



Audiens Interactive

The Newsletter of
The British Association of Paediatricians in Audiology
Newsletter 53
Winter 2015

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Disclaimer

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

AUDIENS

Contacts	Page 3
List of Officers	Page 5
Editorial Dr. Anne Marsden	Page 6
Chair Report Dr Kathleen Coats	Page 8
Reports from around the Regions	Page 11
Census of doctors working in paediatric audiology 2014 Dr Gill Painter	Page 16
Integrated System of Care for Children and Young People with Hearing Impairment	Page 23
Report on networks. Dr Jane Lyons	Page 31
So what was it like? Auditory Processing Disorder, so what! At BACCH DrVeronica Hickson	Page 34
Treasurer's Report	Page 37
Annual Report and Financial statements 2014	Page 38
Advertisers	
Amplivox www.amplivox.ltd.uk	Page 2

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From the Editor

Dear All

I write this on returning from the December BAPA exec meeting. It occurred to me at the last couple of exec meetings that the wider BAPA membership who have had no involvement with the exec probably have little idea what goes on and what is discussed. Hence I am enclosing today's agenda.

When I first joined I expected to discuss finance, membership and the AGM (which we do). However there was much I hadn't expected, liaison with other organisations I had heard of, BACCH, BSA, PAIG, BAAP and some with acronyms I am still getting used to, HABUK, UKCoD etc.

See the draft agenda at the end of this editorial

As you can see, a wide variety of topics are covered.

Veronica and Shankar's session at the BACCH annual meeting is an example, and their experience is shared here. If you or one of your colleagues is interested in leading a session at a future BACCH or RCPCH meeting, please let your rep know. We are always looking for topics (and people to present). Those members working in community/general paediatrics as well as audiology are in an ideal position to know what current topics in audiology are relevant to the wider paediatric audience. We are always looking for more people to take up positions on the exec, don't wait to be asked! Contact your rep if you are interested.

Also included is an update on networks from Jane Lyons. The scope of the work is England only, so if you work in Wales, Scotland or N Ireland, it would be interesting to know how services are working together, and how the challenges are being met there.

Moving to an electronic format for Audiens should make it easier for members to contribute, but despite previous pleas this hasn't happened. Please consider contributing in 2015. Be it an interesting patient, article you have read, meeting you have been to, or changes to your service in the 'new NHS', all gratefully received. I hope to have the next edition ready for May 2015. Please send me any submissions by 30 April 2015.

I am looking forward to the exciting programme Ann Large has compiled for the annual meeting, and especially to the audit presentations. I am sure there will be something for everyone to take away and reflect on for their own practice. It isn't too early to think about your submission for the next BAPA prize or audit submission for the 2016 conference. Details will appear on the BAPA website, or contact your rep.

I hope to see many of you at the conference

Anne Marsden

BAPA EXECUTIVE COMMITTEE MEETING
Tuesday 2nd December 2014 at 10.30am – 4.30pm
Meeting Room 1, on the 5th floor. Venue: - RCPCH
Draft Agenda

1. Housekeeping, Welcome & Apologies for Absence
 2. Minutes of last meeting*
 3. Matters Arising
 4. AGM 2015 - including elections
 5. BAPA website - Any requests to advertise, links, updates – Membership form, Hallpike prize
 6. Meeting Secretary*
 - a. January 2015- Programme, advertising,
 - b. Future circulation
 7. BACCH ASM –2015?
 8. RCPCH meeting 2016?
 9. Aetiology training course - update
 10. BAPA Prize & audit prize – 2015,
 11. E-mail communication with members
 12. Company Information – Membership
 13. QS in NBHSW
 14. Down's Syndrome recommendations
 15. BAAP
 - a. new constitution
 - b. audit presentation
 - c. Paediatric AVM training / Workforce
 16. Rapid Response requests / information circulated since last meeting *
 - a. NDCS Listen Up! campaign
 - b. BSA – Lightning Update
 - c. UCL Ear Institute Master class
 - d. BSA Trustee nominations
 - e. BSA PPC nominations
 - f. <http://www.bbc.co.uk/news/world-asia-29089856>
 - g. BSA Tinnitus in children
 17. Discussion of circulated reports* from
 - a. Chair*
 - b. Past Chair
 - c. Treasurer*
 - d. Regional Representatives**
 - e. HABUK feedback from KC
 - f. RCPCH SIG Convenor
 - g. Audiens*
 - h. UKCoD rep*
 18. Liaison with BACCH, BSA, PAIG
 19. Other organisations meetings – feedback & future dates – BSA Hallpike,, Lunch & learn.
 20. Details of present or forthcoming job vacancies/retirements
 21. AOB
 - a. a...
 - b. b
 22. Dates / venue of future meetings All meetings at RCPCH
 - a. Wednesday 11th March 2015
 - b. Friday 12th June 2015
 - c. Monday 21st Sept 2015 note change date and room
 - d. Thursday 3rd Dec2015*
- (Written report in advance please). *circulated - please read in advance of meeting

British Association of Paediatricians in Audiology (BAPA)

Chairman's Report

Annual General Meeting

January 2015

I have had the privilege and anxiety of being chair of BAPA since the AGM in January 2014 when Gill Painter stepped down. Thanks to Gill's excellent chairmanship and her continued support as past-chair the transition from vice-chair to chair has not been quite as traumatic as I had feared.

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 have these meetings at the RCPCH and have the assistance of the BACCH secretariat with sending out information by email to the membership. For this communication with the membership to be successful it is vital that we hold up to date information of current email addresses. We still have members for whom we have no email address or an address which "bounces". You will have had an opportunity to update/supply an email address when you registered this morning, please can you make sure you have given us this information.

We continue to foster links with the British Association of Community Child Health (BACCH), as chair I attend their meetings. As part of this affiliation we have been contributing to the BACCH Annual Scientific Meeting (ASM) by providing a workshop. The 2014 workshop was on the topic of auditory processing disorder under the thought provoking title "APD-so what". This proved very popular and sessions were full and very interactive. We hope to provide another workshop at the ASM in September 2015 and our aim is for it to be equally as popular.

BAPA and BAAP (British Association of Audio-vestibular Physicians) continue to work together as the Audiovestibular Medical Federation, the chair of each attending the others meetings. BAAP have been updating the guidelines for aetiological investigation into mild to moderate bilateral permanent childhood hearing impairment and for investigation into permanent unilateral hearing loss. BAPA were asked to comment on these before they were submitted for NICE approval. We also contribute to the BAAP Audit meeting in Sheffield, this year Laura Keast, a medical student at Cardiff presented "A Service Evaluation of Routes of Identification of Childhood Hearing Loss Post Newborn Hearing Screen".

We continue to respond to requests from other organisations to endorse or give advice on publications. This year we have been asked for advice on an update on the guidelines on hearing monitoring for children & young people with Down syndrome. This is being rewritten by the Down Syndrome Medical Interest Group (DSMIG) for submission for approval to NICE and we await the final draft. We have also endorsed the guidelines on Microtia.

