

BATOD

British Association of
Teachers of the Deaf

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Auditory implants for today



Con Powell Scholarship
Animojis
Audiology curriculum



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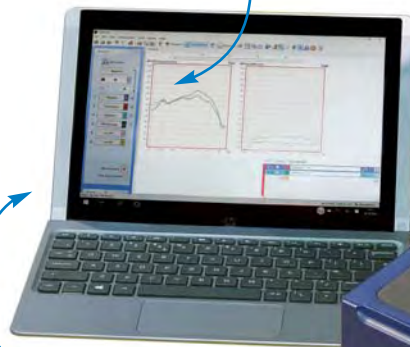
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This edition will be arriving on doormats as we embrace another new calendar year and Spring term for those members who operate their year in line with the

academic cycle.

I am pleased to share with readers some new faces in the BATOD 'team behind the magazine' (page 72). The magazine continues to have articles from new authors. If you have not written an article for BATOD before, maybe 2020 is your year! We also welcome new advertisers to the magazine.

With the 2020 BATOD National Conference fast approaching we remind you to book your place on our new online booking form and we hope you enjoy the new conference format. Maybe you are one of new contributors at the conference. If you are not able to attend we hope to share many of the presentations, workshops and poster details in articles in the May edition.

Happy new year

T Quail

Future issues will focus on:

- March** Early years
- May** Conference 2020 edition
- September** Aetiology
- November** Legislation across the UK

Dear Teresa,

I was so impressed to read about the development of the BATOD membership for developing professional world partners. It looked like a well assembled arrangement, that still allows value for paid UK members but develops genuine value, development and access to literature for world partners who wouldn't normally be able to access. It's a model that I hope other journals adopt.

Congratulations
Tamsin

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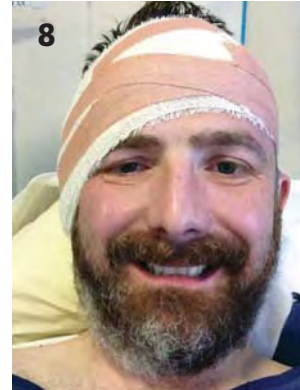
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Need to contact BATOD about other matters?

Talk to National Executive Officer
Paul Simpson

email: batod_neo@icloud.com

Cover photographs: Montage of images from within the magazine pages.

For information on advertising rates please contact the advertising manager, Teresa Quail, on advertising@batod.org.uk



Exeter
Deaf
Academy



New Deaf Academy opens in Devon Easter 2020

“This year we open our new Deaf Academy by the sea in Exmouth. It will be a place of light, colour and aspiration, designed around Deaf young people’s needs. It is the place our young Deaf individuals deserve, where, whatever their additional needs, their development will be supported by state of the art buildings, cutting edge equipment and our flexible, bespoke curriculum.

Innovative DeafSpace architecture will give us a visual learning environment underpinning our commitment to BSL and English literacy, ensuring that all of our young people’s communication needs are met.

The new Deaf Academy will be a place not only for our young people to thrive, but for our dedicated and skilled staff to maximise their potential, continuing to learn and develop too. With tailor-made teaching and therapy spaces, and strong connections with the wider community to support the independence and future success of our young people, it’s an exciting time to work here.”

- Mark Stocks, QToD and Assistant Principal

Find out more at
newdeafacademy.org.uk/BATOD



“Staff at the Academy are passionate... pupils engage positively with staff and their learning.” - Ofsted, 2019



01392 267 029
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Building on the past to secure the future

Steph Halder looks back over her Presidency, the changes she has seen and how her plans for mandatory training for ToDs are bearing fruit

This edition of the magazine is the last where you will hear from me as President. The March 2020 edition will contain the first contribution by President Elect Lesley Gallagher who takes up her position as President at the BATOD Conference in March. As I reflect on my two years, I am reminded more than ever of the strapline for my presidency – building on the past to secure the future. During my time as President this has unexpectedly been true with regards to key roles within BATOD's Steering Group. Notably, Paul Simpson changed his full-time position as National Executive Officer to 0.6 full time equivalent with Teresa Quail coming as in Assistant NEO and Magazine Editor. Recent months have also necessitated securing changes of personnel for BATOD Consultant and also BATOD Treasurer – key roles within the organisation. I'm delighted to say discussions about these changes are well under way so that preparations for the handover can be made.

The NEC remains strong and diverse; however, we continue to work to ensure that NEC is truly representative of our profession. Some more of the 'behind the scenes' roles within BATOD have also seen some change. In this edition you will read about the role of proof reader and find out about the team involved in creating the BATOD Magazine. As time passes, people holding those positions with choose to retire and we will be reliant on our members to volunteer to take up the mantle of various positions.

