29

Review and further investigation as indicated

Aetiology 1-4 years pathway

Paediatric audiology care pathway 0-12 months
5. Development



Confirmation of PCHI
Reference 12
Aetiology 0-12 months pathway
Reference 14, 26

Paediatrician developmental assessment

Onward referrals depending on need

Ongoing monitoring by ToD
Early Monitoring Protocol tool

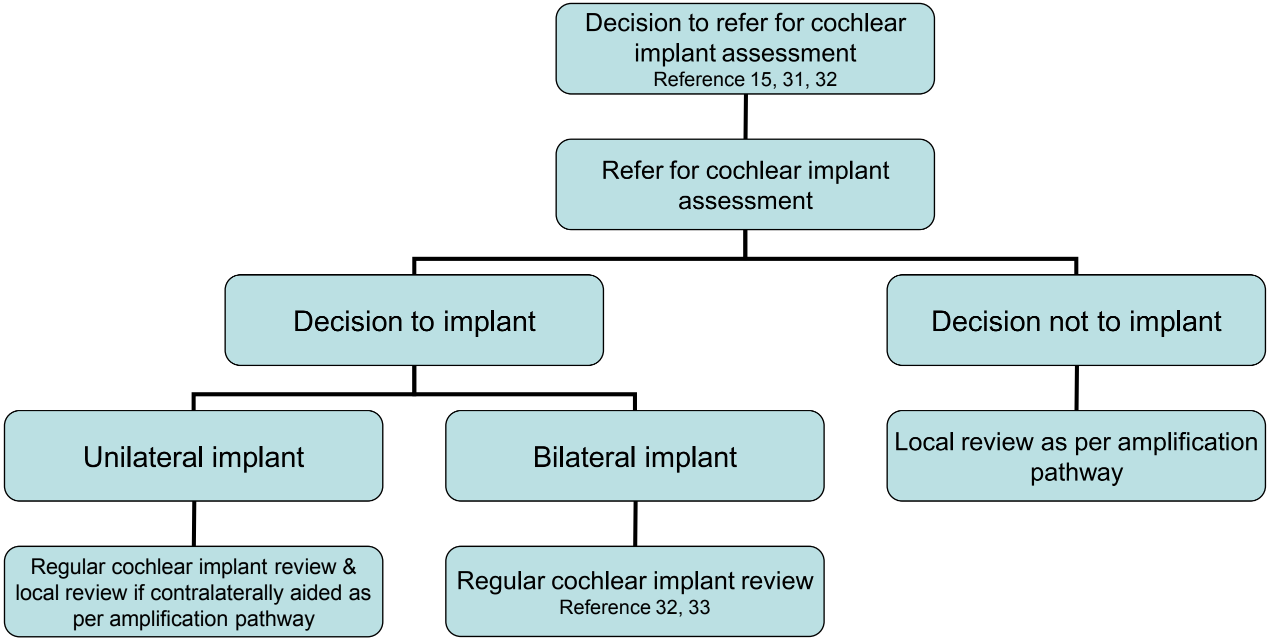
Paediatrician developmental review

Onward referrals depending on need

Development 1-4 years pathway

Contents

Paediatric audiology care pathway 0-12 months
6. Cochlear implant referral



Decision to refer for cochlear implant assessment
Reference 15, 31, 32

Refer for cochlear implant assessment

Decision to implant

Decision not to implant

Unilateral implant

Bilateral implant

Local review as per amplification pathway

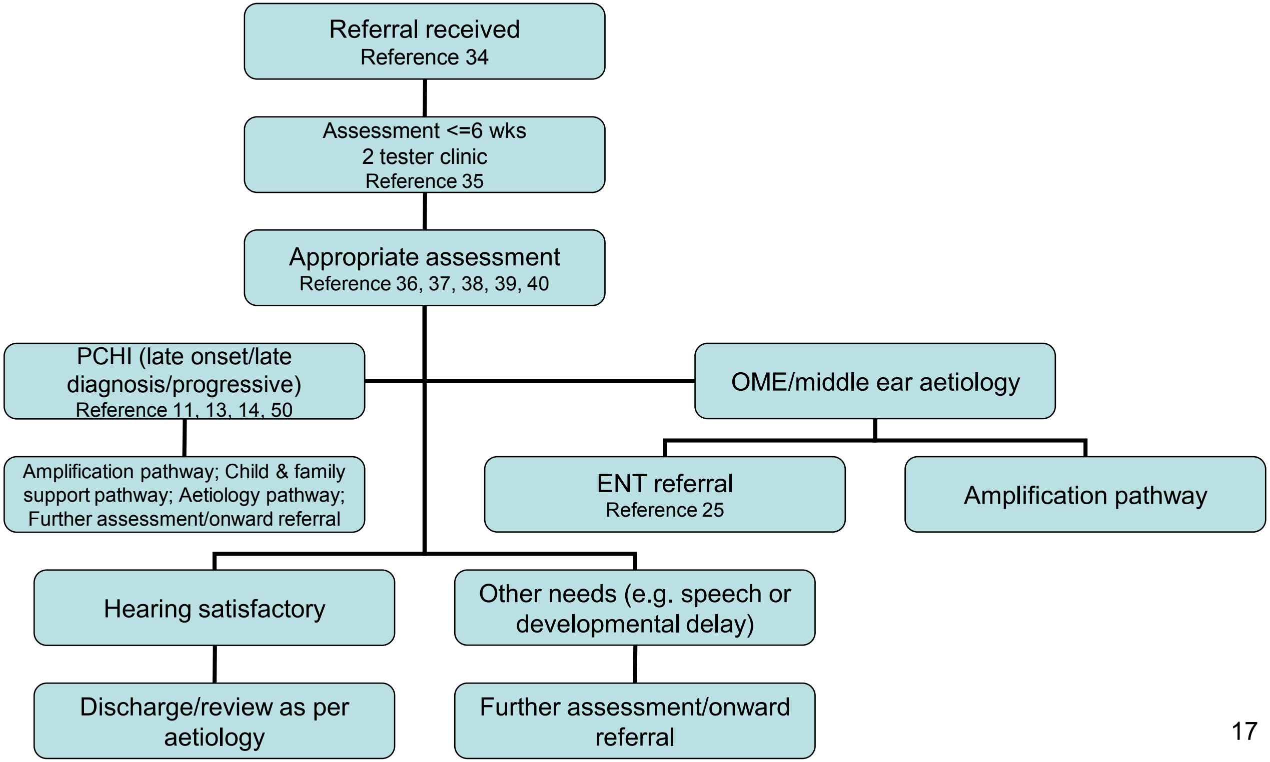
Regular cochlear implant review & local review if contralaterally aided as per amplification pathway

Regular cochlear implant review
Reference 32, 33

Contents

1-4 years care pathways

Assessment: 1-4 years
1. New referrals or NHSP targeted follow up



Referral received
Reference 34

Assessment <=6 wks
2 tester clinic
Reference 35

Appropriate assessment
Reference 36, 37, 38, 39, 40

PCHI (late onset/late diagnosis/progressive)
Reference 11, 13, 14, 50

Amplification pathway; Child & family support pathway; Aetiology pathway; Further assessment/onward referral

OME/middle ear aetiology

ENT referral
Reference 25

Amplification pathway

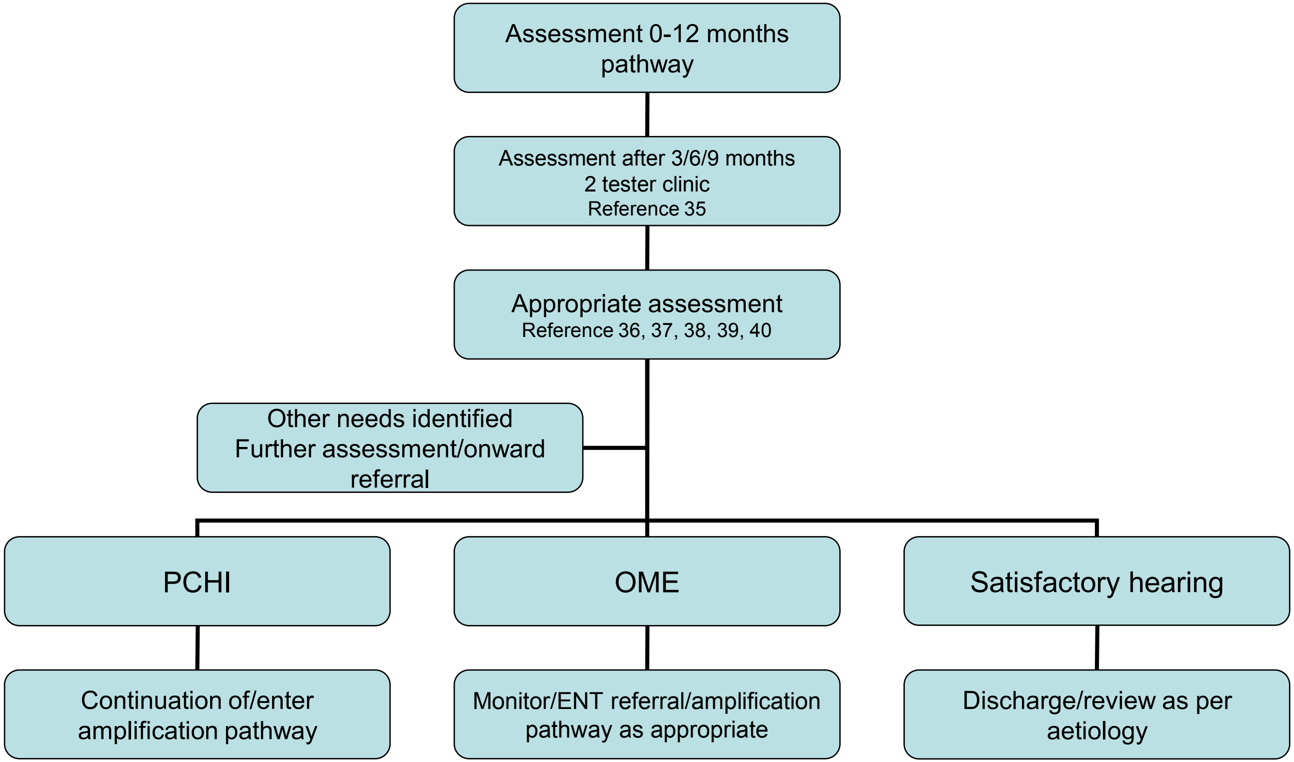
Hearing satisfactory

Discharge/review as per aetiology

Other needs (e.g. speech or developmental delay)

Further assessment/onward referral

Assessment: 1-4 years
2. Existing patients



Assessment 0-12 months pathway

Assessment after 3/6/9 months
2 tester clinic
Reference 35

Appropriate assessment
Reference 36, 37, 38, 39, 40

Other needs identified
Further assessment/onward referral

PCHI

OME

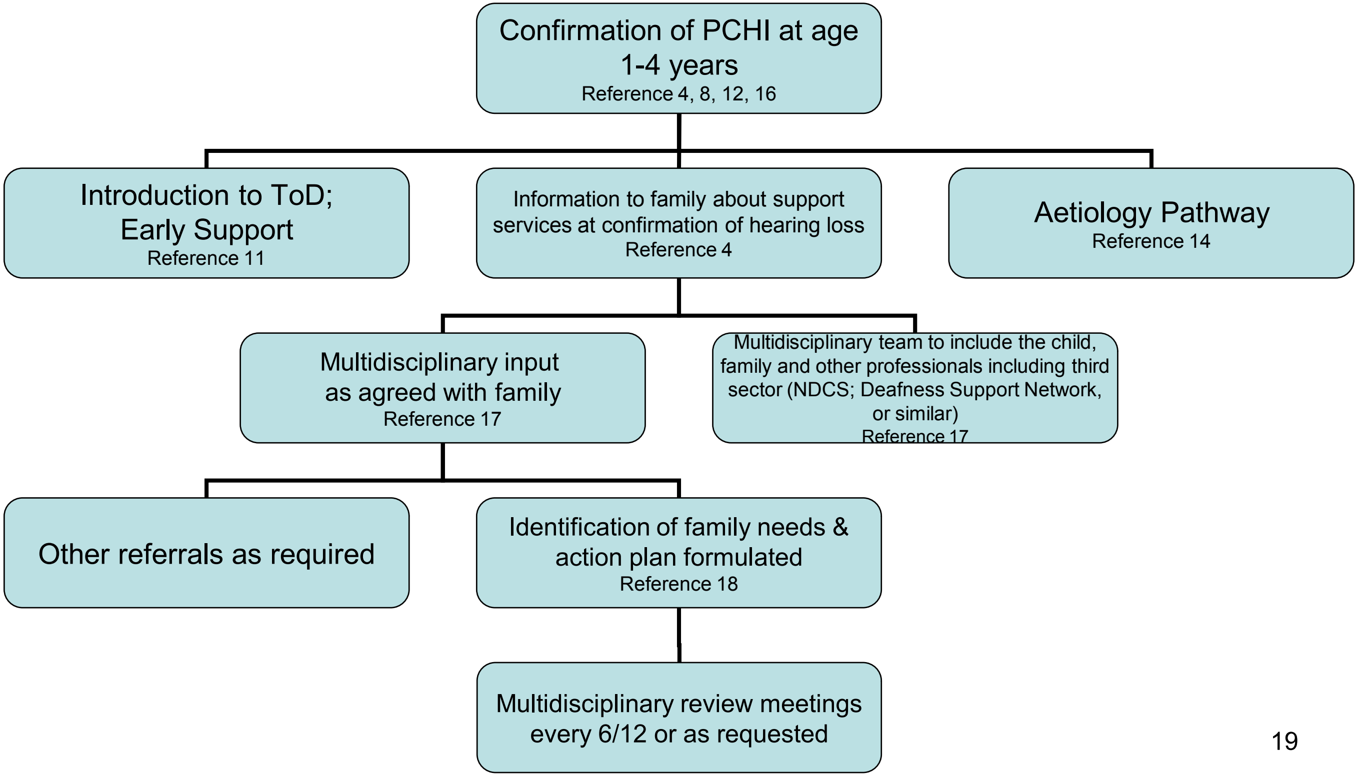
Satisfactory hearing

Continuation of/enter amplification pathway

Monitor/ENT referral/amplification pathway as appropriate

Discharge/review as per aetiology

Paediatric audiology care pathway 1-4 years
1. Child and family support



Confirmation of PCHI at age 1-4 years
Reference 4, 8, 12, 16

Introduction to ToD; Early Support
Reference 11

Information to family about support services at confirmation of hearing loss
Reference 4

Aetiology Pathway
Reference 14

Multidisciplinary input as agreed with family
Reference 17

Multidisciplinary team to include the child, family and other professionals including third sector (NDCS; Deafness Support Network, or similar)
Reference 17