We have had no submission for the BAPA prize for the 2nd year, however the submissions for the audit prize have almost doubled which is very pleasing and you will have the opportunity of hearing some of these this afternoon

Our membership numbers have increased slightly with 3 resignations & 5 new members. We now have 3 categories of membership full: associate membership (reduced cost for retired members & those doctors who are in training posts) and student membership, which is free.

The subject of audiovestibular training for paediatricians continues to be discussed within the RCPCH. There is an acknowledged need for paediatricians with training in this discipline and the College Special Advisory Committee (CSAC) chairs of the RCPCH & RCP have been working on the content of a “module” that would give community paediatric trainees the relevant competencies. A module relating to safeguarding is expected to be rolled out in February 2015 but the timeframe for an audiovestibular module is not yet known

This year there have been changes within England regarding the Newborn Hearing Screening Programme (NHSP). Since March 2014 funding has altered and now comes under Public Health England which will be involved with the “screening aspect”. NHSP therefore no longer takes responsibility for the Quality Assurance (QA) of diagnostic assessment and early habilitation of those babies identified as hearing impaired beyond the initial hearing screening process. BAPA was concerned about the effect this might have on the equality and consistency of the service within England. We therefore, jointly with BAAP, wrote to Mr Duncan Selbie, the Chief Executive of Public Health England, expressing our concern on the subject of the cessation of the Quality Assurance of the Newborn Hearing Screening Programme within England. This was copied to several others including Professor Sir Bruce Keogh, Medical Director, NHS England and Hilary Cass President of RCPCH.

We stressed the importance of the whole pathway (not just the identification of the hearing loss). We expressed the hope that appropriate priority would be given to the re-introduction of some form of Quality Assurance. If this was to be through the proposed managed networks, we felt that there would need to be a robust framework with careful monitoring and evaluation of standards. We stated that our opinion was that any networks should be properly and formally organised with appropriate funding and authority to give recommendations to those Trusts where there are shortcomings in provision. We have had a reply from Public Health England which did not say anything about medical input. It informed us that the National Deaf Children’s Society’s audiologist was working with IQIPs to ensure that standards previously part of the NHSP QA are fully embedded into IQIPs guidance. No real information about the managed networks was given other than to say that Sir Muir Gray & Professor Adrian Davis were involved with the growth & development of regional audiology networks.

NHSP also delivered an aetiology training course which was strongly recommended for all doctors involved in the management of those babies identified as hearing impaired from the newborn screen. The doctors currently organising this course have approached the Audiovestibular Medical Federation to ask whether we would be prepared to take over the organisation and provision of the Aetiological Investigation Course. We have agreed to take this on and have nominated a lead person from each organisation. They will shadow Dr Siramanna & Dr Harrop-Griffiths at the next aetiology course in 2015 and then take over.

We would like to have more involvement from the whole membership and have asked the regional reps to inform us of challenges/risks perceived in their regions as well as any meetings that have taken place. We are also discussing the possibility of putting the Agenda for the exec meetings on the website so that everyone can be aware of what we discuss –this would also give members an opportunity to put forward, through their regional reps, things they might like discussed.

Finally I would like to thank all of the exec committee for the advice & help given throughout the year and to appeal for someone to volunteer as Vice Chair.

Kathleen Coats

Reports from around the Regions

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.

Report Scotland

The Scottish group meets 3 times a year, in March, June and November.

At our March AGM we elected new office bearers and received reports from the chair and treasurer on the previous year. This was followed by a business meeting, considering the following items –

- Information from PASAG on the variability of provision of TOD's across Scotland and on the development of standardised information leaflet
- Exec report
- Plans for the next study day, on 7/11/14
- Production of national microtia guidelines

We then looked at some case studies as our educational component.

At our June business meeting we discussed –

- Information from PASAG on the development of a Local Record of Deaf Children, development of standardised information leaflets, a technology group at the Scottish Sensory Centre, the use of outcome measures by audiology and the possibility of a MCN for paediatric audiology
- Quality assessment visits, which are not taking place in 2014
- Plans for the next study day
- Production of national microtia guidelines

This was followed by a farewell meal with retiring/retired colleagues

The BAPA Scotland Study day, "Balancing Act" – A Multidisciplinary Approach, took place on 7/11/14 at The Royal College of Physicians, Edinburgh.

We had 4 speakers and almost 60 delegates. The day concluded with a panel discussion. The evaluation was mainly positive, the venue was “beautiful” and the food “excellent”. The day was a success, following a lot of hard work by the organising team, and thanks to the speakers, venue staff and caterers.

The group is a great support to the members, as many of us do not have local colleagues in this specialised field. Thank you to all our enthusiastic members.

Alison Schulga – Chair of BAPA Scotland and Regional Representative alison.schulga@nhs.net

South East Region

The South East region covers a broad area of the UK which includes London. We have not met as a region this year but a regional meeting for CPD is planned for 2015. This suggestion was received positively by seven out of the current twenty five members. Consultation is out as to possible topics and speakers, with a venue yet to be confirmed but will probably take place in London.

The Oxford Thames Valley Clinical Network group (which includes some BAPA members) has met twice. This included heard interesting talks about congenital CMV infection and its early diagnosis and treatment and Usher syndrome from our regional clinical genetics service. Members of the group have in particular found it an extremely useful forum for sharing lessons learned from case studies, and also communicate regularly by email as a peer review tool for specific clinical questions. The group also discussed aetiology data entry to eSP and most members are not doing this because of the time pressures.

We are looking at the possibility of introducing a peer review advice sub-group on email to help members who may be relatively clinically isolated in their local areas.

Feedback from members was limited regarding specific regional issues. However, feedback received specifically regarding the medical arm of paediatric services highlighted the main pressure being a general increase in workload. Dr Yogi Thakker, Consultant Paediatrician in Milton Keynes, is retiring this summer and therefore the Trust is proactively seeking an appropriate replacement. She is also the lead paediatrician for children with Down Syndrome, so applicants able to accommodate this would also be welcome, although the lead for aetiological assessments for children with hearing impairment is their main priority.

Georgia Jackson

South East Regional Representative

Report Yorkshire and the North East

As a group we have met up twice this year. Numbers have varied from a small group of 8 to 12. There have been several contributions from most members of the group. We have also had one outside speaker.

During our last meeting we had several case discussions focusing on vestibular difficulties. These were cases referred by members of the group to our regional centre. A case of vestibular difficulties in a child with congenital cytomegalovirus infection and frequent falls resulting in injuries and consequently being put into foster care, illustrated the importance of obtaining a definite diagnosis of an absent vestibular system which then led to a change in management of this child.

General discussions also took place on the responsibilities and changing input for paediatricians in audiology. We touched on a discussion on the eSP database for aetiological investigations.