I stated in March 2018 that my aims as BATOD President would no doubt evolve as the two years progress and this has been true. However, the course I wished to steer remains steadfast as we continue to work towards them. One of my aims was linked with strengthening and securing the mandatory training for Teachers of the Deaf. As I write, BATOD, along with the Course Providers, is working towards reviewing the Mandatory Qualifications and these will be out for consultation in 2020. It is imperative that those working as QToDs in schools, provisions, services and hospitals have involvement in this process as we are the ones who work side by side on a daily basis with those training to be ToDs. Thank you to the work of NatSIP along with BATOD and the QToD profession for responses over a year ago now which helped to secure the DfE's view that the MQ should remain for all teachers of children with sensory impairment.

Another aim was ensuring the practice of Teachers of the Deaf is based in evidence.

The BATOD 2020 Conference 'Researching the Future' is a big step towards this aim with the introduction of inviting abstracts in order to secure speakers and workshop leaders as well as the new poster section. I hope by now you have all taken advantage of the early bird offer and also used our online application. We look forward to welcoming you to Frank Barnes School for Deaf Children on Saturday 14 March 2020.

This edition sees reflections of others including Ann Bradbury writing of 150 years of educating deaf children and young people at St John's Catholic School for the Deaf and Conor Mervyn sharing his experiences as an adult recipient of a cochlear implant and the impact this has on his daily teaching and support of deaf CYP and their families. Cheryl Livingstone writes about being a newly qualified ToD and that being the beginning of lifelong learning in the role. The overall focus of this edition is on the rapidly developing world of Auditory Implants and I hope you find the articles interesting and stimulating.

As with preparing for my first 800 words for the March 2018 Magazine, I have looked back again at how Past Presidents reflected as their terms of office came to an end, as always, learning from what came before. The role of President is certainly not one you do alone. Steering Group, the NEC and all other people who give up their time to do their bit for our professional association are the force that keeps the wheels of BATOD spinning and in turn, support the wider field of QToDs and ToDs. I would like to thank them all and you, for your support over the past two years. I marvel at what has happened in the field of deaf education and how much progress has been made despite the difficult times in which we have found ourselves. With all the changes and those yet to come, I am delighted to be handing over the mantle to Lesley Gallagher. I have no doubt she will be a strong and secure leader for BATOD.

In the words of T. S. Eliot – "To make an end is to make a beginning".

Thank you for all your support. Wishing you all health and happiness for 2020.

Supporting a Deaf family

Martine Monksfield, a QDToD, shares her experience of supporting a Deaf family through the cochlear implant process

Historically, a large proportion of the Deaf community have been against cochlear implants. That view, although complicated, but validating, was based on an alarming number of deaths in the early days (lack of meningitis vaccinations prior to the operation) and nerve damage that causes paralysis or weakness in the face. There was also the belief that cochlear implants on deaf babies and children would erode the Deaf community and force a large number of Deaf children to grow up using only a spoken language and integrate into mainstream culture. Also, there was a lack of evidence that cochlear implants were successful long term.

What often is not always known, understood or acknowledged, is that the Deaf community has been a 'last resort' for children and adults when their cochlear implants had 'failed' and they had 'failed' to mainstream. Those whose cochlear implants were successful, and had 'successfully' integrated into mainstream 'disappear'. Is it like the newspapers, where you only hear about the bad news (ie social services failures) but not the hundreds of good things that do happen? (ie social services following procedure).

The Deaf community will always be in the minority, their voices (pardon the pun) drowned out amongst the majority, but that doesn't make their views, beliefs, experiences, and culture any less valid. As a Qualified Deaf Teacher of the Deaf (QDToD), I often have to ensure they are 'heard' amongst hearing professionals with little experience or understanding of British Sign Language (BSL) and the Deaf community. This includes deaf children who don't use BSL as their experiences in mainstream sometimes means they have elements of language deprivation or/and are socially isolated.