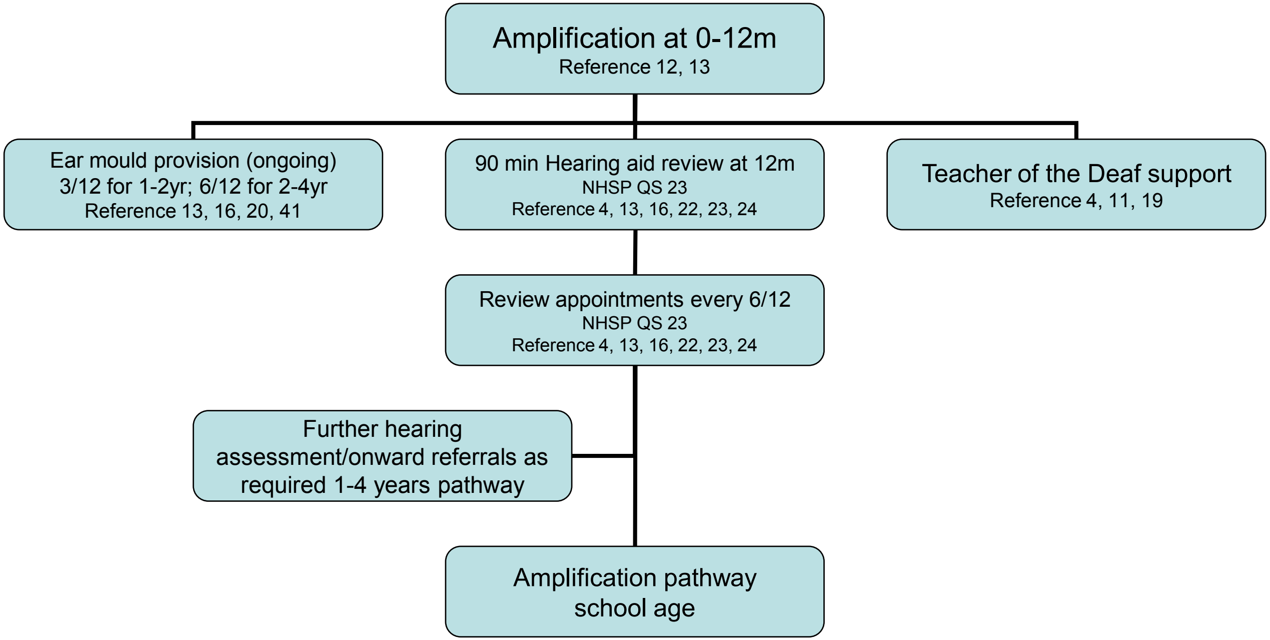
Other referrals as required

Identification of family needs & action plan formulated
Reference 18

Multidisciplinary review meetings every 6/12 or as requested

Contents

Paediatric audiology care pathway 1-4 years
2. Amplification - Existing patients



Amplification at 0-12m
Reference 12, 13

Ear mould provision (ongoing)
3/12 for 1-2yr; 6/12 for 2-4yr
Reference 13, 16, 20, 41

90 min Hearing aid review at 12m
NHSP QS 23
Reference 4, 13, 16, 22, 23, 24

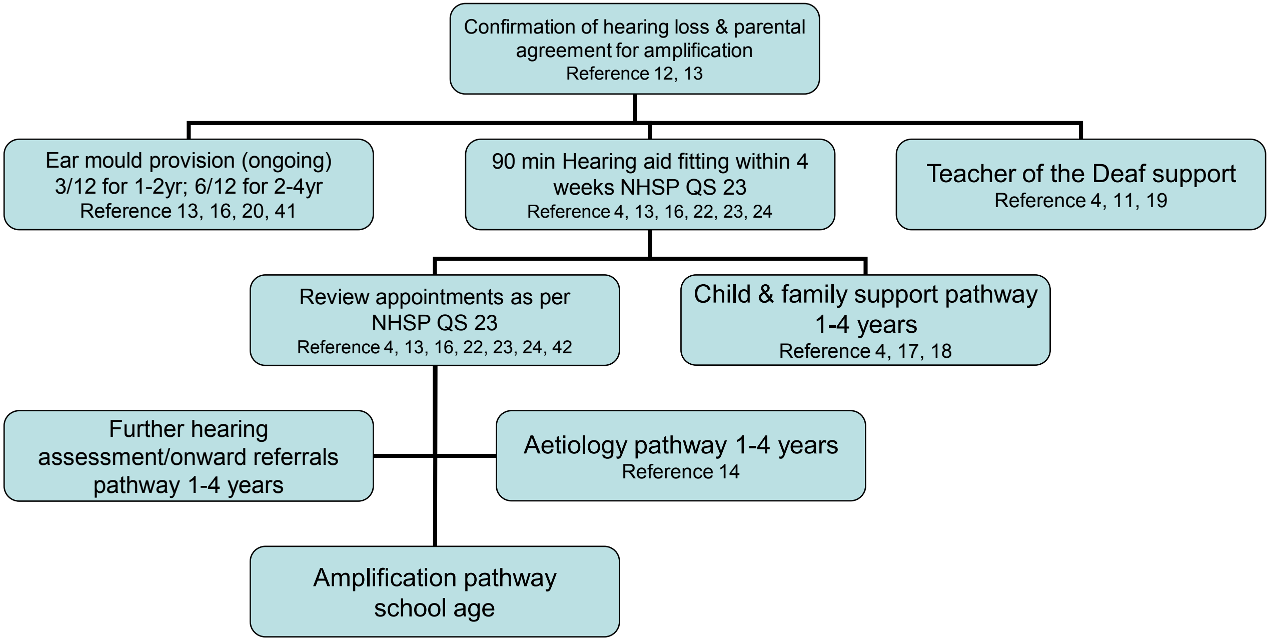
Teacher of the Deaf support
Reference 4, 11, 19

Review appointments every 6/12
NHSP QS 23
Reference 4, 13, 16, 22, 23, 24

Further hearing assessment/onward referrals as required 1-4 years pathway

Amplification pathway school age

Paediatric audiology care pathway 1-4 years
3. Amplification – Newly identified hearing loss



Confirmation of hearing loss & parental agreement for amplification
Reference 12, 13

Ear mould provision (ongoing)
3/12 for 1-2yr; 6/12 for 2-4yr
Reference 13, 16, 20, 41

90 min Hearing aid fitting within 4 weeks NHSP QS 23
Reference 4, 13, 16, 22, 23, 24

Teacher of the Deaf support
Reference 4, 11, 19

Review appointments as per NHSP QS 23
Reference 4, 13, 16, 22, 23, 24, 42

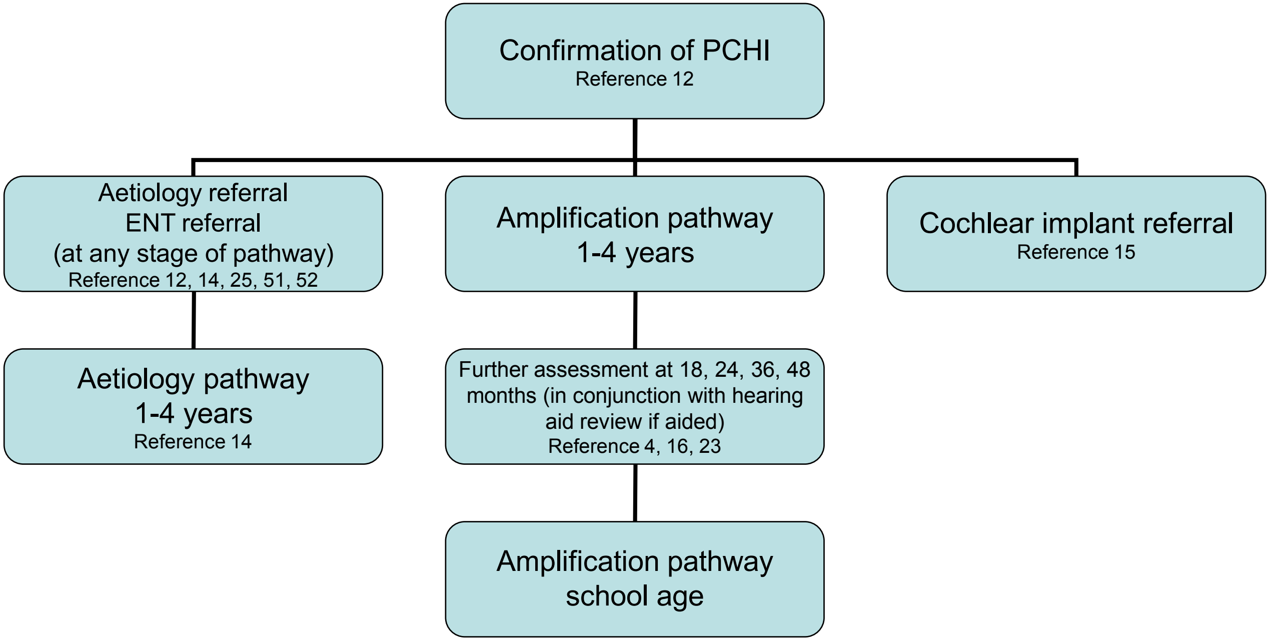
Child & family support pathway 1-4 years
Reference 4, 17, 18

Further hearing assessment/onward referrals pathway 1-4 years

Aetiology pathway 1-4 years
Reference 14

Amplification pathway school age

Paediatric audiology care pathway 1-4 years
4. Further hearing assessment/onward referrals



Confirmation of PCHI
Reference 12

Aetiology referral
ENT referral
(at any stage of pathway)
Reference 12, 14, 25, 51, 52

Amplification pathway
1-4 years

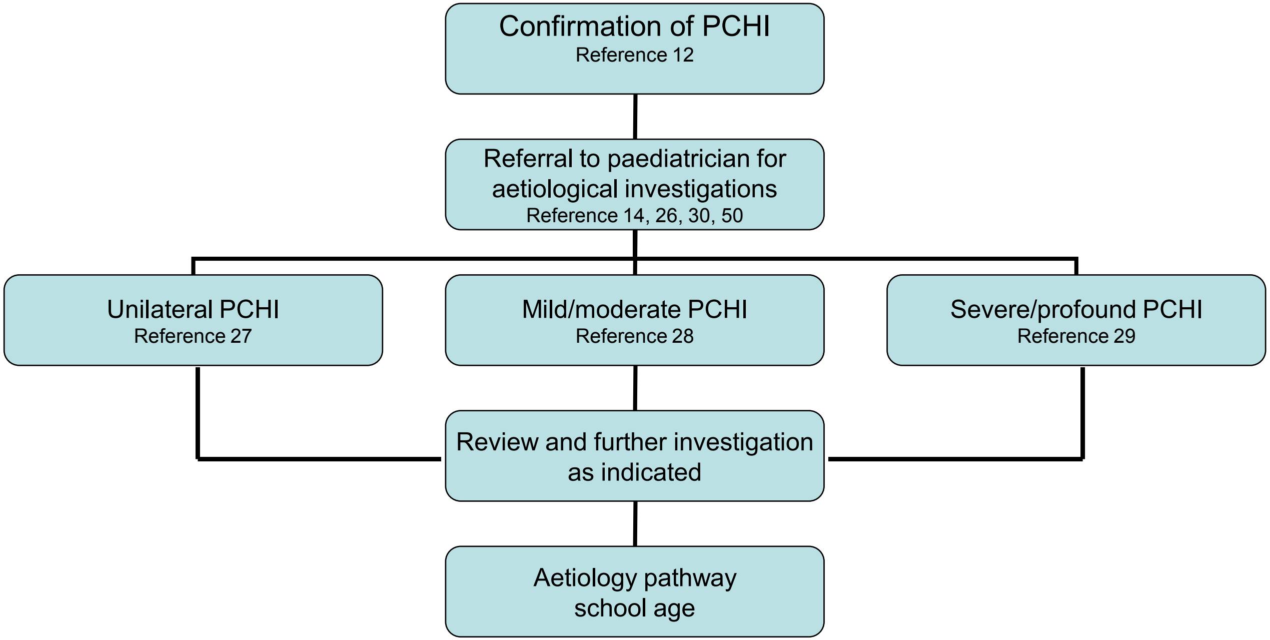
Cochlear implant referral
Reference 15

Aetiology pathway
1-4 years
Reference 14

Further assessment at 18, 24, 36, 48 months (in conjunction with hearing aid review if aided)
Reference 4, 16, 23

Amplification pathway
school age

Paediatric audiology care pathway 1-4 years
5. Aetiology



Confirmation of PCHI
Reference 12

Referral to paediatrician for aetiological investigations
Reference 14, 26, 30, 50