At our previous meeting in May, we had a presentation on 'The process on Peer Review'. This is something that would be useful for a lot of us but rather difficult to implement.

We also talked at length about the management of microtia after a very thought provoking presentation.

We were grateful to have an outside speaker - Lead Speech and Language Therapist (SLT) for the Northern and Yorkshire Regional Cleft Palate Service who spoke on 'Speech and language Therapy and the Patient with Cleft Lip and Palate/Velopharyngeal Dysfunction'.

We endeavour in the near future to invite more outside speakers to keep us up to date with information that overlaps with audio-vestibular work.

Winifred Baddoo (North East and Yorkshire Rep.)

email: winifred.baddoo@nhs.net

NW BAPA region report

The report from the North West can be summarised under the following headings as per feedback received from members:

- Challenges faced by the region and pressures on the workforce – As with other regions in the rest of the country, the North West also faces several challenges. There are increasing pressures on everyday activities in the paediatric services. These include:- reduction in clerical and admin support, relocations of office, change of staff, introduction of electronic health records, centralisation of appointments, choose and book, breaching waiting times, multidisciplinary working with other services who are experiencing the very same pressures
- Changes in the workforce that have occurred and advance warning of any planned changes – Dr Jane Dalzell will be retiring from her post in Chester at the end of March. A Consultant Audiovestibular Physician post will hopefully be advertised there in due course. Other possible retirements include Dr Jane Lyons at Bury and Dr Gill Painter at Manchester. It is not yet very clear how their post will be replaced. There are concerns regarding training in the field. Dr Jane Dalzell commented that she recently met two doctors interested in developing a special interest in audiology, one a specialty doctor who has completed some audiology modules at Manchester but is working primarily in school health. She now does a session of audiology each week and hopes in the future she might train further. Another is a specialist registrar with no experience but would like to know more about the training and a career in paediatric AV Medicine.
- Meetings in the region – BAPA and other relevant/audiology related – There are regular peer group meetings in the North West, including the North West Paediatric Audiology Audit group, Mersey Deanery group, Paediatric Audiology Clinical Network in the North West group and ABR peer review groups. Given the number of such regular meetings, it has not always been possible to arrange other BAPA meetings. This is especially given the pressures on study leave and clinical commitments that everyone faces.
- QA and accreditation status of the local/regional audiology services – Some services are in the process of registering for IQIPS. Paediatric Audiology services, along with the Adult Audiology services, at Rochdale has been IQIPS accredited. Some services have raised their concerns about the cost and increased workload this will produce. It was also felt the QA did not provide any leverage with commissioners to develop parts of the Paediatric Audiology service as recommended
- Networks for audiology and related services – It is generally felt networks are a very good idea and important for this specialty. There is an active Paediatric Audiology clinical network group North West, which meets regularly at Rochdale. Discussions are ongoing about converting the Mersey Deanery Paediatric Audiology Group into a regional network group and try and keep the focus not only on strategic issues but also supporting and sharing knowledge

Dr Shankar Rangan - BAPA North West representative , Consultant Audiovestibular Physician (Paediatrics)

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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 S West & S Wales

A successful local meeting was arranged by Claire Wison which took place in September in Cardiff. She has agreed to continue to organise an Annual Regional Educational Meeting but has felt unable to continue as the representative for the region

Please discuss with other members for a named representative to channel communications and information both between members and the executive. Please inform a Trustee or member of the Executive of details of new Regional Representative.

Census of doctors working in paediatric audiology 2014

Members of BAPA and BAAP were circulated with the census form in January 2014 and a reminder was sent out about 6 weeks later to non responders.

68 responses were received; 29 from consultants, 29 from associate specialists and 10 from specialty doctors or equivalent.

The sessions worked in paediatric audiology are summarised in table 1.

Table 1.

	No. of sessions worked per week in paediatric audiology				
Grade	0	1-3	4-7	8-11	Total
Associate Specialist	3	12	8	6	29
Consultant	3	8	7	11	29
Specialty Doctor or equivalent		7	3		10
Total	6	27	18	17	68

This shows that 59% of the responders work full time or the majority of time in paediatric audiology services.

Many of the doctors also work in other specialties, mainly community paediatrics and adult audiovestibular medicine. This

particularly applies to associate specialists and specialty doctors.

Table 2.

	Grade			
Work in other specialties	Associate Specialist	Consultant	Specialty Doctor or equivalent	Total
None	10	16	2	28
Community paediatrics	15	3	5	23
Adult Audiovestibular medicine		8		8
Acute paediatrics	1		1	2
Educational adviser for SAS doctors			1	1
ENT			1	1
General Practice	1			1
Medical Management		1		1
National Adviser	1			1
Neonatal neurodisability		1		1
Public Health	1			1
Total	29	29	10	68

Only 10 doctors (15%) were not involved in carrying out aetiological investigations on babies / children who have been found to have a permanent hearing loss. For 40%, they were the only ones doing this in their service.

Table 3.

	Grade			
Aetiology carried out by:	Associate Specialist	Consultant	Specialty Doctor or equivalent	Total
Me alone	12	11	4	27
Me with someone else	10	18	3	31
Someone else	7		3	10
Total	29	29	10	68

Where others were also carrying out aetiological investigations, these were mainly community paediatricians and audiovestibular consultants (85%).

Table 4

	Grade			
Aetiology also carried out by:	Associate Specialist	Consultant	Specialty Doctor or equivalent	Total
Acute Paediatrics	3			3
Audiovestibular medicine	4	12	2	18
Community paediatrics	8	5	4	17
ENT	1	1		2
Paediatric Audiology	1			1
Paediatric Neurodisability		1		1
Total	17	19*	6	42

* One consultant indicated that she had two colleagues from different specialties who also carried out aetiological investigations.

Balance assessment in children with a permanent hearing loss has become a required part of aetiological assessment but is only carried out by 41%, mainly consultants.

Table 5.

	Grade			
Carry out balance assessment	Associate Specialist	Consultant	Specialty Doctor or equivalent	Total
No	24	10	6	40
Yes	5	19	4	28
Total	29	29	10	68

The survey then asked about the age range of children seen within paediatric audiology and how many sessions for each group per week. It proved difficult for responders to break this down into number of sessions per week.

The majority of doctors (73%) spent between less than one session to two sessions per week seeing babies identified through newborn hearing screening.

Table 6.

	Grade			
Sessions per week babies from NHSP	Associate Specialist	Consultant	Specialty Doctor or equivalent	Total
None	7	2	3	12
<1	9	6	2	17
1	8	14	2	24
2	2	5	2	9
3	2			2
4		1		1
Not stated	1	1	1	3
Total	29	29	10	68

There was a wider spread of sessions worked seeing children aged 6 months to 4 years.

Table 7.