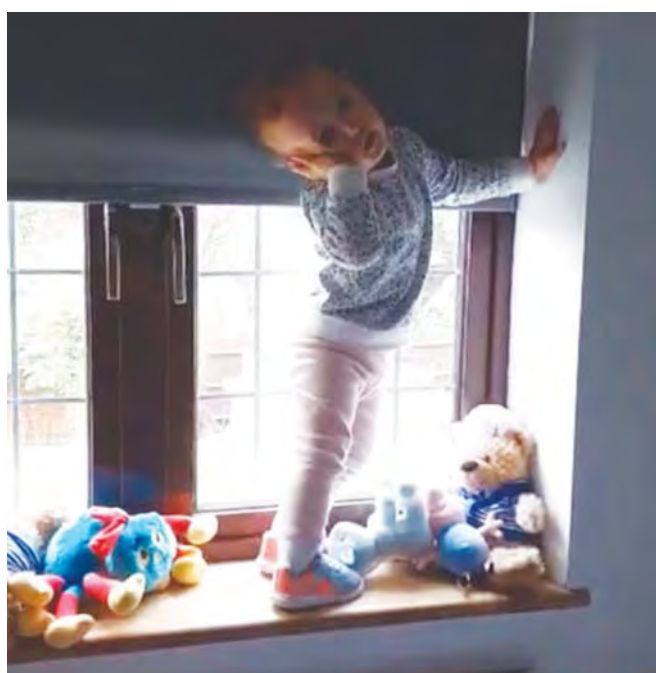
Today, I would say a large proportion of the Deaf community are more accepting of cochlear implants. I would suggest that cochlear implants isn't the main pressing issue today; it's language deprivation. We have a better understanding now that the brain doesn't care how language reaches the brain, as long as it gets there! We are encouraging more families to use sign language in the early days, whether they get cochlear implants or not. The issue is not to rely on one modality (in the majority of cases, a spoken language) but to use both so that the risk of language deprivation is reduced.

As well as my QToD qualification, my personal experience of hearing aids and cochlear implants stands me in good stead to work with Deaf families considering cochlear implants. Imagine my surprise when a referral came through for a Deaf family and the Deaf mum who was in the same year as me at my Deaf school! Initially, (and this is another article for another day) I wasn't going to work with them but after a professional discussion with my

team ToD manager it was agreed I would be the child's ToD. I obviously let the Deaf family know that they could work with another ToD unfamiliar to them, but they made it very clear they needed someone who could use BSL fluently, and understood some international sign language as the Deaf father hailed from Italy.

In the early days, the Deaf family's priority was adjusting to a new (first) baby; sleepless nights, getting to grips with breastfeeding, changing nappies, eating well, all the usual new lifestyle elements that come with a newborn. As they were both Deaf BSL/LIS (Italian Sign Language) users, it was a given that they were going to use sign language even if their baby was hearing. They were adjusting to the surprise of a Deaf baby however, despite some Deaf history on both sides.

One of the things we discussed early on was what they wanted their Deaf baby to achieve. I do this to be able to gauge and establish early on the level of support for amplification support if one of the goals is for the Deaf baby to achieve a spoken language. Their goals were for their Deaf baby to achieve the following; 1) a solid language foundation (in BSL/LIS) 2) a spoken language (in English/some Italian) and 3) to be able to use both languages in either a mainstream, mainstream with a resource base or a Deaf school. I used the Early Monitoring Protocol for deaf babies and children with this family as it has both BSL and spoken English milestones, as well as the other developmental milestones in social and emotional development, play etc.



Climbing up to pull the blind down and sign 'nap time' at her Nanny and Grandad's house at 12 months



Mum pointing to the picture and asking her who it is (11 months)



Responding by signing 'Nonna' (LIS) for her paternal Italian Grandmother (pointed finger next to nose in a twist motion)

From day one, they had excellent early attention and communication skills with their Deaf baby; tapping her to gain her attention, signing to her what was happening; "Nappy change! Smelly!", "Milk!", "Bath-time" etc, and as she got older, she would watch signing conversations, turning her head to whoever was signing. They also used extra time in reading stories with her, pointing at the picture in the book (ie cow) and waiting for her to look at them for the sign for it. This was the same when it came to family photos on the wall, particularly because her father's family live in Italy. She was able to point to the relevant picture of the family member in either BSL or LIS at 12 months old. It came as no surprise to me when she was assessed by the Auditory Implant and Nuffield team at the Royal National ENT that her attention skills were excellent. I said she had what we call in the Deaf Community, 'Deaf Eyes'. Typically, with hearing families of deaf children, we encourage them to come to our toddler groups so that we can model this style of early attention and communication skills, or within the home during our visits, keeping it as natural as possible to the family dynamics without overtaking the relationship between the family members and their deaf child. It is a tricky balance to get right, as I am sure many QToDs can attest.

The family were keen to press ahead with hearing aids as soon as was possible, and they noticed fairly quickly after

the fitting that she did not appear to respond to sounds when they were on. As she was profoundly deaf, the hearing aids were very big for a newborn. The parents do not wear hearing aids themselves, but know what sounds are loud, ie door slamming, accidentally dropping a plate and it smashes, drilling work outside, turning TV on (not realising it is on a high volume). Family members who are hearing also noticed she did not respond to speech sounds, ie her name, or a loud conversation occurring behind her. They knew this for sure when she was sometimes startled when someone came up behind her as she had no forewarning with sound. One lovely thing they were pleased as punch about was their Deaf baby was developing the lip patterns to go with signs, and by the time she was 16 months, she was signing 3-4 signs (the English translation would be longer). When we assessed her using the Early Monitoring protocol, her BSL was at B8 (18-21 months). Obviously, she was not making progress in some areas of spoken English development, but she was grasping many of the early prerequisite elements of attention and communication milestones.