Unilateral PCHI
Reference 27

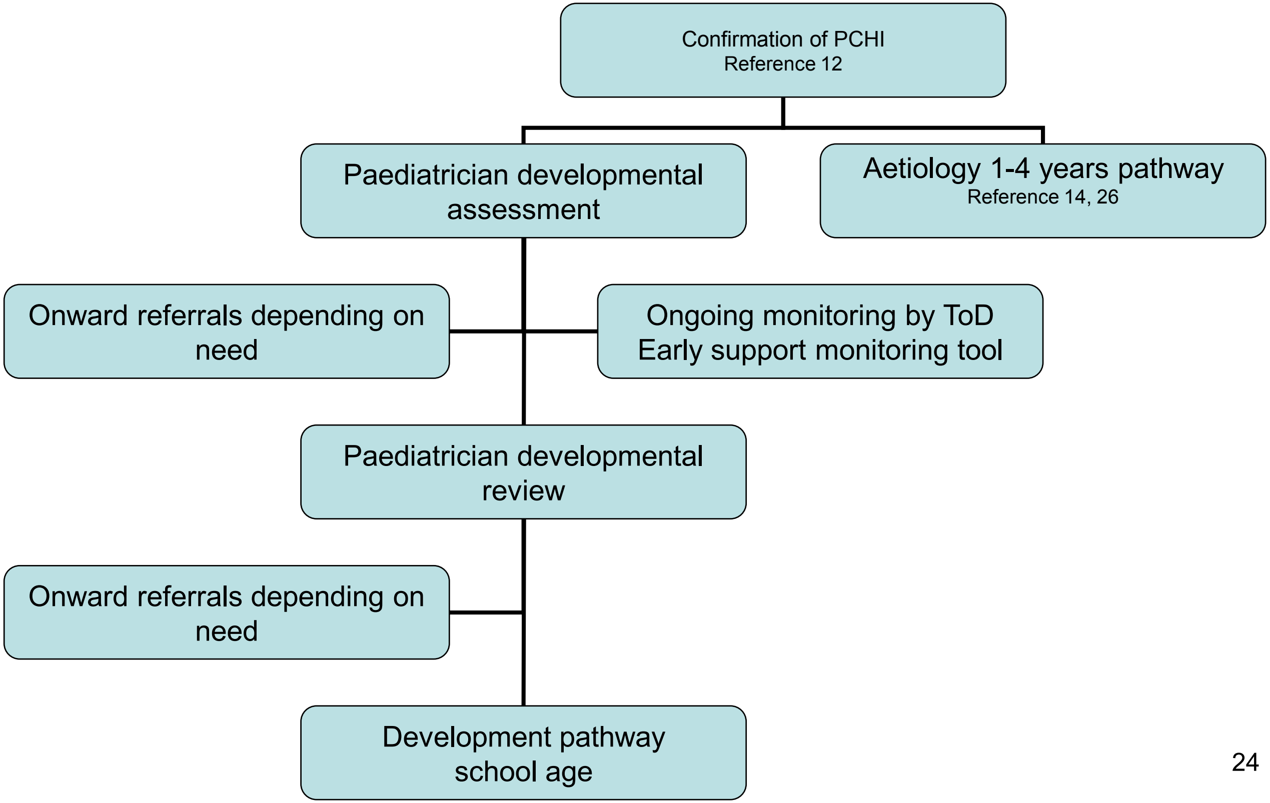
Mild/moderate PCHI
Reference 28

Severe/profound PCHI
Reference 29

Review and further investigation as indicated

Aetiology pathway school age

Paediatric audiology care pathway 1-4 years
6. Development



Confirmation of PCHI
Reference 12

Paediatrician developmental assessment

Aetiology 1-4 years pathway
Reference 14, 26

Onward referrals depending on need

Ongoing monitoring by ToD
Early support monitoring tool

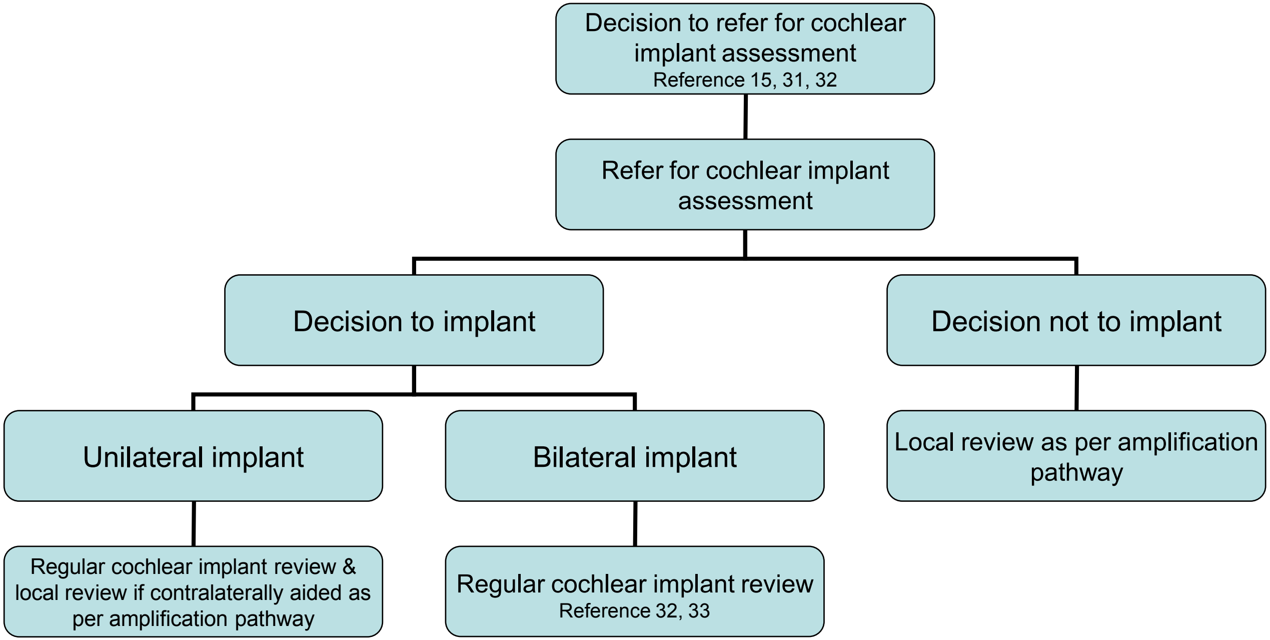
Paediatrician developmental review

Onward referrals depending on need

Development pathway school age

Contents

Paediatric audiology care pathway 1-4 years
7. Cochlear implant referral



Decision to refer for cochlear implant assessment
Reference 15, 31, 32

Refer for cochlear implant assessment

Decision to implant

Decision not to implant

Unilateral implant

Bilateral implant

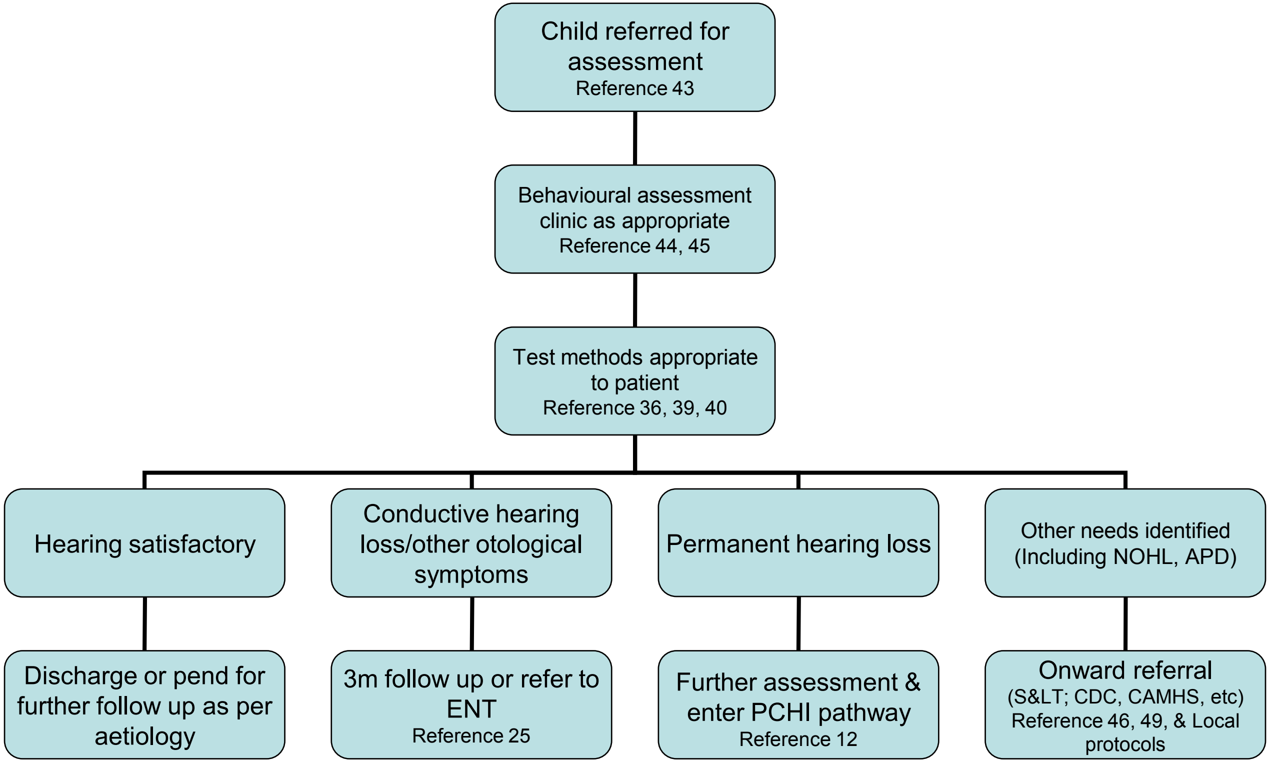
Local review as per amplification pathway

Regular cochlear implant review & local review if contralaterally aided as per amplification pathway

Regular cochlear implant review
Reference 32, 33

School age care pathways

Assessment: school age
1. New patient protocol



Child referred for assessment
Reference 43

Behavioural assessment clinic as appropriate
Reference 44, 45

Test methods appropriate to patient
Reference 36, 39, 40

Hearing satisfactory

Discharge or pend for further follow up as per aetiology

Conductive hearing loss/other otological symptoms

3m follow up or refer to ENT
Reference 25

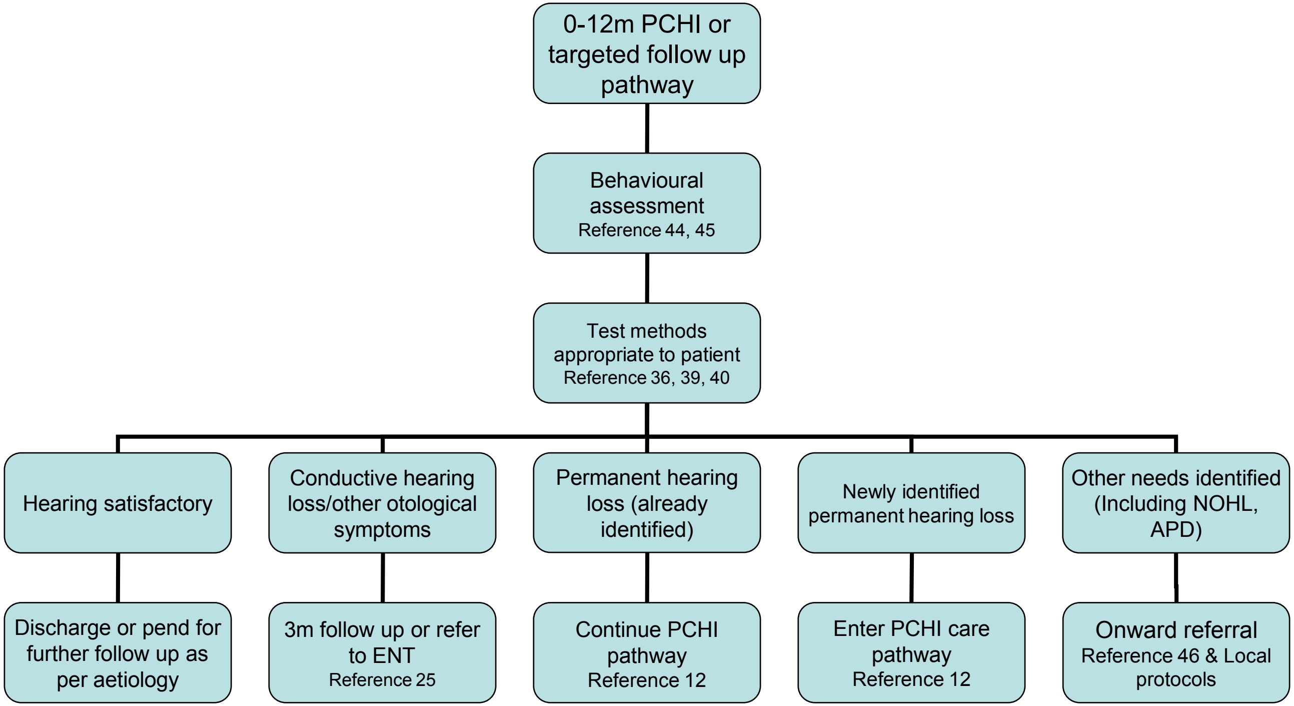
Permanent hearing loss

Further assessment & enter PCHI pathway
Reference 12

Other needs identified (Including NOHL, APD)

Onward referral
(S< CDC, CAMHS, etc)
Reference 46, 49, & Local protocols

Assessment: school age
2. Existing patient protocol



0-12m PCHI or targeted follow up pathway

Behavioural assessment
Reference 44, 45

Test methods appropriate to patient
Reference 36, 39, 40

Hearing satisfactory

Discharge or pend for further follow up as per aetiology

Conductive hearing loss/other otological symptoms

3m follow up or refer to ENT
Reference 25

Permanent hearing loss (already identified)

Continue PCHI pathway
Reference 12

Newly identified permanent hearing loss

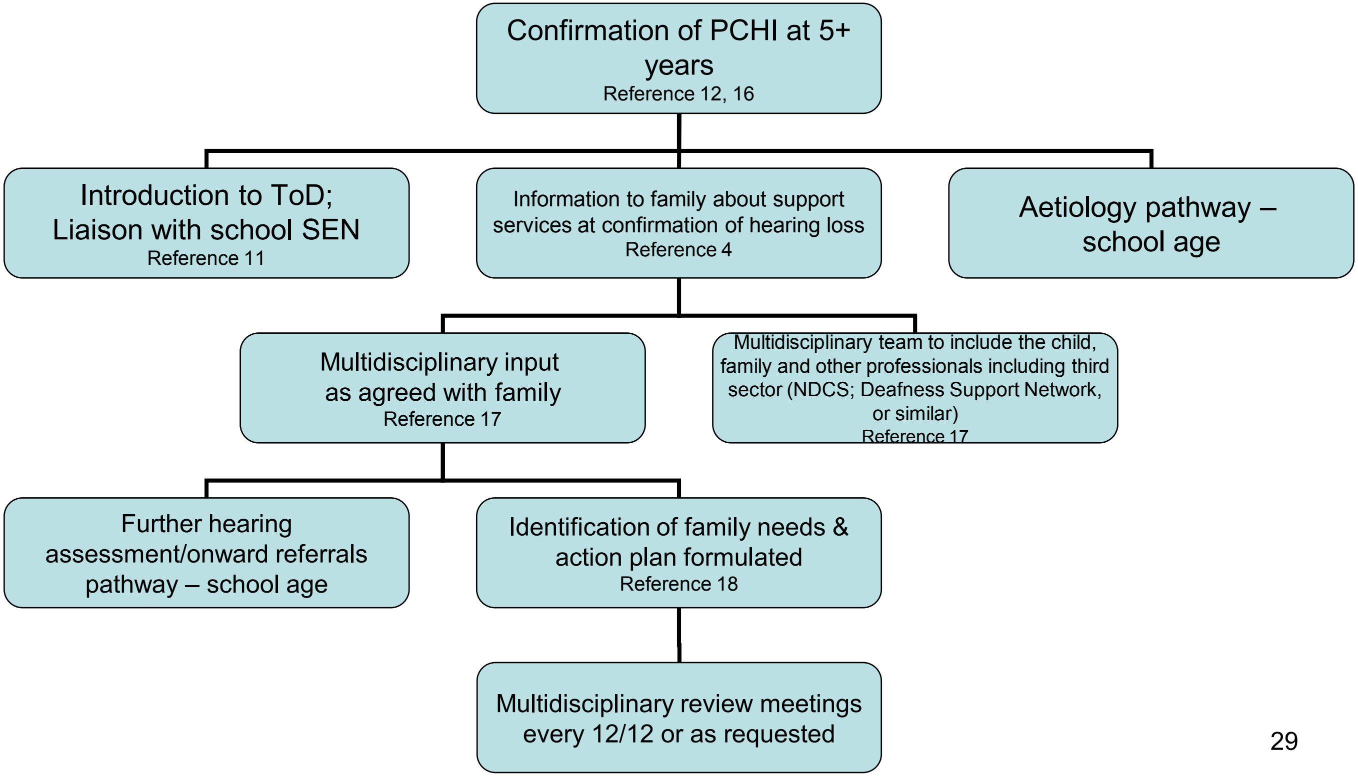
Enter PCHI care pathway
Reference 12

Other needs identified (Including NOHL, APD)

Onward referral
Reference 46 & Local protocols

Contents

Paediatric audiology care pathway school age
1. Child and family support



Confirmation of PCHI at 5+ years
Reference 12, 16

Introduction to ToD; Liaison with school SEN
Reference 11

Information to family about support services at confirmation of hearing loss
Reference 4

Aetiology pathway – school age

Multidisciplinary input as agreed with family
Reference 17

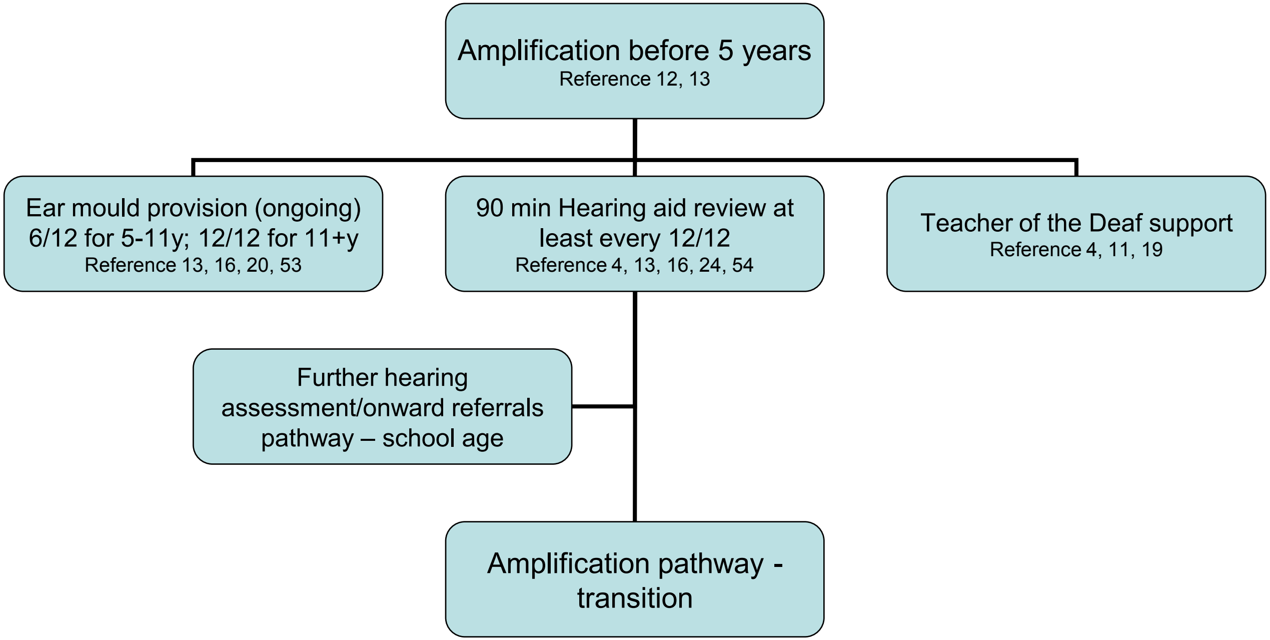
Multidisciplinary team to include the child, family and other professionals including third sector (NDCS; Deafness Support Network, or similar)
Reference 17