	Grade			
Sessions per week 6mths - 4yrs	Associate Specialist	Consultant	Specialty Doctor or equivalent	Total
None	2	1	1	4
<1	6	5	1	12
1	8	6	2	16
2	9	6	2	17
3	3	4	2	9
4	1	5	1	7
5		1		1
Not stated		1	1	2
Total	29	29	10	68

For older children, there were 14 (21%) who do not see this age group at all. This is not unexpected as the majority of these children should be able to be assessed by audiologists.

Table 8.

	Grade			
Sessions per week 4yrs+	Associate Specialist	Consultant	Specialty Doctor or equivalent	Total
None	7	5	2	14
<1	7	10	3	20
1	12	7	2	21
2	2	3	2	7
3		1		1
4		1		1
5		1		1
Not stated	1	1	1	3
Total	29	29	10	68

Children with complex needs are a group that should have medical input and the majority of responders did see these children

Table 9.

	Grade			
Sessions per week complex needs	Associate Specialist	Consultant	Specialty Doctor or equivalent	Total
None	1	2	2	5
<1	8	6	4	18
1	14	7	2	23
2	5	5	1	11
3		5		5
4		2		2
5		1		1
Not stated	1	1	1	3
Total	29	29	10	68

We asked responders when they were likely to retire. 24 (35%) are planning to retire within the next 5 years.

Table 10.

	Grade			
Likely retirement	Associate Specialist	Consultant	Specialty Doctor or equivalent	Total
Next 6 months	4	2		6
Within the next year	3	1		4
Within 5 years	8	6		14
Within 10 years	9	5	3	17
Over 10 years	5	15	7	27
Total	29	29	10	68

There has been concern that over the last few years when doctors working in paediatric audiology have retired, their posts have been lost and replaced by audiological scientists, audiologists, ENT surgeons or community paediatricians.

Responders reported that within their services, 418 sessions of medical paediatric audiology per 4 week cycle had been lost over the last 5 years. This represents more than 10 full time medical posts.

Discussion

The questionnaire was completed by 52 BAPA members (47% of those still working), the rest were members of BAAP who work in paediatric audiology services, at least in part.

There were equal numbers of associate specialists and consultants; more of the AS doctors worked in another specialty, usually community paediatrics.

Only 10 doctors in the survey did not carry out aetiological investigations and many were the sole person doing it in their service. Of the other specialties who carried out aetiological investigations, the majority were either in community paediatrics or audiovestibular medicine.

Only 41% carried out balance assessments and these were mainly consultants. This perhaps identifies a need for training in this area.

Most doctors spent some time each week seeing babies and children aged 6 months to 4 years, as well as complex children whereas there were fewer who saw older children, as might be expected.

There has been a recent increase in the appointment of consultants in paediatric AVM which is reflected in the number of consultants who are not retiring in the next ten years. However 35% of the responders are expecting to retire within the next five years and

there are concerns that the main route to these posts is now through training in AVM. This specialty is experiencing difficulty recruiting to their training posts and there is the potential therefore for there being no one available to fill these posts.

Anecdotal evidence has been confirmed by this survey in that a high number of medical paediatric audiology sessions have been lost over the last 5 years; if this were to continue it would have implications on who would be able to carry out aetiological assessments, monitor babies with permanent hearing loss and those with complex needs.

Gill Painter

AN INTEGRATED SYSTEM OF CARE FOR CHILDREN AND YOUNG PEOPLE WITH HEARING IMPAIRMENT

The document describes an integrated system approach to the delivery of services to children and young people with hearing impairment.

Section A outlines a nationally agreed service scope which has been developed through two national stakeholder partnership workshops and through piloting in five developing networks.

Section B outlines the local network infrastructure and will be completed by each local network to reflect their partner structures and resources.

A. NATIONAL SCOPE	
1. Scope of the system	<p>The system is designed for children and young people in England with all degrees of hearing impairment up to the point of transition to adulthood and adult services (which should occur before the age of 25). All stages in the management of children and young people with hearing impairment and support for their parents should be included: screening, assessment, differential diagnostics, and all aspects of subsequent management including education and social support. This also includes temporary or recurrent episodes of temporary hearing impairment; unilateral and conductive hearing losses; and other specialised paediatric audiological disorders such as auditory processing disorders, auditory neuropathy/spectrum disorder, and children with complex needs.</p> <p>The system does not include paediatric balance disorders, which should be covered by a separate system.</p>
2. Population served	The system covers the whole population of England with care being delivered through local systems which have an annual birth rate of between 15-30K.
3. Aim of the system	The aim of the system is to enable children and young people to fulfil their social, emotional, communicative and educational potential, by maximising their use of auditory sensory information. Central to this is the facilitation of confident communication. The importance of non-speech environmental sound awareness is also acknowledged, as are the needs of sign language users.

4. Objectives of the system	<ol style="list-style-type: none">1. To identify children and young people with hearing impairment through screening and other pathways as early as possible.2. To confirm the nature and degree of hearing impairment accurately and quickly.3. To provide effective medical and surgical assessment and management of hearing impairment and appropriate technical assistance including implantable devices.4. To prevent preventable permanent hearing impairment.5. To provide integrated multidisciplinary cross-organisational support.6. To provide support and information to the child or young person and their family and support them through transition to adult services.7. To enable each child to develop effective communication skills.8. To develop the skills of all staff involved with children and young people with hearing impairment.9. To mitigate inequity.10. To make the best use of resources.11. To promote and support research and the adoption of innovation.12. To provide an annual report to the population served by the system.
-----------------------------	--

Objectives	Criteria	Levels of performance for quality standards
<p>1. To identify children and young people with hearing impairment through screening and other pathways as early as possible</p>	<p>1. A NHSP programme is in place across the system.</p> <p>2. School screening programme in place which may include a school exit screen, and online self testing in schools.</p>	<p>1. The programme is delivered to defined approved national standards.</p> <p>2. 95% coverage; records to include date of assessment; record of loss; and record of intervention.</p>
<p>2. To confirm the nature and degree of hearing impairment accurately and quickly.</p>	<p>1. A comprehensive range of audiological tests and a full audiological assessment is carried out appropriate for the child's age and stage of development and taking into account the presence of additional and complex needs</p> <p>2. The tests that are carried out accurately measure the child's hearing.</p> <p>3. The tests are undertaken in a timely fashion</p> <p>4. A full explanation of the assessment and results is given to the parents or carers</p> <p>5. A full explanation of hearing loss, deafness and the available management and support is given to parents and carers.</p> <p>6. A system of active "watchful waiting" is available for children with "glue ear".</p>	<p>1.a) All referrals are investigated using appropriate testing for the child's age and development.</p> <p>b) Staff who take overall clinical responsibility for the treatment and care of the child must have a specialist qualification in paediatric audiology or be able to demonstrate equivalent clinical paediatric experience.</p> <p>2. a) The equipment used in the assessments is serviced and calibrated at least annually in accordance with the periodic verification of audiometric equipment specified in IEC 60645-1 and ISO 8253-1.</p> <p>b) All children should be assessed in a family friendly, sound proofed room complying to DH Technical memorandum 2045 and ISO 8253.</p> <p>3. 80% of children with PCHI of any degree have their hearing loss confirmed within 3/12 of referral with 98% confirmed within 6 months.</p> <p>4. a) All parents and carers accompanying the child are given an appropriate verbal explanation of the assessment results on the day of the assessment.</p> <p>b) All parents and carers accompanying the child are given details of the next steps on the day of the assessment.</p> <p>c) All parents and carers accompanying the child are given information and contacts for sources of support.</p> <p>5. All parents and carers accompanying the child are given an appropriate explanation and information about hearing loss and deafness including written information about "glue ear" or permanent hearing loss, to include the Early Support information and details of the multi-agency support available.</p> <p>6. All children with "glue ear" are offered an audiological assessment following the period of active "watchful waiting".</p>