They knew this meant the next step was to consider cochlear implants. I knew this process would be very emotionally taxing for a number of reasons; taking that choice away from their Deaf child and putting her through an operation that is not guaranteed to be a success. They understood the importance of early implantation for spoken language development, and with the average deaf child being implanted around 14 months, they had an advantage compared to a hearing family who choose only spoken language modality for their deaf child. This advantage was that their deaf child was developing a secure, solid language foundation (in BSL/LIS) and that, if it worked, cochlear implants would be the last piece of the puzzle for linking sound/speech sounds to her overall language development. They had to deal with conflicting opinions and information from family members, professionals and friends who were Deaf and hearing. I made recommendations to meet with other Deaf families whose children had cochlear implants.

One particular thing (of many) I learnt from this process with this Deaf family was that the Deaf father from Italy had understood and learnt about cochlear implants differently to Deaf parents in the UK. They were not aware that the internal parts of the cochlear implants don't work with any cochlear implants, ie if you choose Med-El, you have to get a Med-El processor etc. Also, they thought that static electricity would still affect deaf children with cochlear implants and had to restrict particular activities (not true now). One big question was airport security since there is a lot of travel to Italy; the general advice is that children with cochlear implants carry a card where they bypass the scanner and get a pat-down or similar. I added that as I regularly travel to Northern Ireland, I often put my processor through the bag scanners and go through the scanner as normal – sometimes I get pulled aside for coins in my pocket, a belt on etc, but I had never been pulled aside for a magnet in my head, nor had to explain this. However, some of my Deaf friends do carry cards and follow this advice. I am not sure what the surgeon thought

Auditory implants for today

of me adding this information in, but I felt it was important to relay the daily practicalities of those living with cochlear implants.

One of the Deaf family's worries was supporting her listening and spoken language development, as they don't use a spoken language themselves or wear hearing aids. I explained that as they are adults, they know that things make sounds; ie a washing machine. As they are so cued into their Deaf child's attention and communication skills, they will know if she turns her head to a sound, they will make that link (ie washing machine on its last cycle) and be able to sign to her that it's the washing machine (signing washing machine very fast to indicate it's on the last cycle). As their Deaf child knows sign vocabulary for animals, colours etc, they would be able to use nursery songs on the ipad with subtitles (karaoke style for timing) and sign along with the volume on. So they may not hear it, or speak/sing, but they certainly have the ability to make the links to speech/sounds in other ways. Also, as a QToD I will be able to specialise visits around activities based on listening/spoken language that they can continue with when I am not there (again, modelling, but not overtaking, tricky balance!). Their Deaf child has hearing family members who I know will support her spoken language development (ie her hearing maternal nanny looks after her every week). We will also be able to implement a radio aid system when appropriate.

Research generally tends to show Deaf children of Deaf parents do better than Deaf children of hearing parents,

and this is shown again even in Deaf children with cochlear implants of Deaf parents. Is this because Deaf families use sign language even alongside cochlear implants? We must continue to encourage families to use sign language to support language acquisition whether they have hearing aids, BAHAs, cochlear implants, or nothing. They mustn't be discouraged by the idea they are not native signers of BSL to begin with. That is where we QToDs can support them. We must reduce the risk of language deprivation. Amplification devices are excellent tools when they work, but they are not language and communication devices. For hearing families, we have to acknowledge that learning BSL is not readily available for a myriad of reasons; from a lack of BSL services in the area, lack of Deaf role models etc. Although BSL is a recognised language, it does not have the same rights as Welsh does, and this makes it particularly difficult to be assimilated into services for families with deaf children. If we put as much time, effort and money into BSL as we did into amplification, surely we will start to see consistent positive outcomes for deaf children all over the UK? ■



Martine Monksfield is a Deaf Qualified Teacher of the Deaf working for Haringey and Enfield LA as an advisory QToD. She is also the Chair of the d/Deaf Teachers group and represents them at the BATOD NEC meetings.



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Are you out there?

Do you work with deaf learners in a sixth form, in an FE college, with apprentices or do you have several Post 16s on your case list?



How many ToDs are working with this age group?

There is almost no data about ToDs working with this age group, such as employment status, types of learners, working patterns, etc.

So will you please respond so that we can start collecting information?

Please contact me, Jill Bussien (member of the BATOD National Executive Council), on JillBussien@gmail.com

Three years later...