Further hearing assessment/onward referrals pathway – school age

Identification of family needs & action plan formulated
Reference 18

Multidisciplinary review meetings every 12/12 or as requested

Paediatric audiology care pathway school age
2. Amplification – Existing patients



Amplification before 5 years
Reference 12, 13

Ear mould provision (ongoing)
6/12 for 5-11y; 12/12 for 11+y
Reference 13, 16, 20, 53

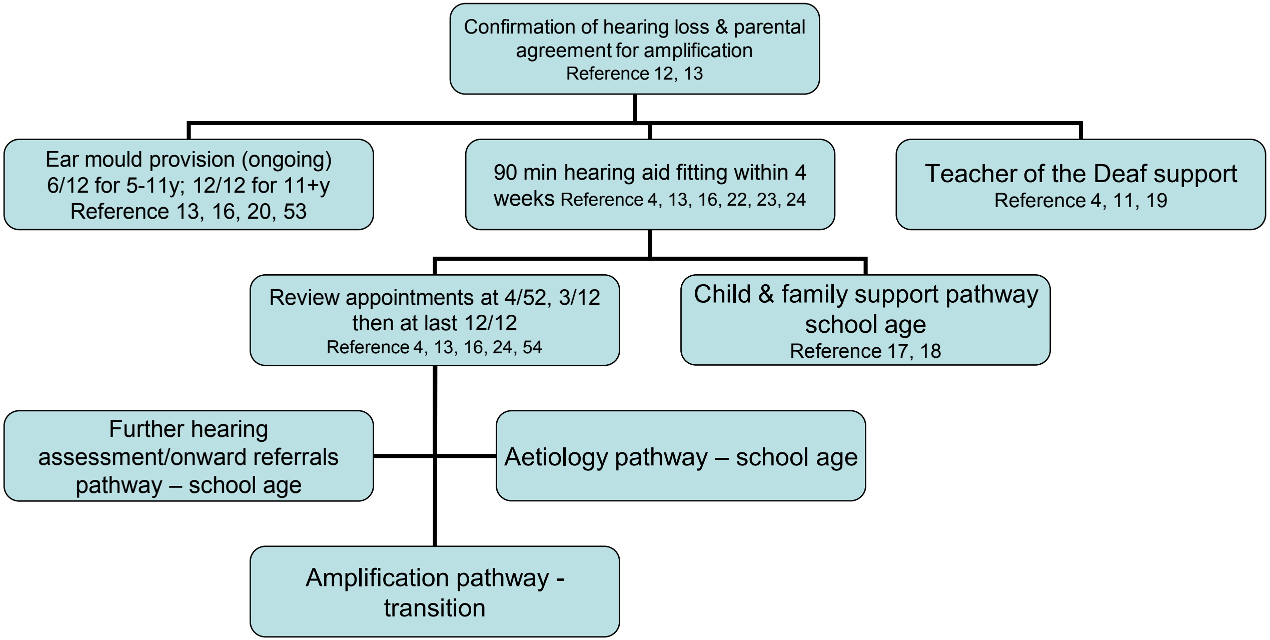
90 min Hearing aid review at least every 12/12
Reference 4, 13, 16, 24, 54

Teacher of the Deaf support
Reference 4, 11, 19

Further hearing assessment/onward referrals pathway – school age

Amplification pathway - transition

Paediatric audiology care pathway school age
3. Amplification – Newly identified hearing loss



Confirmation of hearing loss & parental agreement for amplification
Reference 12, 13

Ear mould provision (ongoing)
6/12 for 5-11y; 12/12 for 11+y
Reference 13, 16, 20, 53

90 min hearing aid fitting within 4 weeks Reference 4, 13, 16, 22, 23, 24

Teacher of the Deaf support
Reference 4, 11, 19

Review appointments at 4/52, 3/12 then at last 12/12
Reference 4, 13, 16, 24, 54

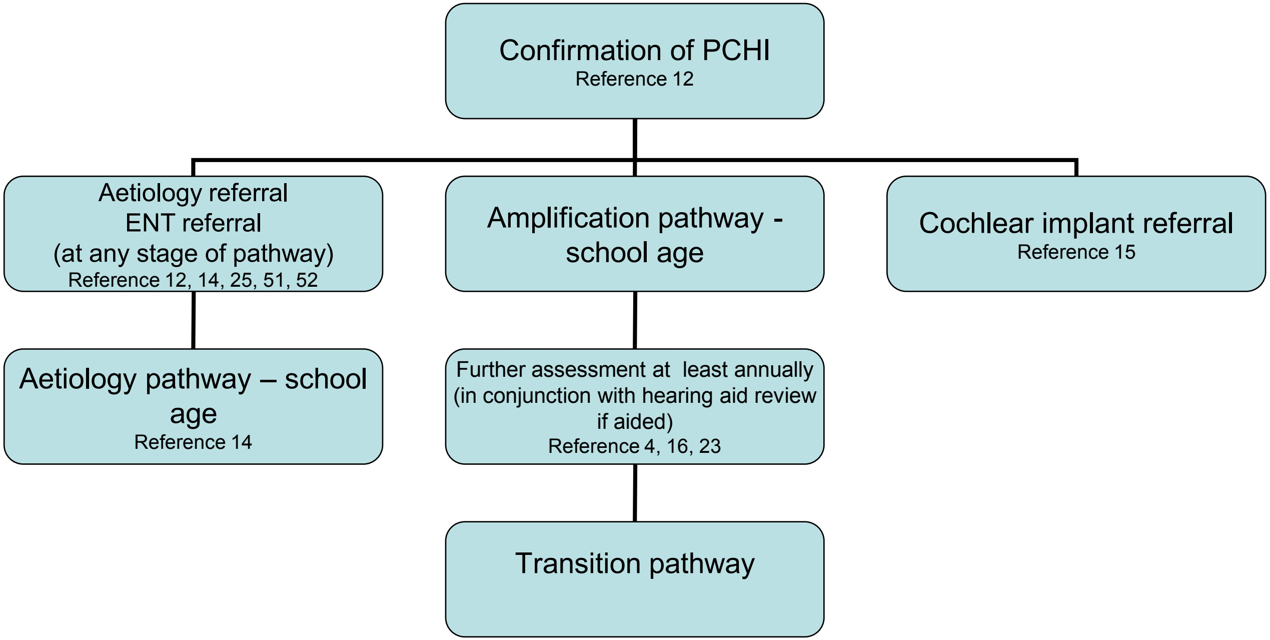
Child & family support pathway school age
Reference 17, 18

Further hearing assessment/onward referrals pathway – school age

Aetiology pathway – school age

Amplification pathway - transition

Paediatric audiology care pathway school age
4. Further hearing assessment/onward referrals



Confirmation of PCHI
Reference 12

Aetiology referral
ENT referral
(at any stage of pathway)
Reference 12, 14, 25, 51, 52

Amplification pathway - school age

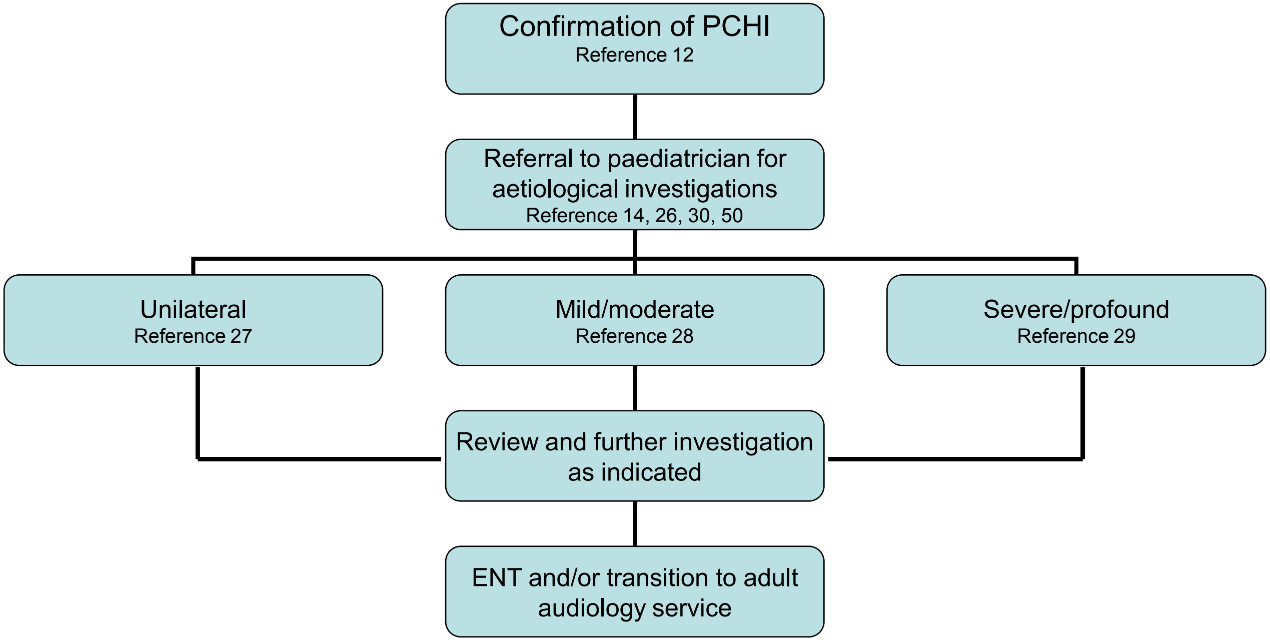
Cochlear implant referral
Reference 15

Aetiology pathway – school age
Reference 14

Further assessment at least annually (in conjunction with hearing aid review if aided)
Reference 4, 16, 23

Transition pathway

Paediatric audiology care pathway school age
5. Aetiology



Confirmation of PCHI
Reference 12

Referral to paediatrician for aetiological investigations
Reference 14, 26, 30, 50

Unilateral
Reference 27

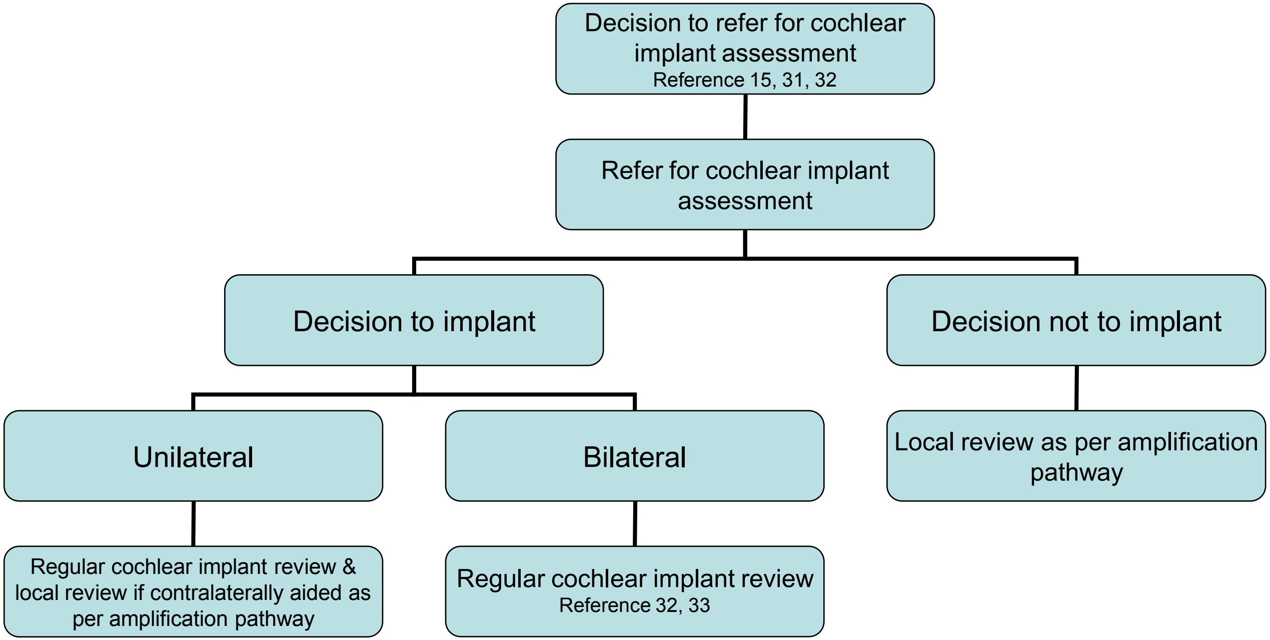
Mild/moderate
Reference 28

Severe/profound
Reference 29

Review and further investigation as indicated

ENT and/or transition to adult audiology service

Paediatric audiology care pathway school age
6. Cochlear implant referral



Decision to refer for cochlear implant assessment
Reference 15, 31, 32

Refer for cochlear implant assessment

Decision to implant

Decision not to implant

Unilateral

Bilateral

Local review as per amplification pathway

Regular cochlear implant review & local review if contralaterally aided as per amplification pathway

Regular cochlear implant review
Reference 32, 33

Transition care pathway

Transition from paediatric to adult audiology services

Reference 47, 48

14-15 years – Discuss transition at hearing aid review appointment with paediatric service

15-16 years – Decide appropriate time to transition with paediatric service
(school leaver/entering workplace; college leaver/entering higher education or the workplace)

16-18 years – Final paediatric appointment. Joint appointment with transition audiologist.
Encourage patient to complete transition by 18 years

1-6 months after transition – Patient offered review appointment in adult service

Email/telephone/text contact with transition audiologist as required

12 months after transition – Patient offered review appointment in adult service with transition audiologist

Patient to arrange repairs and further appointments as required. Regular reviews arranged if under complex needs clinic

Missed appointments care pathways

Failure to attend appointments (DNAs) – New patients (local protocol)

- New patient referral
- Referral graded
- Appointment letter sent in post
- Telephone/text reminder (local protocol)
- DNA appointment
- DNA letter to parents & relevant professionals
- Discharge. Discuss with Safeguarding Children Team if appropriate (local protocol)

Failure to attend appointments (DNAs) – Existing patients (local protocol)

Appointment letter sent in post

Telephone/text reminder (local protocol)