Objectives	Criteria	Levels of performance for quality standards
<p>3. To provide effective medical and surgical assessment and management of hearing impairment and appropriate technical assistance (including implantable devices).</p>	<ol style="list-style-type: none"> 1. Referral for aetiological investigation and paediatric assessment. 2. Provision of appropriate amplification as required: <ol style="list-style-type: none"> a) Hearing aid fitting offered for confirmed cases of hearing loss where appropriate. b) Hearing aids fitted to match the amplification needs of the infant in order to provide effective amplification. c) Provide support for hearing aid use and monitor hearing aid function. 3. Referral for cochlear implant assessment is offered where indicated. 	<ol style="list-style-type: none"> 1. All parents of babies and children with confirmed hearing loss to be offered referral to appropriate medical consultants in a timely fashion – evidence based or informed by professional guidance. <ol style="list-style-type: none"> a) All appropriate cases offered hearing aid fitting within 4 weeks of confirmation of hearing loss, unless delayed for management reasons. b) Appropriate hearing aids are fitted according to MCHAS guidelines and programmed with appropriate features using real ear measures and prescriptive fitting rule. c) Robust ongoing audiological care including regular checking of hearing aids, hearing aid settings, and use in the home is carried out. This information is shared with colleagues to form part of each child's integrated support and audiology care plan. 3. 90% of profoundly deaf children identified through newborn screening whose parents wish for implantation to be implanted before the age of 12 months.
<p>4. To prevent preventable permanent hearing impairment.</p>	<ol style="list-style-type: none"> 1. Promote awareness of preventable causes of hearing impairment. 2. Raise awareness among healthcare professionals of the preventable causes of hearing impairment. 3. Provide robust evidence to support epidemiology of hearing loss. 	<ol style="list-style-type: none"> 1. Information available in all healthcare settings. 2. Reduction in number of children with preventable hearing impairment per 1,000 births.
<p>5. To provide integrated multidisciplinary cross-organisational support.</p>	<ol style="list-style-type: none"> 1. Cross organisational integrated care from multidisciplinary teams is available to support children and their families. 2. Develop a common approach to pathway support and the data needed to assure the pathway. 	<ol style="list-style-type: none"> 1. <ol style="list-style-type: none"> a) A written agreement (with terms of reference) which details how different service providers will give integrated support across disciplines and organisations is available. b) The universal Health and Development review process is used and reviewed every 2 years. c) Education Health and Care assessments (detailed in the Children and Families Bill) are delivered through appropriately commissioned joint arrangements. 2. Data is available to, and shared across all partners providing care to children and their families. The system is working towards shared data systems.

Objectives	Criteria	Levels of performance for quality standards
<p>6. To provide support and information to the child or young person and their family, and to support them up to and during their transition to adult services.</p>	<ol style="list-style-type: none"> 1. Availability of reliable evidence based, age, cultural and language appropriate information (for children, young people and their families); access to information through a range of media including email and web based technologies. 2. Information is developed in partnership with children, young people and their families to ensure it is appropriate. 3. All children with permanent hearing impairment to have access to support from an appropriately skilled workforce 52 weeks of the year: <ol style="list-style-type: none"> a) Informing education/support services b) Availability of early support c) Support networks d) Ongoing coordinated support e) Access to social care support 4. Transition to adult services. 5. Developing early communication. 	<ol style="list-style-type: none"> 1. All families are given information in appropriately accessible form 2. Information given to families reflects a partnership approach to its development. 3. a) Children's Services (usually education) are notified within one working day of confirmation of PCHI. <p style="margin-left: 40px;">Families are offered a visit within two working days of contact (year round).</p> b) All families of babies and children with confirmed PCHI are provided with an explanation of the full range of support available. c) All families of babies and children with PCHI are given the opportunity to meet other families of deaf children and also contact with older deaf children and adults. d) All families of babies and children with confirmed PCHI are offered a main professional contact to provide ongoing regular support and ensure a co-ordinated and coherent service. Integrated support and audiology care plans are shared with children, young people and their families; education and social care plans are shared across all partners. e) The social care needs of all families with a deaf child should be reviewed as part of an initial assessment by the lead professional. In all areas there should be available a member of Social Care staff, with appropriate expertise in working with deaf children and their families to respond to the identified needs. 4. All families are supported through a structured transition to adult services and independent self-care where appropriate. 5. All families of babies with PCHI to be given information about the full range of communication approaches and supported in their choices, in accordance with the principles of Informed Choice.

Objectives	Criteria	Levels of performance for quality standards
<p>7. To enable each child to develop effective communication skills.</p>	<p>1. Information about the ways in which children's communication skills are developed and the relationship between hearing and communication is given at the audiological assessment.</p> <p>2. Information is given to the parents on accessing resources and facilities which are available to support and develop the child's communication.</p> <p>3. Communication and language development of children with PCHI should be equivalent to their normally-hearing peers</p>	<p>1. All parents and carers accompanying the child are given information which will contribute to the integrated support and audiology care plan and which addresses the child's communication skills and requirements.</p> <p>2.</p> <p>a) All children with a PCHI must have their integrated support and audiology care plan reviewed regularly and at least annually.</p> <p>b) All children with a PCHI should have their language and communication progress continually monitored and outcomes measured at regular and prescribed intervals.</p> <p>c) The results of the language and communication assessments must be available to the parents and the multi-agency team with ongoing assessments available to monitor the child's progress.</p> <p>3. Children with PCHI should have language and communication skills at the key developmental stages comparable to their hearing peers.</p>
<p>8. To develop the skills of all staff involved with children and young people with hearing impairment.</p>	<p>1. Staff can produce documented evidence of appropriate and ongoing professional development.</p>	<p>1. All staff to participate in appropriate CPD and educational programmes.</p>
<p>9. To mitigate inequity.</p>	<p>1. Action across the multidisciplinary teams to support hard to reach and engage families, children and young people with hearing loss.</p> <p>2. Appropriately trained interpreters available when required.</p> <p>3. Minimum training standards for care professionals supporting hard to reach and engage families, coordinated across professional groups.</p> <p>4. Routine collection of data on service use in areas of deprivation.</p>	<p>1. All services</p> <p>2. All services</p> <p>3. All services</p> <p>4. All services</p>