Conor Mervyn shared his reflections as a relatively new adult cochlear implant user

Hello, I was invited to write an article on my experiences about my cochlear implant (CI).

I first considered a CI in 2007 but decided against proceeding with the operation after being offered surgery, as the timing wasn't right at that stage of my life.

In early 2015, after years of trying to get the most out of the super powered hearing aids, I noticed I was becoming more exhausted after a long working day involving lots of lipreading and listening (without a lot of benefit from the hearing aids). I reconsidered the idea of CIs again having seen the benefit it had brought to students I was working with as a peripatetic QToD.

I underwent the standard implant assessment checks again at the Belfast Auditory Implant Centre. During the listening assessments, to determine what I could and could not discriminate with and without lip reading, I made the implant centre aware that I was familiar with the speech discrimination tests that they used, as I also used these in my peripatetic QToD role with deaf students.

I was offered the implant surgery having received a date for 4th July 2016. I returned to Belfast for the surgery while working in East Renfrewshire, Scotland. I liaised with my employer about time off as the surgery recovery period would have been during my summer holiday break (6.5 weeks) with another 6 weeks off (totalling 3 months). This was to enable me to recover fully and focus on listening rehabilitation to maximise the most from the CI. The other reasoning was that due to the timing of the surgery, my switch on would be one month later, 4th



Few weeks before CI June 2016

August. Schools returned on 12th August; this was too soon for my old "analogue" brain as it needed time to adjust to a new way of listening.

I prepared for the surgery and I was wheeled away to the theatre at 4 pm and back on the ward just before 8 pm.

I was a bit groggy, naturally. Once I had the best slices of toast (I was starving) and a cup of instant coffee (it had to do until I'd a proper coffee), I caught up with my wife (then girlfriend at the time) via FaceTime. Thankfully being able to communicate via BSL while I was without my



X ray CI Conor 1



X ray CI Conor 2

Auditory implants for today



Post op after recovery ward 4th July 2016

hearing aid (as the surgery was on my better ear) helped to reduce any frustrations with communication breakdown! Having BSL as an additional language for deaf children and adults is beneficial in the long run.

I was discharged the next day and returned to my parents' home to recuperate! Prior to discharge I asked if I could take pictures of my CI X-ray so I could use this to explain



Post Ci appointment with the surgeon to monitor the facial paralysis

to family and students who may be curious.

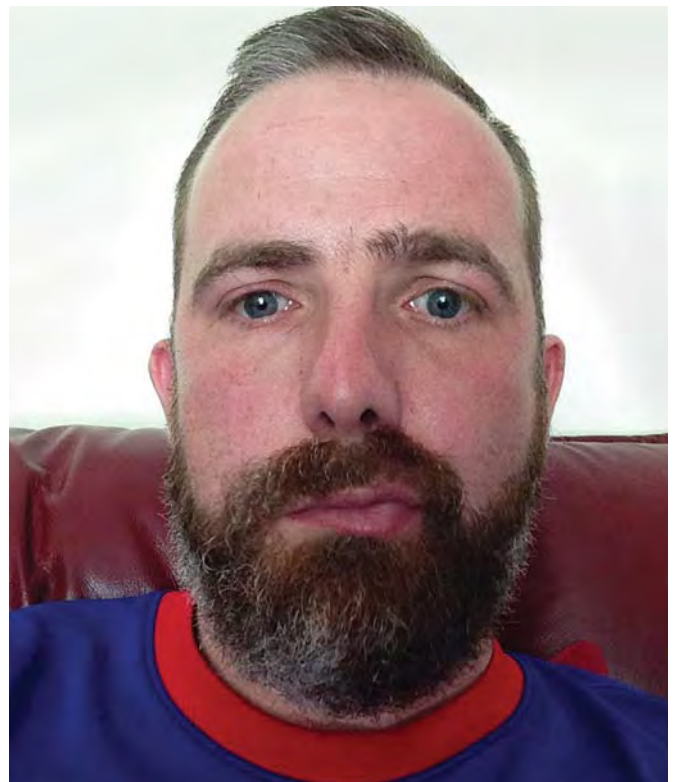
My father drove as he normally would do forgetting I'd just had a major operation, so I was feeling more sensitive to his driving style!

The post surgery recuperation meant that I was catching up on my sleep as the anaesthesia was still in my system. I was still a bit wobbly on my feet and needed to hold onto things for support. It took a while to build up my walking stamina again as going for a five minute walk meant that I was exhausted.