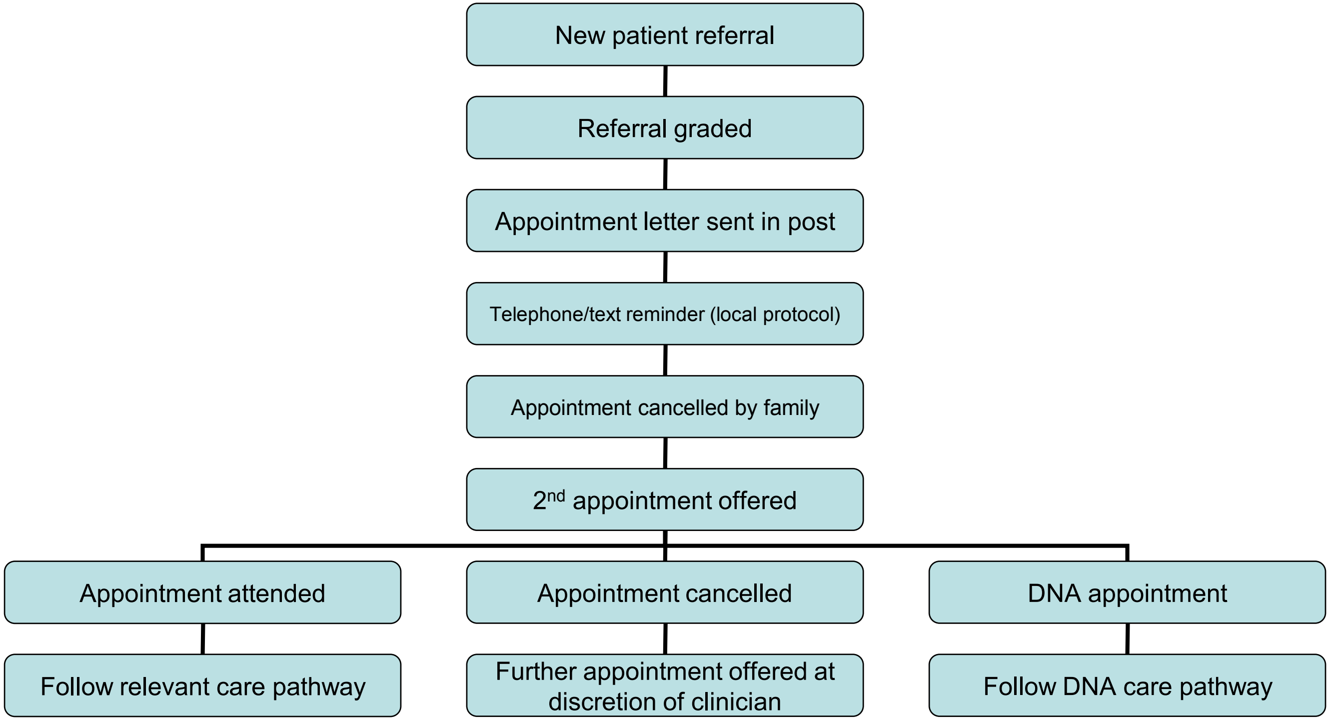
DNA appointment

‘To contact’ letter sent to parents & copied to relevant professionals

Further appointment arranged upon request

If no contact made then discharge
Discuss with Safeguarding Children Team if appropriate (local protocol)

Cancelled appointments – New patients (local protocol)



New patient referral

Referral graded

Appointment letter sent in post

Telephone/text reminder (local protocol)

Appointment cancelled by family

2nd appointment offered

Appointment attended

Follow relevant care pathway

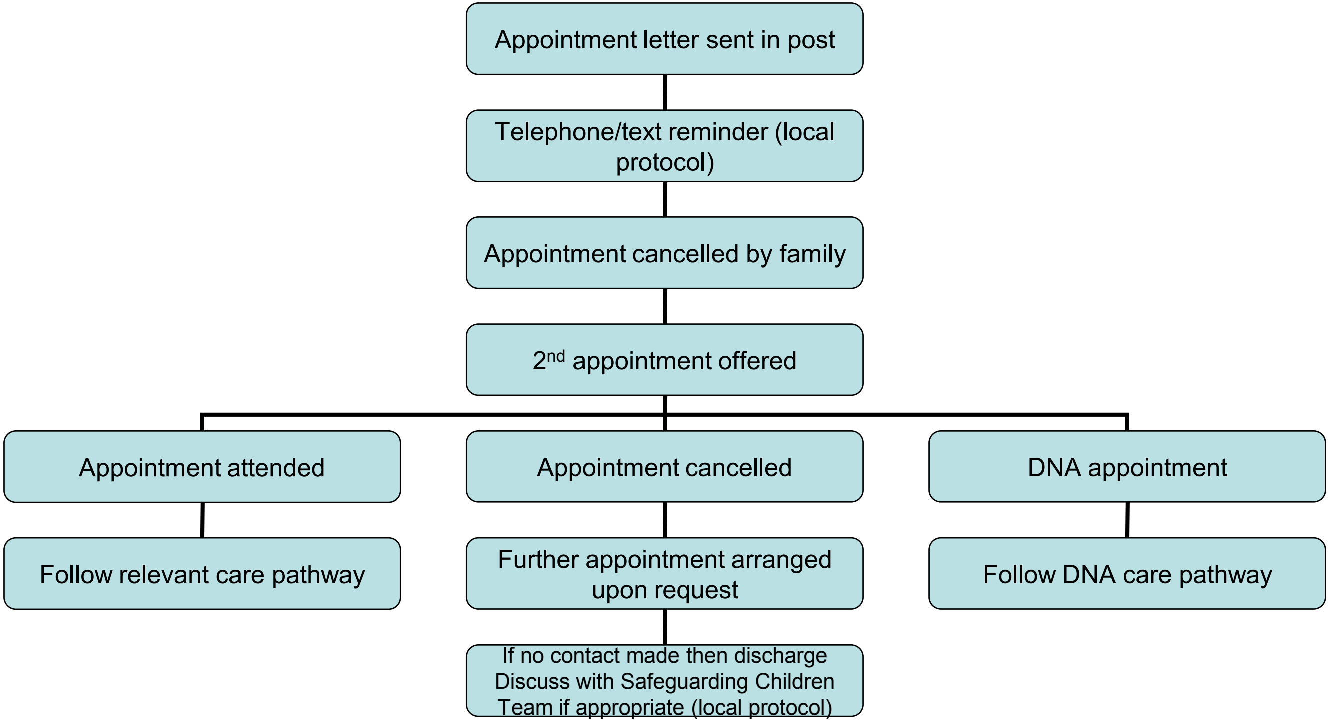
Appointment cancelled

Further appointment offered at discretion of clinician

DNA appointment

Follow DNA care pathway

Cancelled appointments – Existing patients (local protocol)



Appointment letter sent in post

Telephone/text reminder (local protocol)

Appointment cancelled by family

2nd appointment offered

Appointment attended

Follow relevant care pathway

Appointment cancelled

Further appointment arranged upon request

If no contact made then discharge
Discuss with Safeguarding Children Team if appropriate (local protocol)

DNA appointment

Follow DNA care pathway

Contents

References

1. Newborn Hearing Screening, Map of Medicine, 20 January 2011
2. Newborn Hearing Screening – NICU or SCBU protocol, Map of Medicine, 20 January 2011
3. Newborn Hearing Screening – Well Baby protocol, Map of Medicine, 20 January 2011
4. Quality Standards in the NHS Newborn Hearing Screening Programme, Newborn Hearing Screening Programme, revised July 2010
5. Resources for identification of PCHI following Newborn Hearing Screening, Cheshire CHSWG subgroup
6. Guidance for Auditory Brainstem Response testing in babies, v2.1, NHSP Clinical Group, March 2013
7. Summary of recommended ABR parameters v4, NHSP Clinical Group, 7 June 2013
8. Early audiological assessment and management of babies referred from the newborn hearing screening programme, v3.1, NHSP Clinical Group, July 2013
9. Guidelines for surveillance and audiological monitoring of infants and children following the newborn hearing screen, v5.1, NHSP Clinical Group, June 2012
10. Resources for targeted surveillance following Newborn Hearing Screening, Cheshire CHSWG subgroup
11. Cheshire East Sensory Inclusion Service, Joint Working Protocols from Diagnosis to Hearing Aid Fitting, December 2010
12. Permanent childhood hearing impairment management, Map of Medicine, printed February 2012
13. Amplification, Map of Medicine, printed February 2012
14. Guidelines for aetiological investigation of infants with congenital hearing loss identified through newborn hearing screening, BAAP/BAPA, January 2008
15. Cochlear implant – referral, Map of Medicine, printed 10 August 2009
16. NDCS Quality Standards in Paediatric Audiology, Guidelines for the Early Identification and the Audiological Management of Children with Hearing Loss, Volume IV, NDCS, October 2000
17. A Who's Who, A guide to relevant professionals following diagnosis of your child's hearing loss, The Countess of Chester NHS Foundation Trust
18. Family Needs Survey, Adapted with permission from Bailey and Simeonsson by Jane Dalzell, CHCD, University of Manchester, 2000. Bailey, D.B. and Simeonsson, R.J. (1988). Family Assessment in Early Intervention. Columbus, Ohio. Merrill Publishing Co.
19. Guidelines for Professional Links between Audiology and Education Services within a Children's Hearing Aid Service, Modernising Children's Hearing Aid Services, September 2005
20. Guidelines for the Taking of Impressions and Provision of Ear Moulds within a Children's Hearing Aid Service, Modernising Children's Hearing Aid Services, September 2005
21. Resources for earmould provision for 0-12 month old infants, Cheshire CHSWG subgroup

References

22. Guidelines for fitting hearing aids to young infants, NHSP Clinical Group, December 2009
23. Resources for hearing aid fittings and reviews for 0-12 month old infants, Cheshire CHSWG subgroup
24. Guidelines for the Fitting, Verification and Evaluation of digital signal processing hearing aids within a Children’s Hearing Aid Service, Modernising Children’s Hearing Aid Services, September 2005
25. Surgical management of otitis media with effusion in children, NICE Clinical Guideline 60, National Institute for Health and Clinical Excellence, February 2008
26. Role of the Doctor in the NHSP Team, BAAP/BAPA, July 2008
27. Medical Evaluation of children with permanent unilateral hearing loss, BAAP/BAPA, August 2009
28. Aetiological investigation into bilateral mild to moderate permanent hearing loss in children, BAAP/BAPA, April 2009
29. Aetiological investigation into severe to profound permanent hearing loss in children, BAAP/BAPA, October 2008
30. Vision care for your deaf child, NDCS, 2009
31. Cochlear implant – suitability, Map of Medicine, printed 10 August 2009
32. Cochlear implants for children and adults with severe to profound deafness, NICE technology appraisal guidance 166, National Institute for Health and Clinical Excellence, January 2009
33. To MAP or not to MAP: a pilot study of local cochlear implant reviews 2009, presented at BSA 2009 and BCIG April 2010
34. Referral reasons for pre-school children, Cheshire CHSWG subgroup
35. Resources for 2-tester behavioural hearing assessment, Cheshire CHSWG subgroup
36. Recommended procedure: Tympanometry, British Society of Audiology, August 2013
37. Protocol for the distraction test of hearing, Newborn Hearing Screening Programme, June 2003, www.nhsp.info/prots.shtml
38. Visual reinforcement audiometry testing of infants: A recommended test protocol, Version 2.0, NHSP Clinical Group, June 2008
39. Recommended procedure: Ear examination, British Society of Audiology, January 2010
40. Recommended procedure: Pure-tone air-conduction and bone-conduction threshold audiometry with and without masking, British Society of Audiology, 9 September 2011
41. Resources for earmould provision for pre-school children, Cheshire CHSWG subgroup
42. Resources for hearing aid fittings and reviews for pre-school children, Cheshire CHSWG subgroup
43. Referral reasons for school-age children, Cheshire CHSWG subgroup
44. Resources for 1-tester behavioural hearing assessment, Cheshire CHSWG subgroup
45. Resources for Audiology visits to special schools, Cheshire CHSWG subgroup

References

46. Practice Guidance – An overview of current management of auditory processing disorder (APD), British Society of Audiology, August 2011
47. Quality Standards: Transition from paediatric to adult audiology services, Guidelines for professionals working with deaf children and young people, The National Deaf Children’s Society, October 2011
48. Over to you: A report of young deaf people’s experiences of audiology, The National Deaf Children’s Society, March 2011
49. Resources for tinnitus and hyperacusis, Cheshire CHSWG subgroup
50. Resources for aetiological investigations into permanent childhood hearing impairment, Cheshire CHSWG subgroup
51. Vestibular pathway, Gill Painter and Jane Lyons, January 2010
52. Resources for vestibular investigations in children, Cheshire CHSWG subgroup
53. Resources for earmould provision for school-age children, Cheshire CHSWG subgroup
54. Resources for hearing aid fittings and reviews for school-age children, Cheshire CHSWG subgroup

Acknowledgements

Acknowledgement is given to Dr Lesley Batchelor for her contribution to earlier versions of this work.

The subgroup would also like to thank members of the Cheshire CHSWG for their feedback and comments on this work.

National Care Standards for Patients with Microtia and Meatal Atresia

On 18th September 2013 a meeting was held in Bradford Royal Infirmary to bring together professionals from around the UK working with patients who have microtia and meatal atresia, together with representation from patient groups and the voluntary sector.

Participants included plastic and reconstructive surgeons, otologists, maxillofacial surgeon, paediatricians, psychologist and audiologists.

The aim of the meeting was to collaborate to produce agreed Care Standards for this group of patients.

At the end of the meeting, some participants were given specific tasks to write contributions for the Care Standards and the result is a comprehensive document which integrates the cosmetic and hearing aspects in a holistic approach to the patient.

A follow up meeting took place at the Institute for Child Health in London on 18th June 2014. The draft Care Standards were reviewed and discussed.

It is planned that the final document will be produced by the end of August and that the Care Standards will be endorsed by BAPRAS, ENT UK, BAPA, BAAP, BAA, Microtia UK and will be made widely available.

Ruth Henderson

Associate Specialist,

Community Child Health

NHS Lothian

Hearing problems in cleft palate: Findings from parents and children involved in a qualitative study

Stephanie Tierney, Research Fellow, University of Manchester

Otitis media with effusion (OME) is common among patients with a cleft palate (CP); approximately 90% develop this problem (Grant et al., 1988; Sheahan et al., 2003). At present there is clinical uncertainty about the best way of treating OME in these children; are ventilation tubes (VTs) or hearing aids (HAs) best? The most robust way of addressing this question is through a randomised controlled trial. However, before carrying out such research, it is important to understand the experiences of those who have OME, to consider outcomes of importance to them and potential barriers to recruitment. This is why a team of researchers from the Cleft Collective in Manchester carried out MOMENT (Management of Otitis Media with Effusion in Children with Cleft Palate), a feasibility study funded by a Health Technology Assessment grant.

MOMENT consisted of several elements, including a qualitative study. We interviewed 36 mothers and 7 fathers; all had a child aged 0-11 years who had CP and experience of OME. We also talked to 22 of their children, if they were aged 6-11 years. Semi-structured interviews with parents lasted an average of 45 minutes. Those with children ranged from 10-40 minutes. Participants described their experiences of living with OME and approaches to managing it. We used framework analysis (Ritchie et al., 2003) to assist with interpreting the mass of data collected. In this article, some headline findings that will be of interest to audiologists are presented. Further details can be found in two papers that have been published from this study (refs).