Objectives	Criteria	Levels of performance for quality standards
10. To make the best use of resources.	<ol style="list-style-type: none"> 1. Systems are in place to minimise missed appointments. 2. With the agreement of the parent or carer, information is properly shared across clinical staff and agencies. 3. There is a system of joint procurement and rationalisation of hearing aids, listening systems and other devices to minimise purchase and maintenance costs. 	<ol style="list-style-type: none"> 1. DNA rate <5%. 2. Compliance with the sharing of information on children assessed in the audiology department is regularly audited. 3. The use of hearing aids, listening systems and other devices that have been purchased through a joint procurement system is regularly audited.
11. To promote and support research and the adoption of innovation.	<ol style="list-style-type: none"> 1. Establish networks for sharing research expertise and for joint data collection. 2. Participate in locally and nationally led research projects. 3. Understand the national and international evidence to promote early adoption of innovation. 4. Links with Academic Health Science Networks for support and help. 5. Establish protected time for research and the promotion of innovation adoption. 	<ol style="list-style-type: none"> 1. All services 2. All services 3. All services 4. All services 5. All services
12. To provide an annual report to the population served by the system.	<ol style="list-style-type: none"> 1. Data on meeting the standards outlined in this template to be published by networks. 	<ol style="list-style-type: none"> 1. All services

B. LOCAL INFRASTRUCTURE	
6. Resources (Identify all the resources in the system, to create a system budget)	
7. Partners (All the partners to be engaged in a clinical network)	
8. System specification	
9. Define a plan to build the system	

Integrated System of Care for Children and Young People with Hearing Impairment

Background

There have been 3 meetings on this theme in the last few months. Following a mandate from Sue Hill, Muir Gray and Adrian Davies, Lesley Burn and Gwen Carr have been driving forward the development of networks and a national system for paediatric audiology. This applies only to England and not for other areas of the UK, and in England there are 146 audiology services and 100 community services, 152 local authorities and 211 CCGs. It has been made very clear that there is no funding for these proposals. The first meeting that I was aware of was in January, but I was unable to attend, and so I attended the next one in February, and the most recent one in September. The aim seems to be that following the changes to the Quality Assurance (QA) for Newborn Hearing Screening (NHSP) and audiology there should be a system for ensuring high quality in paediatric audiology services.

A document entitled “An integrated system of care for children and young people with hearing impairment” has been produced. This describes an integrated system approach to the delivery of services to children and young people with hearing impairment.

“Section A outlines a nationally agreed service scope which has been developed through two national stakeholder partnership workshops and through piloting in five developing networks.

Section B outlines the local network infrastructure and will be completed by each local network to reflect their partner structures and resources.”

NHSP QA is no longer running as a full service peer review. NHSP is now peer reviewed with other screening programmes, so that there is now no QA for audiology, education and social services. Therefore the thrust of the discussions at these meetings is to develop clinical networks in paediatric audiology, so that no service should work in isolation, and networks should meet together for peer review and quality assurance.

Networks

At the meeting in February there were questions about the scope of the networks and population size, but probably covering a birth rate of 20-30,000. Although initial discussions were just around audiology services, it has been quickly realised that our education colleagues should be included. The document, “An integrated system of care for children and young people with hearing impairment” mentions 5 pilot sites which are East Midlands, North East Anglia, North East, North East London and East of England. All are at different stages of development. North East England, North East Anglia and East Midland have registered on NHS networks as paediatric audiology clinical networks.

The North East of England network has commenced with a description the network, but feel that they are very restricted because of lack of funding and resources. The network has engaged with education. All participants are hospital trusts. The first exercise was service mapping, including any gaps, and a spreadsheet has been circulated to participating services in that area, with aim being to build up a directory.

East Midlands reported in February that they have found it difficult and have made limited progress, and there was no report in September.

North East Anglia has formed a network with paediatric audiology services only. However, some data has been collected on birth rate, available training, services available and staffing levels. Some key challenges include finance, time, QA, IQIPPS, training, NHSP consumables, children & families act, governance of network & effecting change. The question was raise as to what happens if a service does not engage.

East of England (which I think is around Essex) network meets quarterly, has held regional training days, and has a confederated CHSWG, with annual meeting, and local CSHWGs. The work includes report sharing, minimal discharge criteria and standardised listening questionnaires, to try and standardise care across the area. There are challenges of leadership, resourcing, ensuring continued involvement, implementing agreed changes, IT infrastructure.

North East London network covers 5 districts. There are no problems with networking for the 3rd tier audiology services, but there is difficulty engaging 2nd tier and school screening. The network has been looking at quality measures, e.g. repair clinics and glue ear, and also performance indicators (listed in “An integrated system of care for children and young people with hearing impairment”), but they are only able to report on 50% of these. As second tier audiology is often managed by Child Health in this area it has been difficult to ascertain how these 2nd tier services perform in terms of quality. The network has identified that 1.5 audiologist are needed per 100, 000 of population for regular review of deaf children. The network has also feels that there needs to be integrated pathways between health & education, as well as discussions with ENT, paediatrics, school nursing etc.

In addition to the pilot sites there is an established network in the North West, chiefly centred on **Greater Manchester**. The population of Greater Manchester is 2.7 million, with a birth rate of just over 37,000. As other networks have already, mentioned lack of funding is a problem, as even basic secretarial support is limited. The network meets twice a year to discuss current practice and share ideas.

Annual Report

Muir Gray has placed a lot of emphasis on the importance of producing an annual report, which he says should be for both parents and commissioners. He feels that no paediatric audiology service should work in isolation. The annual report should be shared with Health & Well-being boards through the Director of Public Health. It should cover performance compared with national standards

and other similar services. It should be used for learning and improvement, and use the objectives listed in “An integrated system of care for children and young people with hearing impairment”. The report should be factual with figures on 1 side of A4, taken from the objectives, so that it can be used to inform CCGs as to what is a good paediatric audiology service. The next task is to develop a template for a report, but I don’t think there are further meetings planned at the moment.

I feel that BAPA members should become actively involved in clinical networks, including setting them up where necessary. This is a good opportunity to promote high quality paediatric audiology services. Below is the link for presentations from the September meeting:

<http://www.healthcarepublichealth.net/hearing-re-sources.php>

Jane Lyons, October 2014

So what was it like?

Auditory Processing Disorder, so what! At BACCH

On the way back from the Executive meeting I wondered what I had let myself in for. I should never have opened my mouth to suggest the need to present APD to the general population of Paediatricians at the BACCH meeting. At least it was going to be near to home in Cardiff and I was sharing the responsibility with Shankar Rangan.