During the week, I was chatting to my wife on FaceTime and she noticed that my lip looked different from normal, I thought otherwise. The next day on 12th July, I went for my morning shower and I noticed that I could not close my right eye as one would normally expect. I spoke to my parents and they thought I was being silly! Later I met up with a university friend (also a QToD) for brunch. I noticed that my lip and cheek started to go numb and I asked my friend if she noticed anything, she stated that the lip had dropped a bit.

I returned home to liaise with my parents to be brought to ENT casualty and back to the CI ward. It was confirmed after checks by the CI/ENT doctor that I suffered from facial paralysis. This was quite worrying as I wasn't sure if it would be permanent and it was ironic that it had happened to me as a QToD. It is often reported to be a very small risk side effect from surgery.

I was advised to take prescribed steroids to reduce the inflammation of the facial nerve. I had to return to the CI centre for appointments with the CI surgeon and team to monitor the facial paralysis. The CI surgeon advised that there was no medical reason or infection that caused the



Facial paralysis improving after 7 weeks



A few weeks later with Jane July 2016

facial paralysis and it was likely to be as a result of inflammation of the nerve.

The CI centre staff were very reassuring and they did an unofficial switch on at three weeks to reassure me that the internal implant device was working ok. This was a strange sensation because I could just hear beeps via the speech processor.

On 4th August 2016, I was switched on. It was an odd experience post switch on as I could hear beeps and whooshing from cars passing. My mother took me for a meal and while she was chatting, I was relying on lip reading even more, while her voice was sounding like R2D2 from Star Wars with every word sounding as a beep.

Later that day, I started my auditory rehabilitation and went around the house switching on objects that made a noise or standing near objects to see what they sounded like. I started counting to thirty and the numbers were beeps then gradually my brain recognised my voice at ten. I watched my favourite TV programmes with subtitles to work out what was being said. The dialogue from the TV meant that the voices sounded robotic. Family members voices sounded normal with an electronic sensation at the end. People I never met before when speaking to them and listening to their voices was completely electronic. It took a while for my brain to normalise their speech.

I was surprised at how quickly my brain was adapting to the CI and hearing the quiet sounds that I never heard before in my life.

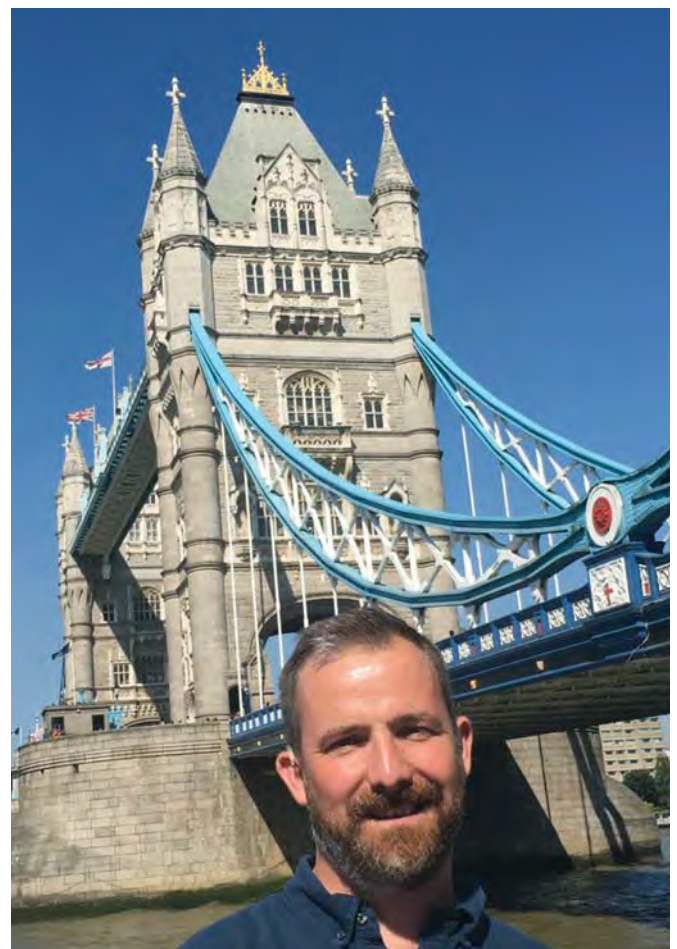
However, at the same time I was conscious of the facial paralysis and how it would impact on my role as a ToD especially if students were unable to lipread me. Family members used typically blunt Belfast humour to reduce the tension in the room about the facial paralysis.