Experiences with audiology:

Children were asked how they felt about going for a hearing test. Many described this experience as just another part of treatment, but several said they got anxious about these appointments. Their fear related, in part, to a lack of knowledge about what it was for, how it was performed and what the consequences might be if they had hearing difficulties. Several comments were also made about the discomfort that could be experienced during these tests due to the equipment used:

“Well, the headsets that they put on me are sometimes uncomfortable… It doesn’t have any stuff on it to make it soft… every time I go there I think I don’t like the headset.” (child 27)

A recurring statement from parents was how they struggled to comprehend feedback they received from audiology:

“I get reports from them, it gets sent to me, the school and the doctors, and I don’t understand it much [laughs]…The school actually asked me when I went for the meeting and said urm we keep receiving these, can you tell us what they mean and I’m don’t know, it’s just all sort of gobbledy gook …” (mother 34)

Some expressed their doubt about being able to pick up hearing problems when children were very young; they were unconvinced that the procedures used were rigorous enough to enable such a conclusion to be reached:

"I think there's someone playing with something in front of her while the other person switches on the sound and then she will turn round even before it urm moves. So sometimes I felt how accurate is it? I wasn't sure. Maybe she just likes looking to see what's going on rather than she's actually hearing that particular noise." (mother 11)

Most parents had been made aware of the possibility of VTs at diagnosis of the cleft but not everyone was told about HAs at this point. This meant that if HAs were later mentioned, parents thought this was because the child's hearing was more severe and required an escalation in treatment. When there was an option, parents were often swayed to try VTs if they could be inserted as part of the palate repair. However, other interviewees did not feel that the nature of the problem warranted a surgical approach, when there was what they perceived to be a suitable alternative:

"…when they told me that glue ear is something they can grow out of I didn't want, when they said you know 'if we keep putting these grommets in, we can only put so many in and it can cause damage, scar tissue,' I didn't want to go down that road. I thought well I'd rather him just have these hearing aids." (mother 1)

"It's not really fair on them to be put to sleep for half an hour while they stick the grommets in. So I've said if she needs any more she can have hearing aids. I don't want to put her through like being put to sleep, it's not very nice for them." (mother 29)

Ventilation tubes:

Interviewees were split in their views about VTs. Some described them as life-changing:

"I just think that [VTs] sort of opened up his world…It brings him in touch, keeps him in touch with everybody else [laughs]." (mother 4)

One mother talked about VTs giving the child more 'rounded' hearing because they did not have to be taken out at night. There was discussion about the everyday sounds that children heard once the VTs had been inserted, such as rain running down the window and bubbles in the bath. Yet for some children, initially at least, the amplified sound could be frightening:

"…we walked out of the door at [hospital] and a plane went over and he went screaming back into the hospital because he didn't like it, he…put his hands over his ears and he said 'Daddy I don't like it, I don't like it' and he wanted his balaclava and it was like in the middle of summer." (mother 5)

Other parents blamed VTs for the numerous ear infections their child endured:

"…you think you're doing the best for your child and it turns out that you're doing the worst because you come home and you can hear them crying in bed because they've got yet another ear infection [mum's eyes welling up]…I feel like every time she had [VTs] it didn't work so it was disappointing." (mother 24)

A major problem with VTs was that when they fell out the hearing loss often recurred. There was a sense of annoyance among interviewees when this happened because it could mean further surgery to get another set inserted. This related to a key concern mentioned by children about VTs – having an operation. Some did remark that they would be asleep so would not be aware of what was taking place, which made surgery easier to accept:

"…scared and nervous…how they do the operation, what they have to do, like if they have to cut the ear open or something…but when I had an operation on my hip urm well I didn't, I wasn't, you can't feel anything when you're asleep and they're doing it and you forget, when you wake up you forget what's happened." (child 27)

Conversely, other children expressed anxiety about being unsure what was taking place whilst they were anaesthetised:

"…not happy…you go to sleep and you don't know what they're doing to you." (child 9)

"I was a tiny bit nervous to be honest…I was not sure what was going to happen to me once I was inside the room." (child 35)

Hearing aids:

Parents were initially reticent to allow a son or daughter to have HAs, fearing it would be something else (aside from a visible scar or speech difficulties) that marked their child out as different. However, those who did opt for this management approach were pleasantly surprised at how well their son or daughter tolerated these devices. Children who wore HAs liked being able to customise them with stickers and glitter. Any difficulties with getting children to wear HAs tended to occur as they approached the time to move to secondary school and became more self-conscious about looking different:

"Since he's got a bit older now this is when it's bothering him. It's horrible to say like an image thing but obviously because he's always had them it's been nothing. Children at school have been brilliant because they've only ever known [child] with hearing aids…But I've noticed just these last few months he's questioned why he needs them." (mother 1)

There could be issues for parents with maintaining HAs, especially ordering enough batteries, if these had to be shared between home, a second location if parents were separated, and school. Parents also found it embarrassing having to request a new HA if their child had lost or broken one:

“I feel terrible ringing, they must thinking what are these parents doing with these hearing aids [laughs]. So I’ve had to leave it and look for it, give me a chance to look for it, give him a chance to turn round and say here are, here it is, cause he has done.” (mother 15)

“…he loses them quite regularly [laughs]…the last time he lost it was alright cause we obviously had, we had another hearing aid that he didn’t use any more, which they could re-programme cause I understand they’re quite expensive, the hearing aids…So that’s the only thing really cause they’re so small and expensive, like losing them’s bad.” (mother 33)

Children who wore HAs talked about how annoying it was when they had to change the batteries if they were in the middle of playing. There was also some discussion about having to remove a HA if they were in a noisy setting:

Interviewer: “Can you tell me a little bit more about what that’s like when the kids start screaming in the restaurant?”

Child 3: “Well it makes me a little bit, when they do it, it makes me feel like wanting to go over and just say ‘can you just shut up that baby please’…It’s just really going through my ears and hurting them… it drives me a bit crazy and you don’t want to see me crazy.”

Interviewer: “So when you’re in the restaurant what will you do?”

Child 3: “I turn them off and start trying to calm myself down but when I put it on, turn them back on, if they’re still screaming I turn them off again and if I turn them off three times, a third time, I just start getting a little bit more angry every time.”

Certain children mentioned being worried when they first got HAs in case they were uncomfortable or hurt. New moulds, according to some children, could take a bit of getting used to:

“…sometimes, when you…have to get the mould and everything, like the mould’s stiff to the other one, so like sometimes it’s like slimy or something like that and it’s not like what you had before and then like you want to change it or something. Sometimes I have to get used to the hearing of it, like it gets dead loud at first and then you get used to it.” (child 18)

Impact on social life:

Difficulty hearing was not always evident when the child was very young and in the home. Sometimes it only became noticeable once the child moved to nursery or school and was in a noisier environment. Mothers and fathers felt that they possibly adapted to the child’s lack of hearing, talking to them at eye level. Communicating with those outside the family was more problematic and when children were unable to make themselves understood or when they could not understand what others were saying they could become frustrated, which they demonstrated internally by becoming very withdrawn or externally by having a tantrum:

"…she was very closed off from people at school…She didn't really talk to anybody and I didn't understand how difficult that was until we found out how much of a hearing loss she had." (mother 13)

"…she was you know losing her temper a bit more quickly you know, I suppose frustration with it, when she couldn't hear what was going on." (mother 10)

Having OME could affect the child's participation in social activities. For example, swimming lessons could be difficult if they were unable to hear what instructors were saying. In addition, some children with a chronic ear infection refused to wear an ear plug because none of their friends did; ear plugs seemed less well tolerated then HAs, perhaps because children could not see an immediate benefit from wearing the former, compared to improved hearing with the latter.

Parents worried that poor hearing could be a barrier to learning and some felt their child was behind educationally because of their OME and a CP. As a consequence, most asked for their son or daughter to be sat at the front of the class, regardless of whether they had received VTs or HAs. Concentration, in particular, was an issue for some children and concerns were expressed about the move to secondary school where it was felt students were less supported and may experience more teasing:

"…the only anxiety I have, it would be nice for him to go to high school without having to wear hearing aids…he's gonna be in a bigger environment and once you're in the bigger environment it stands to reason someone's gonna say something and that and he can be quite sensitive sometimes, he can be you know, he'll bottle it or whatever but so there is that anxiety." (mother 27)

Advice to other parents:

At the end of an interview, parents were asked what advice they would give to others whose child had OME. Their comments included not waiting too long to address the problem, not missing appointments, asking questions and getting information about different treatment options. One person said be prepared for the long-haul, as hearing loss can be something that affects the child for years. A few interviewees said not to worry as it is not the most serious thing that can happen and there are ways it can be treated. Some interviewees recommended VTs, stating their insertion was a simple procedure that worked for their child, but others reiterated the point made above that VTs should not be used, believing they had caused their child numerous ear infections. Finally, parents said people should recognise that a child's behaviour may be a sign of frustration because he/she cannot hear, rather than labelling it as 'naughtiness'.

Conclusion:

A key idea to emerge from interview transcripts was an overall sense of not being prepared fully for various aspects of OME and how it may affect a several areas of the child's life. In particular, data implied that parents do not always receive all the information they require on treatment options and can be confused about the best means of assisting their child. Likewise, children were unclear about the role of hearing tests and what results may lead to, suggesting a lack of age-appropriate communication with them about these checks. We plan to carry out further work on the management of OME in CP. For details, please visit our website (http://cleftcollective.org.uk/) or sign up to receive our newsletter (http://cleftcollective.org.uk/manchester/) or follow us on Twitter (@CleftCollective).

This project was funded by the National Institute for Health Research Health Technology Assessment (NIHR HTA) Programme (project number 09/167/02) and will be published in full in Health Technology Assessment. The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HTA programme, NIHR, NHS or the Department of Health. This study is also supported by the Healing Foundation (Registered Charity number 1078666 Registered Company number 3831398). A special thank you to all the children and parents who took part in an interview for their time and for sharing their experiences.

A paper has been published describing this work: International Journal of Pediatric Otorhinolaryngology 77 (2013) 1742–1748

Summary of delegates evaluation of the BAPA London Conference

31st January 2014

Jane Dalzell BAPA Meetings Secretary, February 2014

71 delegates attended the conference and 58 evaluation forms were returned at the meeting. Three forms were returned later by post; the scores have been omitted because of time restraint however comments have been included.

The response rate was 85% which is very good.

We had 6 external speakers, 4 prize audit presenters, 2 exhibitors (2 did not attend) and 1 poster at the conference

Specialty and job title given at registration.

29 Associate Specialists

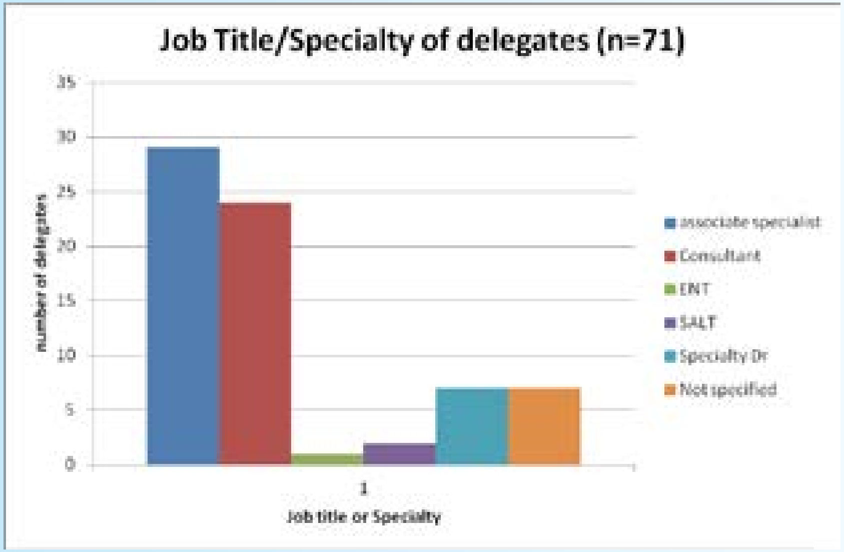
24 consultants

1 ENT Consultant

2 Speech Therapists

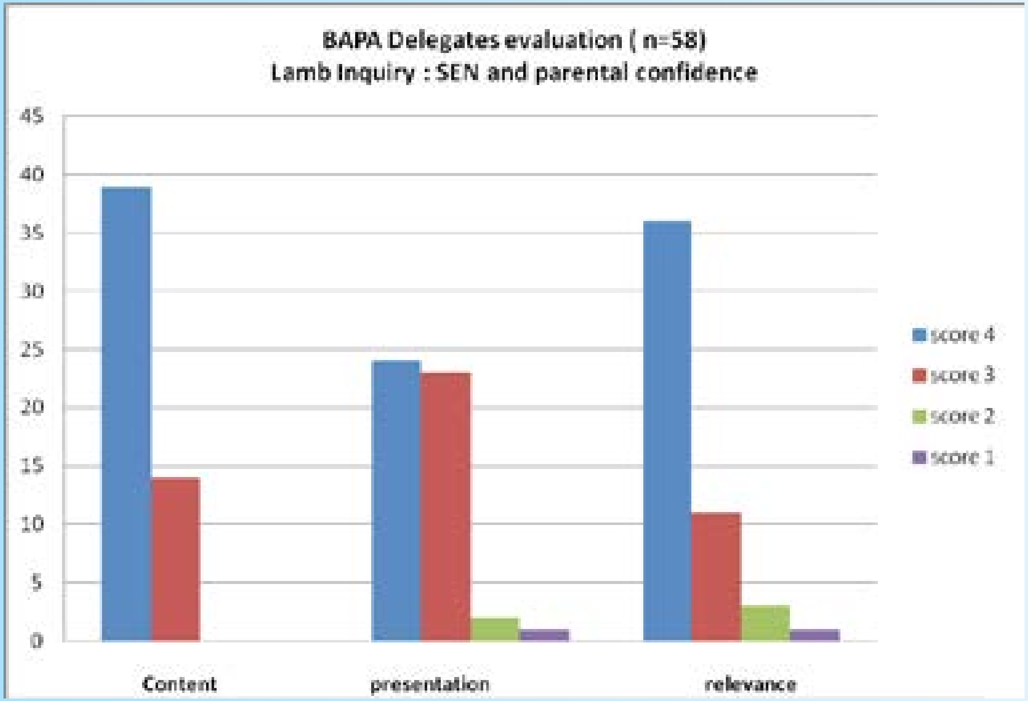
7 Speciality doctors

7 other – or unknown

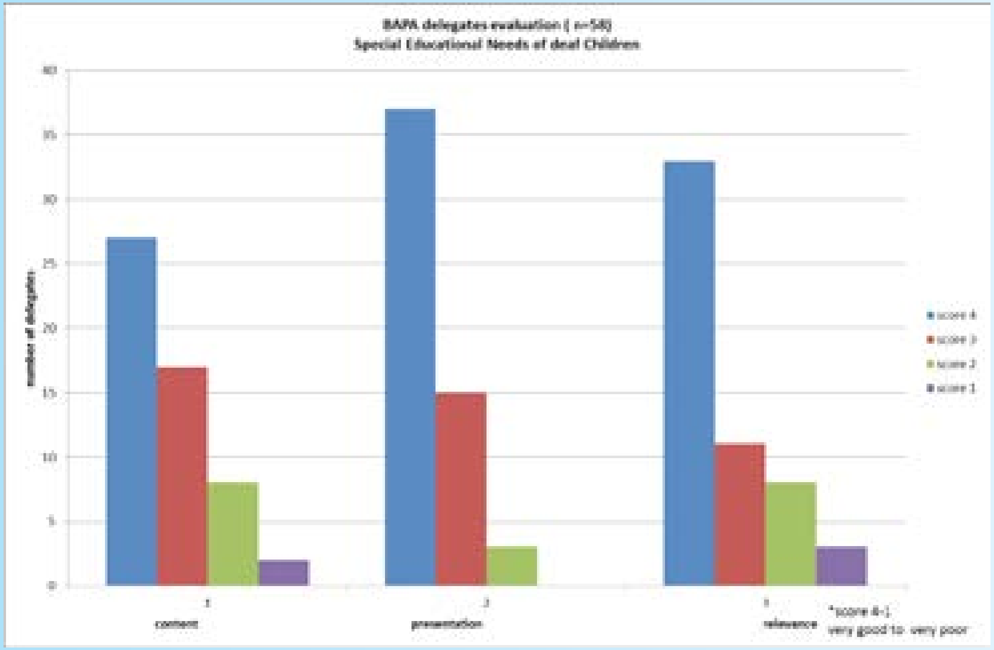


Presentations (score 4 = very good- score 1=very poor)