The first 'hurdle' was filling in the Application Form. We decided by email that we wanted to try and present an interactive questioning workshop. We got this done in time – oh, and I applied for study leave! We have to get everything signed off in plenty time to cancel clinics and not upset anyone. Once the Application was accepted I was able to tell my manager that I would get a free day and travel paid on the day I was presenting. It all helps with the Department Budget.

It all went quiet for awhile. Suddenly the date began to loom on the horizon – along with my Annual Appraisal, requests for information for an audiology audit from a neighbouring area looking at the wider picture, a presentation for the S West and S Wales BAPA study day and annual leave – to complicate it Shankar was off on Annual Leave at a different time. It was as well to have some leave as the NATO summit affected many of the local roads with police and security fencing all over the place. The two of us we agreed that we would open up the sessions with a list of questions to get the attendees thinking. We would discuss the answers and queries and then attempt to provide more information and answers as far as possible utilising a PowerPoint. Shankar had done a similar talk in his locality which was the main backbone of the PowerPoint and helped a lot.

Knowing how most people like a copy of a presentation we checked up on the process. We would have to print them out ourselves. I checked with Isabelle Robinson at BACCH and she said our sessions were a popular choice. From previous experience I knew that even though a session list was full it did not prevent people attending the 'full' session. In theory there were 40 people each session. In practice we had well over this. We had each printed out more than 40 copies of a list of questions and handouts. They all went with 3 people requesting copies by email afterwards as they had not managed to get one!

On the day I arrived at the car park to discover all the pay machines refused to accept my credit card – even though it was fine the day before. I did not have sufficient change on me. Other people in the car park told me that this happened at times and the decision was made to ring the emergency number and leave messages on the answer phone and in my vehicle. I then ran through the park to the School of Music and Drama for the morning session, arriving a little late. At coffee/tea break I high-tailed it back to the car park and found an official checking the machines. He was helpful and gave me a ticket which I left in the Land Rover instead of my note, thankful to have escaped a parking ticket. I got back in time for the remainder of the morning and didn't have time to worry too much about the afternoon.

Shankar arrived just before dinner. We found the room we were using and put out copies of the questionnaire in time for the first

cohort of attendees. Despite the large number we thought that we had managed to make it interactive and got people asking questions and discussing the issues.

Hopefully people went away with more information and a better understanding of APD, its diagnosis and management. It is not a diagnosis to be lightly given. The feedback I have received from people in my own Health Board has been positive as was the feedback to us through the BACCH questionnaire/feedback system. It was worth doing it. I think we both learnt from the process – if nothing else, to make sure you have lots of change for car parking! I did get all the other tasks completed and my Appraisal has led to Revalidation – not a bad thing!

Appendix 1

Our questions for Attendees of the Workshop:

1. What do **you** think APD is?
What makes you / when do you consider it?
What might make you discount it when someone else has raised the possibility?

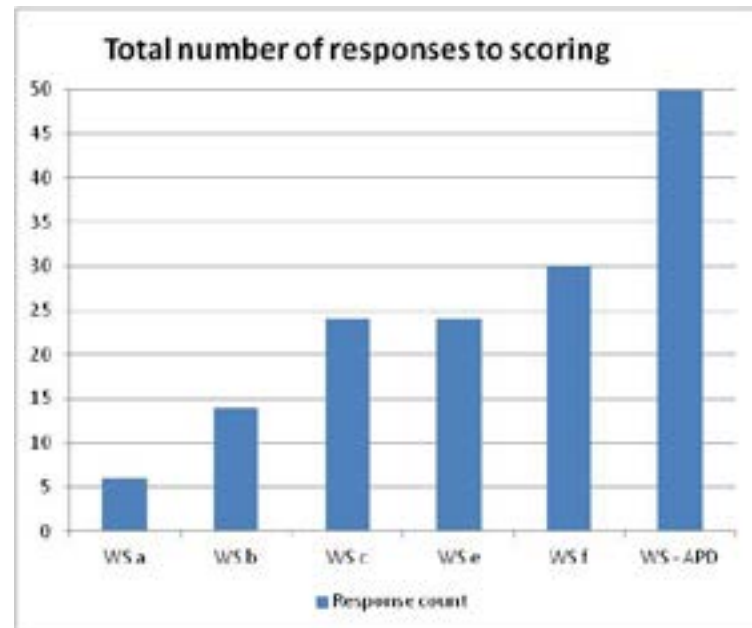
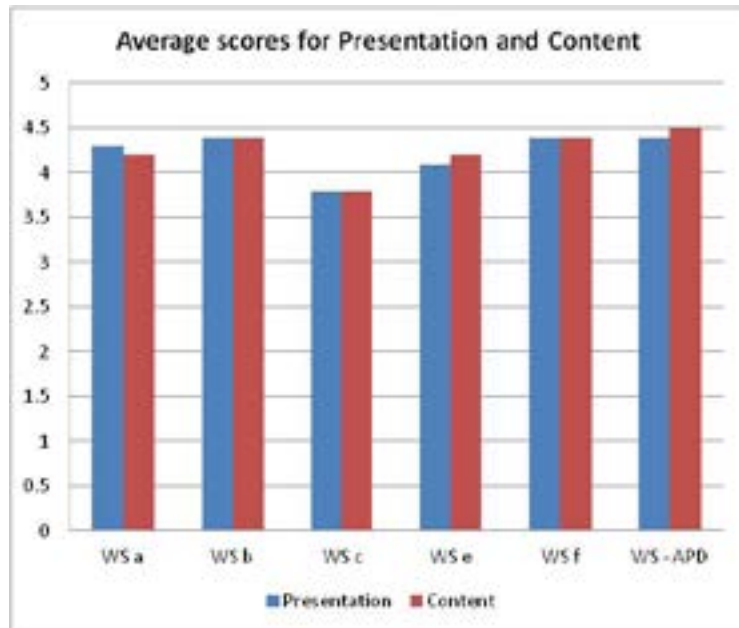
2. What would you do if you had a child in your clinic?
What might someone else do? (who is the someone?)
Who carries out an assessment?
Who makes and/or gives the diagnosis?

3. What will you tell child / parents / school /

Appendix 2

Feedback – Scores and comments

We had feedback on the scores given to us by attendees. We were pleased that the minimum score we received was 2. 46 of 50 gave us scores of 4 or 5 for presentation and for content. On requesting an anonymous feedback for comparison with other workshops we were able to see that ours was well rated. The feedback also highlighted the relative number of people that attended our workshop.



There were a few comments.

Comments

Very useful workshop on Auditory Processing. Very practical ideas.

APD workshop excellent

Auditory processing was most interactive workshop I went to.

The auditory processing disorder workshop was very clear and well-led. I feel much more confident in recognising that there may be a problem and arranging onward referral.

Auditory processing disorder - too much information on slide, with insufficient time to read them - less would have been more!