The recovery from the facial paralysis took seven weeks

before my face returned to normal. I have to say I did enjoy having no frown lines on my forehead or crow's feet for a while! On a serious note, time was a great healer and it required a lot of patience about the situation. It has given me greater empathy and insight to the experiences that a deaf adult or deaf children and young people may go through pre and post implant. I am able to share my experiences as a CI and hearing aid user with professionals and students. When I returned to work, colleagues remarked that they noticed the difference with the CI compared to the hearing aid. I returned to work on a staggered return, so I was not overwhelmed by the noises of a busy school and working environment. I ensured that I had timeout because I would be exhausted from the auditory experience of having to discriminate new sounds and learn to determine if they were not relevant. One of the worse

sounds is the clock ticking in a quiet room and this eventually fades away.

As a result of my experiences with the CI, I eventually secured a promoted teaching post in London with involvement at a local CI Centre as an Implant Centre ToD.



End of September 2016



End of September 2016

I enjoyed this experience being on the other side of the coin, gaining both perspectives.

Despite my early experiences of the CI with facial paralysis, I am very much aware of how much benefit I have gained from my CI. Ideally, I would love a second CI as the left side hearing aid does not give much benefit compared to the CI. However, I live in hope that the NICE guidance will eventually recommend sequential CI for adults. More importantly, I am aware of the risk relating to the life span of a CI's internal device so it would be beneficial to have a sequential CI, if there ever was a device failure. A colleague had suggested that I should crowdfund!



Conor Mervyn is a DQToD (D/Deaf Qualified Teacher of the Deaf) with Northern Ireland's Sensory Service (EANI) and a member of BATOD's NEC.

British Academy of Audiology have released a video for adults to assist with developing awareness about cochlear implants

www.baaudiology.org/index.php/news/news-home/new-cochlear-implant-video-sqc-team



Conor Mervyn shares a brief history of his radio aid use

I have used radio aids since I was a child at primary school, using the original PC Werth bulky aids with the button receiver fitted to the solid mould. Later I progressed onto the radio aid shoe with the wire for the later stages at primary and secondary school. I also used the group aid system at a school for the deaf which was a bit strange given that we would become annoyed with people who breathed heavily into their microphones causing discomfort. As I went to university, I continued with the radio aid and the direct input shoes with the receivers.

As a professional I have sought to use the same radio aid devices as students.

The Roger technology brought improvements but the first device I'd used had teething problems in which the signal was affected by the design of buildings if there was a metallic beam.

As I underwent a CI three years ago, I was keen to trial the Mini Mic. I found this to be beneficial primarily for the volume control which the Roger device did not have. However, I noticed when the person wearing the device was 20 paces ahead the device would cut out if they turned their head to the side. This was useful feedback for students who were keen to use their mini mics.

Each device has its pros and cons with design and appearance which is important to most deaf students at an older age. They do not want to stand out from the crowd, so the Roger Pen and Mini Mic are discreet.

As the Roger Technology has moved on, I used the Table Mics for a year and found these to be extremely beneficial as the speech clarity with the omnidirectional features of the microphone were useful.

Both the Roger devices and Mini Mic could be paired if one had a Roger X (02) receiver to allow a connection. This was before Roger secondary mini mic style microphones came along.



Bilateral cochlear implantation – supporting a teenager

Andrea Dodds and Annabel Caiger describe their experience and the process involved in supporting a 15 year old and her family making informed consent leading to bilateral cochlear implantation

The cochlear implant (CI) process requires a client centred approach for the individual to make an informed decision. Each individual referred for cochlear implant assessment will be considered on the grounds of audiological, medical and motivational criteria with input from the CI team, local services and family members. A CI is an elective surgical procedure; in the case of adult recipients, the individual concerned will give consent. In the case of young children the parents or legal guardian will elect to proceed with the surgery. However, in the case of a teenager this process is less transparent, if the child is Gillick competent (NHS Consent to treatment 2019, Gillick v West Norfolk and Wisbech AHA 1985).

Background

The teenager concerned had been referred previously for assessment as a possible implant candidate but the family had withdrawn from the assessment process. Her parents lived separately but were both very involved in her care and happy to meet with agencies to discuss future options. The teenager’s father was keen to pursue the possibility of CIs as he reported having had discussions with her regarding her deteriorating hearing and her difficulties in communicating with others. Her mother had reservations regarding sacrificing residual hearing and the teenager’s