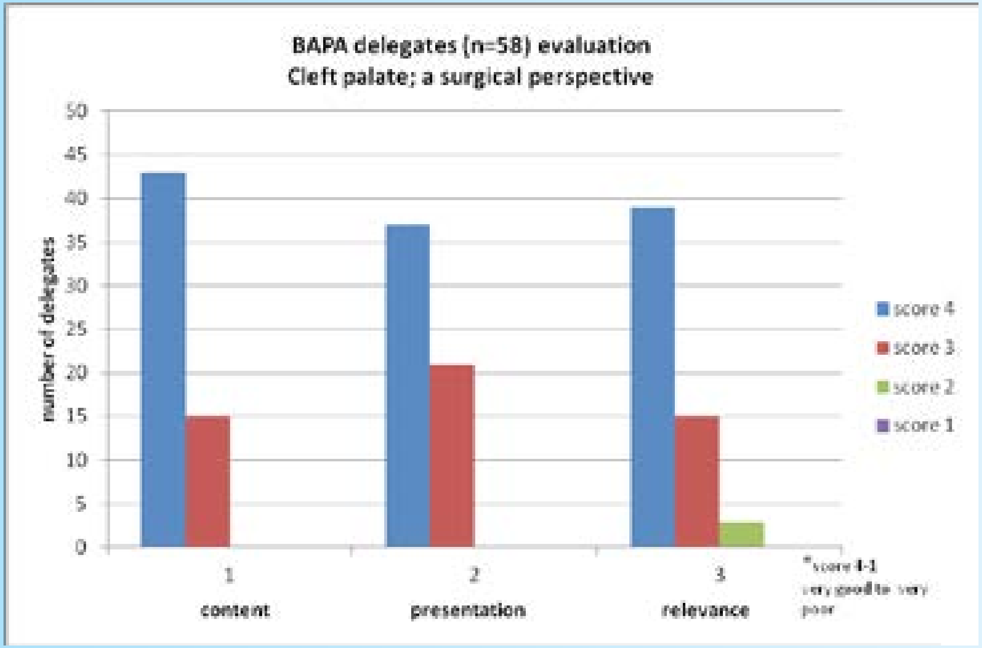
Brian Lamb OBE



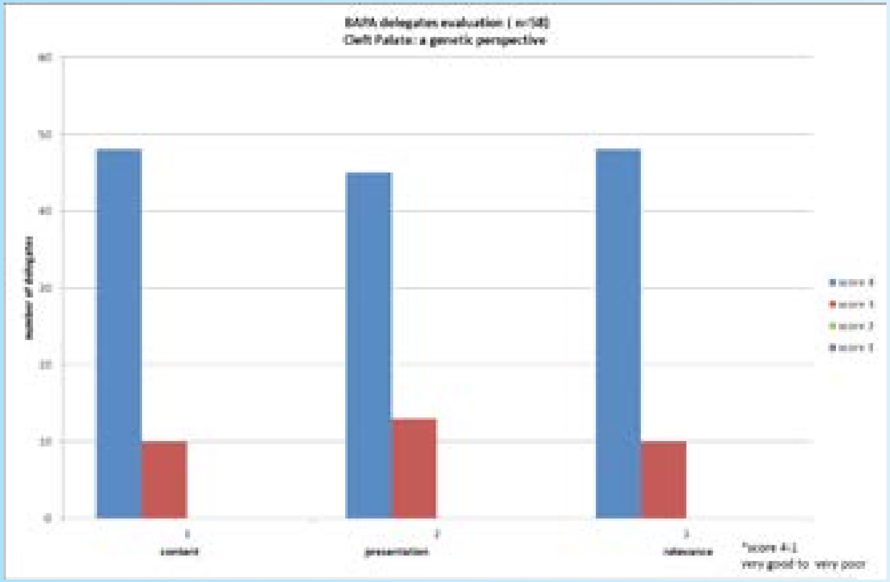
Mandy Shiel



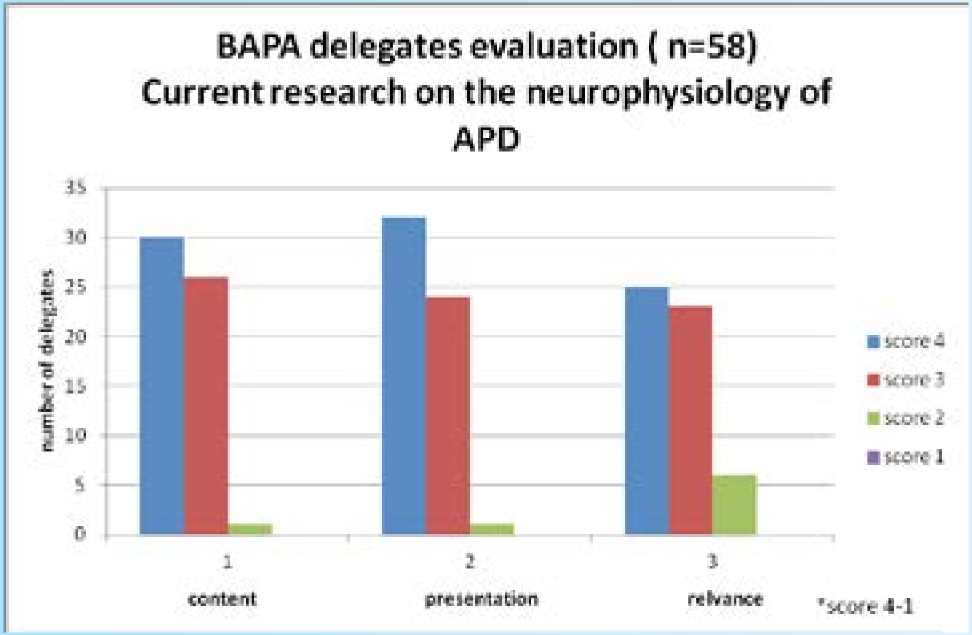
Contents


BAPA delegates (n=58) evaluation
Cleft palate; a surgical perspective
number of delegates
50
45
40
35
30
25
20
15
10
5
0
1
content
2
presentation
3
relevance
score 4
score 3
score 2
score 1
*score 4-1
very good to very poor

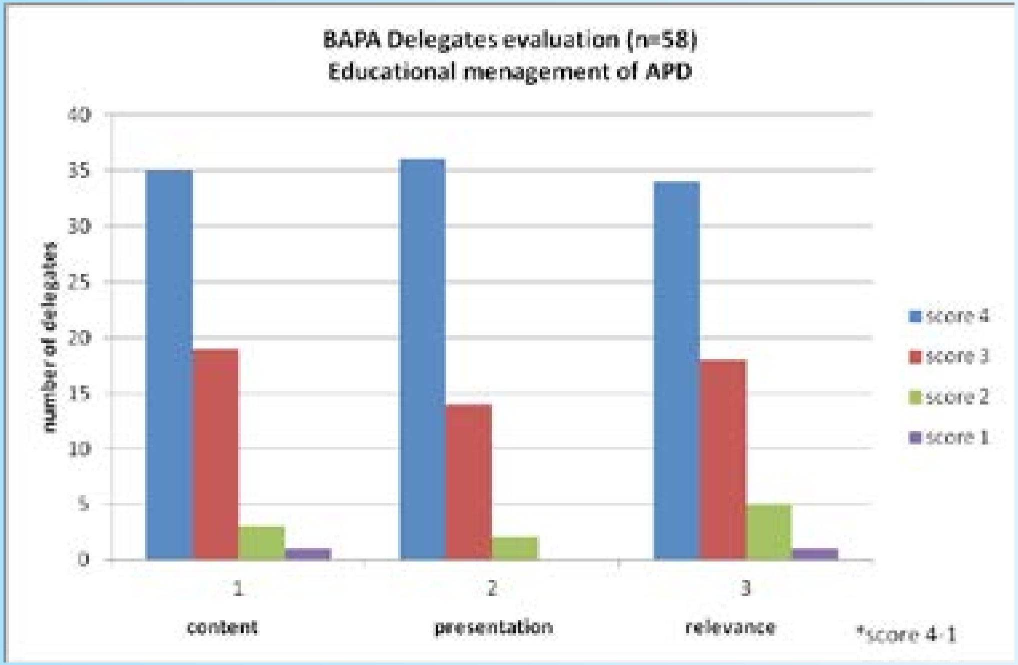
Annie Procter

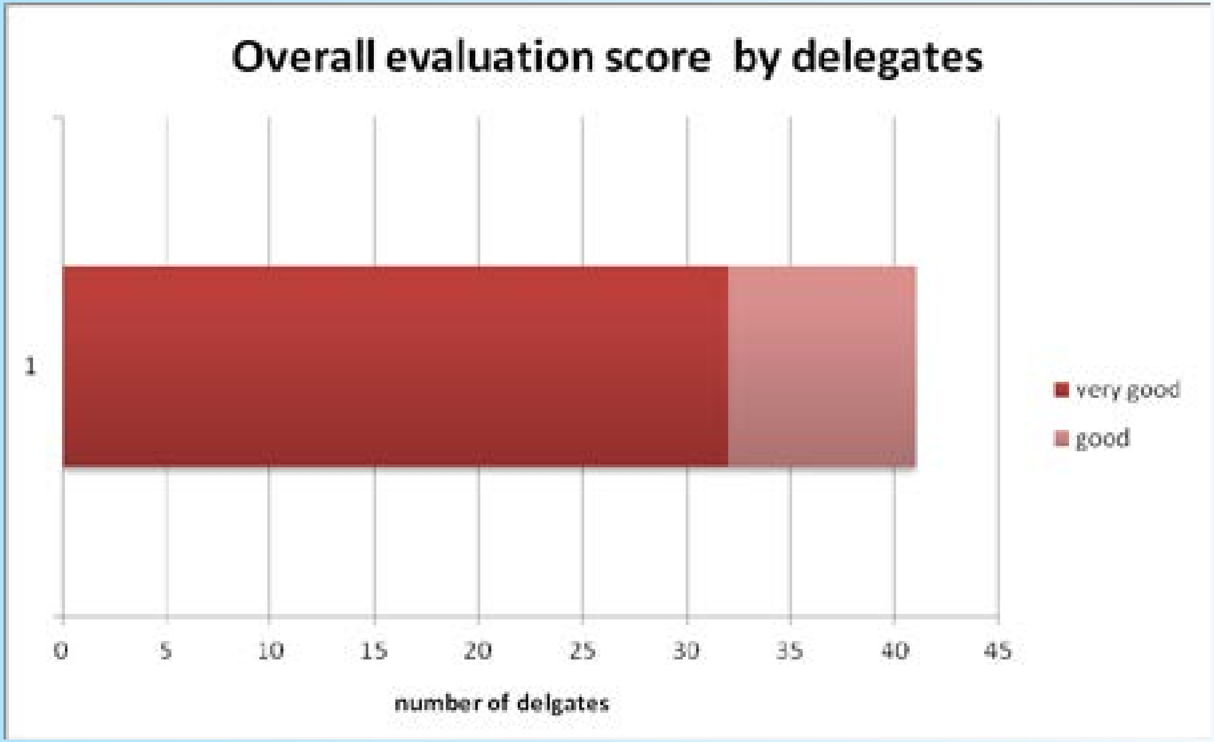


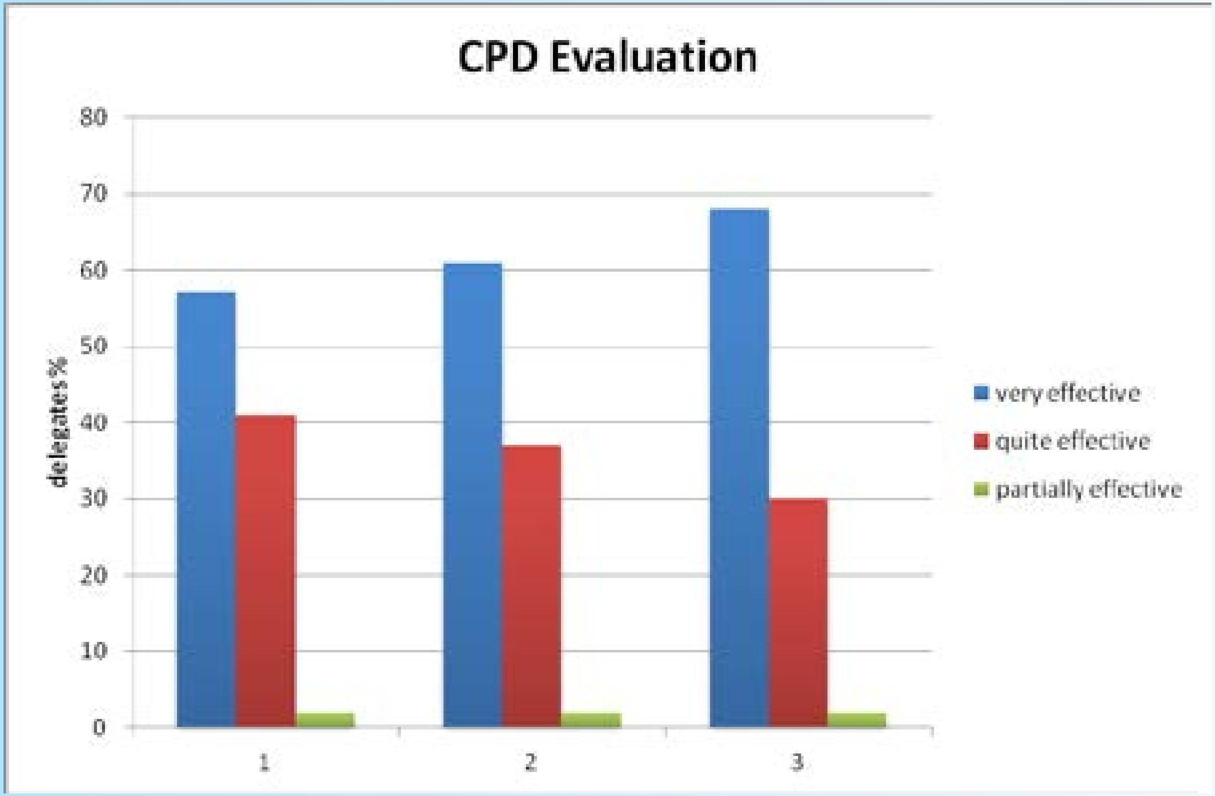
Jennifer Linden



Pauline Grant




Overall evaluation score by delegates
1
0
5
10
15
20
25
30
35
40
45
number of delgates
very good
good



1= relevance of meeting your educational needs

2= overall quality of education

3=overall effectiveness for cpd

Comments from delegates n=61

Terrible lunch (consider salad or veg to replace bread and rice)

Hardly any cakes/biscuits for tea in the morning-they were finished by 9.15 am in spite of very few people present

Another good meeting

Audit prize presentations added variety and should be continued-hopefully more entries next time

Excellent conference with good mix of different but related topics. I thought the audits a v. interesting addition to the conference

Another excellent meeting-thank you

Good meeting-interesting and informative

Wonderful. Happy, interesting and informative

Very good audits

Another good session

Venue very good, day well managed, excellent lunch, excellent audits-I would like to see copy of these on the website

Good to see ENT trainee involved

Great meeting thank you

Very good especially audit part -excellent

Liked the audit session

New to role so lots of useful info and also pointers on where to look for more information. Nice venue, easy to reach, able to hear speakers clearly

An excellent day

Overall excellent meeting-thank you. Many speakers referred to info in the pack that wasn't there. Hand outs that are readable and available for every talk would be very helpful.