Great to hear about APD a very useful overview although i am still unsure how to manage this problem in our locality

Veronica Hickson

December 2014

BAPA TREASURER'S REPORT
THE ANNUAL GENERAL MEETING
SOAS
30th JANUARY 2015

Having submitted all the financial documents to the Accountants, Hallidays Ltd, the Financial Report was prepared in order to comply with the regulations of the Charities Commission and the Companies House. The report will be circulated to those present at the meeting and will also appear in the Audiens Newsletter.

On the whole it has been a very satisfactory year in that there have been few retiring members, but we have gained many new members.

Our balance sheet this year is £34,358 compared to £36,359 last year. This is mainly due to investments, subscriptions and clinical meeting activities.

Overall the Association is in a healthy position and I would like to thank the Chair, Directors, Trustees and the Executive for their hard work and cooperation. Special thanks to the Secretariat, Isabelle Robinson and Pam Williams for their dedication and hard work enabling me to make my work much easier.

Thank you.

Dr Ken Abban
Honorary BAPA Treasurer
12/12/2014

**British Association of Paediatricians
in Audiology
(A company limited by guarantee)
Annual Report and Financial Statements
for the Year Ended 30 September 2014**

Contents

Reference and Administrative Details	39
Trustees' Report	40
Accountants' Report	42
Statement of financial activities	43
Balance Sheet	44
Notes to the financial statements	45 - 49

The following page does not form part of the statutory financial statements:

Statement of financial activities per fund 50

British Association of Paediatricians in Audiology
Reference and Administrative Details

Charity name British Association of Paediatricians in Audiology

Charity registration number 1142712

Company registration number 07445618

Principal office 22 Goring Road,
Llanelli, SA15 3HN

Registered office 22 Goring Road,
Llanelli, SA15 3HN

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
 Riverside House
 Kings Reach Business Park
 Yew Street,
 Stockport.
 SK4 2HD

British Association of Paediatricians in Audiology

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 existing trustees. Trustees retire by rotation. 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 prevention, 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 70 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 6 November 2014 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 2014 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 year.

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
Chartered Accountants
6 November 2014

Riverside House
Kings Reach Business Park
Yew Street
Stockport
SK4 2HD

British Association of Paediatricians in Audiology
Statement of Financial Activities (including Income and Expenditure Account)
for the Year Ended 30 September 2014

		Unrestricted Funds	Total Funds Year ended 30 September 2014	Total Funds 1 December 2012 to 30 September 2013
	Note	£	£	£
Incoming resources				
Incoming resources from generated funds				
Activities for generating funds	2	14,036	14,036	14,780
Investment income	3	58	58	56
Total incoming resources		14,094	14,094	14,836
Resources expended				
Charitable activities	4	8,326	8,326	10,167
Governance costs	4	7,805	7,805	6,389
Total resources expended		16,131	16,131	16,556
Net movements in funds		(2,037)	(2,037)	(1,720)
Reconciliation of funds				
Total funds brought forward		36,395	36,395	38,115
Total funds carried forward		34,358	34,358	36,395

The notes on pages 45 to 49 form an integral part of these financial statements.

British Association of Paediatricians in Audiology (Registration number: 07445618)

Balance Sheet as at 30 September 2014

			30 September 2014		30 September 2013
	Note	£	£	£	£
Fixed assets					
Tangible assets	8		17		23
Current assets					
Cash at bank and in hand		41,421		43,482	
Creditors: Amounts falling due within one year	9	(7,080)		(7,110)	
Net current assets			34,341		36,372
Net assets			34,358		36,395
The funds of the charity:					
Unrestricted funds					
Unrestricted income funds			34,358		36,395
Total charity funds			34,358		36,395

For the financial year ended 30 September 2014, 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 year 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 6 November 2014 and signed on its behalf by:

Dr Jane Lyons Trustee,

Dr Gillian Painter Trustee

British Association of Paediatricians in Audiology
Notes to the Financial Statements for the Year Ended 30 September 2014

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

	Unrestricted Funds	Total Funds Year ended 30 September 2014	Total Funds 1 December 2012 to 30 September 2013
	£	£	£
Subscriptions			
Subscriptions	5,645	5,645	5,910
Clinical meetings			
Clinical meetings- delegate fees	7,291	7,291	7,270
Advertisers & exhibitors	1,100	1,100	1,600
	8,391	8,391	8,870
	14,036	14,036	14,780

3 Investment income

	Unrestricted Funds	Total Funds Year ended 30 September 2014	Total Funds 1 December 2012 to 30 September 2013
	£	£	£
Interest on cash deposits	58	58	56

4 Total resources expended

	Membership	Clinical meetings	Other charitable activities	Governance	Total
	£	£	£	£	£
Direct costs					
Cost of goods sold	400	6,810	-	-	7,210
Accountancy fees	-	-	-	2,160	2,160
Depreciation of tangible fixed assets	-	-	-	6	6
	400	6,810	-	2,166	9,376
Support costs					
Office expenses	-	582	-	-	582
Printing, posting and stationery	196	-	-	-	196
Subscriptions and donations	-	-	220	-	220
Sundry and other costs	-	-	118	-	118
Cost of trustee meetings	-	-	-	5,462	5,462
Bank charges	-	-	-	177	177
	196	582	338	5,639	6,755
	596	7,392	338	7,805	16,131

5 Trustees' remuneration and expenses

No trustees received any remuneration during the year.

6 Net expenditure

Net expenditure is stated after charging:

	Year ended 30 September 2014	1 December 2012 to 30 September 2013
	£	£
Depreciation of tangible fixed assets	6	8

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 October 2013 and 30 September 2014	29	24	53
Depreciation			
As at 1 October 2013	16	14	30
Charge for the year	3	3	6
As at 30 September 2014	19	17	36
Net book value			
As at 30 September 2014	10	7	17
As at 30 September 2013	13	10	23

9 Creditors: Amounts falling due within one year

	30 September 2014	30 September 2013
	£	£
Other creditors	5,530	5,640
Accruals and deferred income	1,550	1,470
	7,080	7,110

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 October 2013	Incoming resources	Resources expended	At 30 September 2014
	£	£	£	£
General Funds				
Unrestricted income fund	36,395	14,094	(16,131)	34,358

13 Net assets by fund

	Unrestricted Funds	Total Funds 30 September 2014	Total Funds 30 September 2013
	£	£	£
Tangible assets	17	17	23
Current assets	41,421	41,421	43,482
Creditors: Amounts falling due within one year	(7,080)	(7,080)	(7,110)
Net assets	34,358	34,358	36,395

	Unrestricted income fund 2014	Unrestricted income fund 2013
	£	£
Incoming resources		
Incoming resources from generated funds		
Activities for generating funds	14,036	14,780
Investment income	58	56
Total incoming resources	14,094	14,836
Resources expended		
Charitable activities	8,326	10,167
Governance costs	7,805	6,389
Total resources expended	16,131	16,556
Net movements in funds	(2,037)	(1,720)
Reconciliation of funds		
Total funds brought forward	36,395	38,115
Total funds carried forward	34,358	36,395