Very good

Excellent update. I would like to have handouts by email for presentations that are not in the pack, thank you!

Very well organised day. It was a very good idea to have audit presentations

Excellent meeting. I like the audit format

Audit very good

If presenter's slides have detailed writing on them could there just be 4 slides per handout so they are more readable?

Good meeting. Well attended great catering and venue

Lovely food, great venue good talks good breadth very relevant

An excellent day. Very much liked the audit presentation session. More satisfying the Q and Q session

Excellent

Liked audit session but need to look at times. Would suggest speakers for 10min followed by 5 mins for questions

Much better balance of morning and afternoon with BAPA AGM in morning

Delicious lunch thank you

Well organised and quite informative meeting

Well-chosen themes

Lack of hand-outs after second speaker was unhelpful

Thank you for the lovely meeting!

Excellent, well organised. Good to give enough time to morning speakers this year felt less rushed. Excellent time keeping!

Future Conferences

Neuroimaging

Vestibular

Update of physiology of inner ear and auditory pathways

In-depth on APD (?by a lead clinician eg from GOSH)

Feedback from NHSP re PCHI identification including late diagnosis OAE vs AABR effectiveness (x2 requests)

Aetiological investigations- practicalities x3

Syndromes where both hearing and vision are affected

Non organic hearing loss (x2 requests)

More audits (x4 requests)

Sharing good practice in running community paediatric audiology clinic

Investigating late onset SNHL

Management of hypersensitive hearing in school

More genetics and auditory neuropathy

ANSD/ Auditory dysynchrony

Safeguarding and deafness; progress re social care and deaf child

Health and education plans

Autoimmune- hearing loss and investigation

Update on CMV (x3 requests)

CCG perspective about commissioning paediatric audiology services

Training in paediatric audiology

Contents

Appendix
Financial

Company registration number: 07445618   Charity registration number: 1142712
British Association of Paediatricians in Audiology (A company limited by guarantee)
Principal office 22 Goring Road, Llanelli, SA15 3HN

Annual Report and Financial Statements for the Period from 1 December 2012 to 30 September 2013

Trustees Dr Jane Lyons, Dr Veronica Hickson Dr Gillian Painter Dr Adrian Dighe, Dr Ken Abban, Dr Kathleen Coats

Bankers Royal Bank of Scotland
Preston Fulwood Branch, 2 Lytham Road, Fulwood, Preston. PR2 8JB

Accountant: Hallidays LLP, Chartered Accountants
Riverside House, Kings Reach Business Park, Yew Street, Stockport SK4 2HD

Trustees' Report

Structure, governance and management

British Association of Paediatricians in Audiology (BAPA) was incorporated on 19th November 2010 and is governed by the Memorandum and Articles of Association as amended by special resolution dated 10th June 2011.It became a registered charity on 4th July 2011. The assets of a not for profit organisation of the same name which was not a registered charity were transferred to BAPA on its registration.

BAPA is a private company limited by guarantee.

New trustees, who are also directors, are recruited by the exsisting trustees. Trustees retire by roatation. The charity may by ordinary resolution appoint a person who is willing to be a trustee, and determine the rotation in which any trustees are to retire.

Objectives and activities

BAPA's objectives are the relief of the handicap by the furtherance of the study of audiology and the revention, diagnosis and management of hearing impairment in children and other groups for the benefit of the public.

The objectives are met by the following activities-

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

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

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

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

Achievements and performance

During the period under review BAPA held its annual clinical meeting in London which was attended by 81 delegates. For the furtherance of higher learning, BAPA interacted with other professional bodies including: The Royal College of Paediatrics and Child Health, the British Association of Audiological Physicians, the British Society of Audiology, the Royal National Institute for the Deaf, the National Deaf Children's Society and the British Association for Teachers of the Deaf.

Financial Review

At the year-end BAPA had free reserves equivalent to approximately 30 months expenditure. The Trustees and Directors have approved a reserve policy of £34,000.

Small company provisions

This report has been prepared in accordance with the small companies regime under the Companies Act 2006.

Approved by the Board on 3 December 2013 and signed on its behalf by: Dr Ken Abban, Trustee

Chartered Accountants' Report to the Trustees on the Unaudited Accounts of British Association of Paediatricians in Audiology

In accordance with the engagement letter, and in order to assist you to fulfil your duties under the Companies Act 2006, we have compiled the financial statements of the charity which comprise the Statement of Financial Activities, and the related notes from the accounting records and information and explanations you have given to us.

This report is made to the Charity's Board of Directors, as a body, in accordance with the terms of our engagement. Our work has been undertaken so that we might compile the financial statements that we have been engaged to compile, report to the Charity's Board of Directors that we have done so, and state those matters that we have agreed to state to them in this report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Charity and the Charity's Board of Directors,
as a body, for our work or for this report.

We have carried out this engagement in accordance with technical guidance issued by the Institute of Chartered Accountants in England and Wales and have complied with the ethical guidance laid down by the Institute relating to members undertaking the compilation of financial statements.

You have acknowledged on the balance sheet as at 30 September 2013 your duty to ensure that the charity has kept proper accounting records and to prepare financial statements that give a true and fair view under the Companies Act 2006. You consider that the charity is exempt from the statutory requirement for an audit for the period.

We have not been instructed to carry out an audit of the financial statements. For this reason, we have not verified the accuracy or completeness of the accounting records or information and explanations you have given to us and we do not, therefore, express any opinion on the financial statements.

Hallidays LLP

British Association of Paediatricians in Audiology
Statement of Financial Activities (including Income and Expenditure Account) for the Period Ended 30 September 2013

		Unrestricted Funds	Total Funds 1 December 2012 to 30 September 2013	Total Funds Year ended 30 November 2012
	Note	£	£	£
Incoming resources				
Incoming resources from generated funds				
Activities for generating funds	2	14,780	14,780	16,348
Investment income	3	56	56	8
Total incoming resources		**14,836**	**14,836**	**16,356**
Resources expended				
Charitable activities	4	10,167	10,167	9,948
Governance costs	4	6,389	6,389	5,240
Total resources expended		16,556	16,556	15,188
Net movements in funds		(1,720)	(1,720	1,168
Reconciliation of funds				
Total funds brought forward		38,115	38,115	36,947
Total funds carried forward		36,395	36,395	38,115

British Association of Paediatricians in Audiology (Registration number: 07445618)
Balance Sheet as at 30 September 2013

		30 September 2013		30 November 2012	
	Note	£	£	£	£
Fixed assets					
Tangible assets	8		23		30
Current assets					
Cash at bank and in hand		43,482		46,136	
Creditors: Amounts falling due within one year	9	(7,110)		(8,051)	
Net current assets			36,372		38,085
Net assets			36,395		38,115
The funds of the charity:					
Unrestricted funds					
Unrestricted income funds			36,395		38,115
Total charity funds			36,395		38,115

For the financial period ended 30 September 2013, the charity was entitled to exemption from audit under section 477 of the Companies Act 2006 relating to small companies.
The members have not required the charity to obtain an audit of its accounts for the period in question in accordance with section 476.
The directors acknowledge their responsibilities for complying with the requirements of the Act with respect to accounting records and the preparation of accounts.
These accounts have been prepared in accordance with the provisions applicable to companies subject to the small companies regime and with the Financial Reporting Standard for Smaller Entities (effective April 2008).
Approved by the Board on 3 December 2013 and signed on its behalf by: Dr Jane Lyons, Trustee. and Dr Gillian Painter, Trustee

1

Accounting policies

Basis of preparation

The financial statements have been prepared under the historical cost convention and in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities (SORP 2005)', issued in March 2005, the Financial Reporting Standard for Smaller Entities (effective April 2008) and the Companies Act 2006.

Fund accounting policy

Unrestricted income funds are general funds that are available for use at the trustees' discretion in furtherance of the objectives of the charity. Further details of each fund are disclosed in note 12.

Incoming resources

Income derived from events is recognised as earned (that is, as the related goods or services are provided).

Investment income is recognised on a receivable basis.

Resources expended

Liabilities are recognised as soon as there is a legal or constructive obligation committing the charity to the expenditure. All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category.

Charitable expenditure comprises those costs incurred by the charity in the delivery of its activities and services for its beneficiaries. It includes both costs that can be allocated directly to such activities and those costs of an indirect nature necessary to support them.

Governance costs

Governance costs include costs of the preparation and examination of the statutory accounts, the costs of trustee meetings and the cost of any legal advice to trustees on governance or constitutional matters.

Support costs

Support costs include central functions and have been allocated to activity cost categories on a basis consistent with the use of resources, for example, allocating property costs by floor areas, or per capita, staff costs by the time spent and other costs by their usage.

Fixed assets

Individual fixed assets costing £100 or more are initially recorded at cost.

Depreciation

Depreciation is provided on tangible fixed assets so as to write off the cost or valuation, less any estimated residual value, over their expected useful economic life as follows:

Audiology equipment	25% written down value
Fixtures and fittings (including computers)	25% written down value

2
Activities for generating funds

		Total Funds	Total Funds
	Unrestricted Funds	1 December 2012 to 30 September 2013	Year ended 30 November 2012
	£	£	£
Subscriptions			
Subscriptions	5,910	5,910	6,530
Clinical meetings			
Clinical meetings- delegate fees	7,270	7,270	8,413
Advertisers & exhibitors	1,600	1,600	1,405
	8,870	8,870	9,818
	14,780	14,780	16,348

3 Investment income

		Total Funds	Total Funds
	Unrestricted Funds	1 December 2012 to 30 September 2013	Year ended 30 November 2012
	£	£	£
Interest on cash deposits	56	56	8

4

Total resources expended

	Membership	Clinical meetings	Other charitable activities	Governance	Total
	£	£	£	£	£
Direct costs					
Cost of goods sold	723	6,964	-	-	7,687
Accountancy fees	-	-	-	2,040	2,040
Depreciation of tangible fixed assets	-	-	8	-	8
	723	6,964	8	2,040	9,735
Support costs					
Office expenses	-	1,502	-	-	1,502
Printing, posting and stationery	288	-	-	-	288
Subscriptions and donations	-	-	332	-	332
Sundry and other costs	-	-	350	-	350
Cost of trustee meetings	-	-	-	4,224	4,224
Bank charges	-	-	-	125	125
	288	1,502	682 4,	349	6,821
	1,011	**8,466**	**690 6,**	**389**	**16,556**

5

Trustees’ remuneration and expenses

No trustees received any remuneration during the period.

6

Net (expenditure)/income

Net (expenditure)/income is stated after charging:	1 December 2012 to 30 September 2013	Year ended 30 November 2012
	£	£
Depreciation of tangible fixed assets	8	10

7 Taxation

The company is a registered charity and is, therefore, exempt from taxation.

8

Tangible fixed assets

	Plant and machinery including motor vehicles	Fixtures, fittings and equipment	Total
	£	£	£
Cost			
As at 1 December 2012 and 30 September 2013	29	24	53
Depreciation			
As at 1 December 2012	12	11	23
Charge for the period	4	3	7
As at 30 September 2013	16	14	30
Net book value			
As at 30 September 2013	13	10	23
As at 30 November 2012	17	13	30

9

Creditors: Amounts falling due within one year

	30 September 2013	30 November 2012
	£	£
Other creditors	5,640	6,527
Accruals and deferred income	1,470	1,524
	7,110	8,051

10

Members' liability

The charity is a private company limited by guarantee and consequently does not have share capital. Each of the members is liable to contribute an amount not exceeding £10 towards the assets of the charity in the event of liquidation.

11

Related parties

Controlling entity

The charity is controlled by the trustees who are all directors of the company.

12

Analysis of funds

	At 1 December 2012	Incoming resources	Resources expended	At 30 September 2013
	£	£	£	£
General Funds				
Unrestricted income fund	38,115	14,836	(16,556)	36,395

13

Net assets by fund

	Unrestricted Funds	Total Funds 30 September 2013	Total Funds 30 November 2012
	£	£	£
Tangible assets	23	23	30
Current assets	43,482	43,482	46,136
Creditors: Amounts falling due within one year	(7,110)	(7,110)	(8,051)
Net assets	36,395	36,395	38,115

British Association of Paediatricians in Audiology
Statement of financial activities by fund Period Ended 30 September 2013

	Unrestricted income fund 2013	Unrestricted income fund 2012
	£	£
Incoming resources		
Incoming resources from generated funds		
Activities for generating funds	14,780	16,348
Investment income	56	8
Total incoming resources	14,836	16,356
Resources expended		
Charitable activities	10,167	9,948
Governance costs	6,389	5,240
Total resources expended	16,556	15,188
Net movements in funds	(1,720)	1,168
Reconciliation of funds		
Total funds brought forward	38,115	36,947
Total funds carried forward	36,395	38,115

This page does not form part of the statutory financial statements.

Any changes?

If any of your details have changed, please let BAPA know by sending your details to Isabelle Robinson: isabelle.robinson@rcpch.ac.uk

Please be sure to include the following:

Name,

Address,

Post code.

Preferred Email address,

Home Tel. No.,

Work Tel. No.

BAPA Conference Registration Form

BAPA Conference – Friday 30th January 2015

Please reserve me a place at this meeting

Name	
Address, (for confirmation of place)	
Post code	
Work address (for delegate list)	
Post code	
E-mail	

- ☐ I enclose a cheque/BACS for £120 (BAPA members)
- ☐ I enclose a cheque/BACS for £130 (Non- members)
- ☐ Early Bird Offer £95 (BAPA and non-members – payment before 1st Dec)
- ☐ I enclose a cheque/BACS for £55 – Non-medic BSA, BATOD, BAA RCSLT: membership number ______

Payment options

☐ Cheque with your registration form made payable to BAPA

☐ Bank transfers to be credited to BAPA-RBS Preston Fulwood RBS 2 Lytham Road, Fulwood, Preston, PR2 8JB.

Account details: Sort code 16-20-16; A/C No. 10068508.

Please forward a copy of your payment advice to Mrs. Pam Williams, quoting the Customer name

☐ Please indicate here if you require a loop system

Special dietary requirements ____

Opportunities for poster displays, enquires to:

Dr J Dalzell / Mrs Pam Williams: pamelawilliams@onetel.com

Delegates are invited to submit audit presentations – please see BAPA website www.BAPA.uk.com for details.

Please email Dr Anne Large by 15 November 2014 (closing date)

ann.large@wwl.nhs.uk

Please return this form by email or post: Mrs Pam Williams

23 Stokesay Road SALE Cheshire M33 6QN, Tel: 0161 962 8915 pamelawilliams@onetel.com

Closing date for applications Friday 16th January 2015