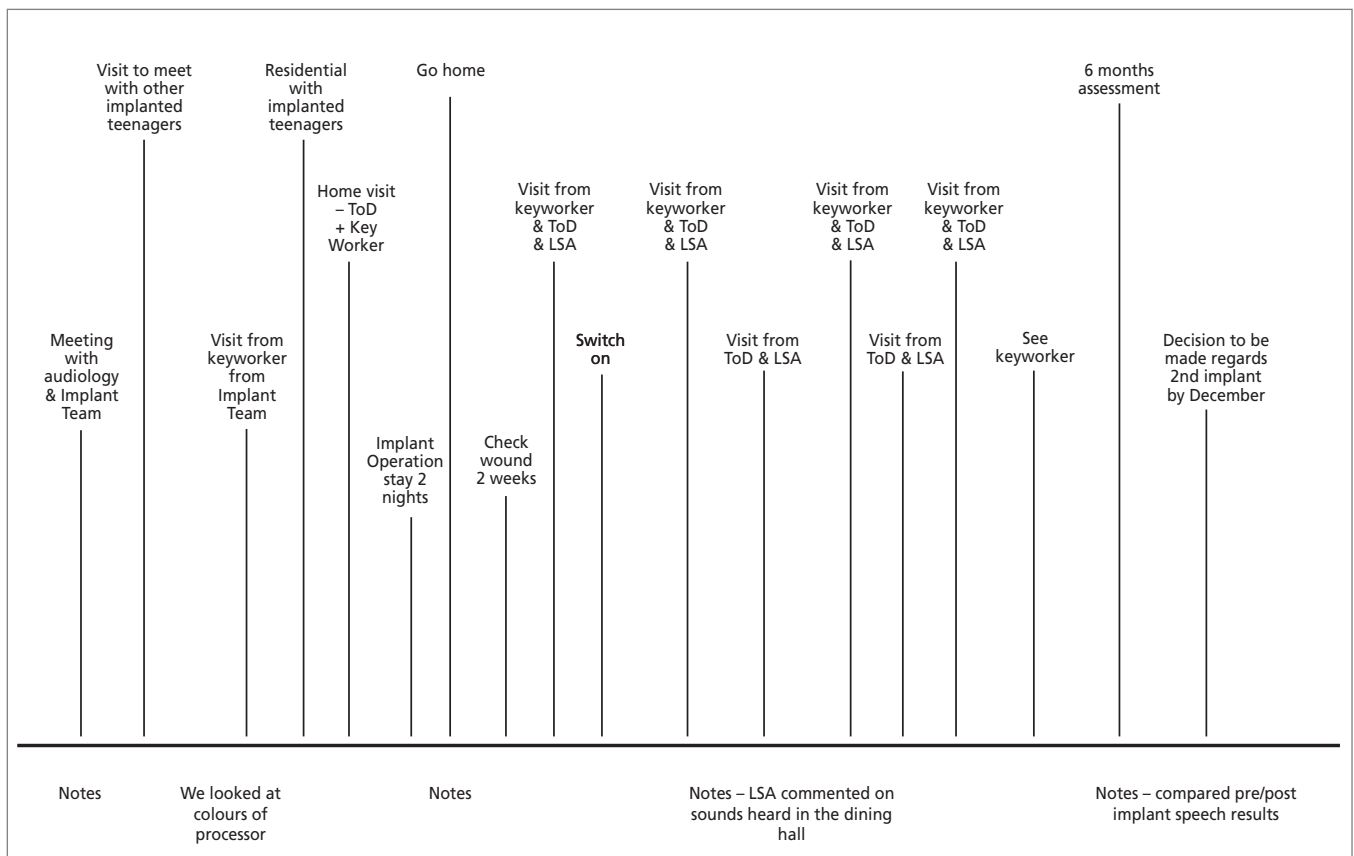
possible rejection of the CI post-surgery.

The teenager herself had little knowledge of what CIs involved having not had contact with CI recipients prior to the referral. Her understanding of some of the concepts was further compounded by additional language processing difficulties. She attended a local special school with a high level of small group and one to one support.

The assessment process

Following re-referral, initial meetings were set up at school with the teenager, parents, QToD, CI keyworker and Learning Support Assistant (LSA) to discuss the basic CI assessment process. For all children, simultaneous bilateral implantation is advocated as likely to have the best outcomes for the individual. However, given that she had some good residual low frequency hearing and was an excellent hearing aid user to have both ears implanted simultaneously raised further concerns for the family in terms of sacrificing the hearing in both ears.

This concern was taken to the CI multidisciplinary team meeting and it was agreed to make an individual funding request for staged bilateral implantation. This was granted on the grounds that it would be psychologically too traumatic to sacrifice hearing in both ears in an individual



Auditory implants for today

at this age who was gaining measurable benefit as a bilateral hearing aid user. However, best outcomes in sequential CI are related to the length of time between CI 1 and CI 2, the shorter the interval resulting in the better outcomes (Cullington, H.E et al, 2017). It was therefore clarified from the CI team that should she proceed with the first CI the decision to receive the sequential would need to be made within the year.

The process of informed decision making

Regular collaborative meetings were held at school with the teenager, parents and services involved. School allowed her LSA to be present at all joint visits made by the CI keyworker and QToD. The full range of outcomes were discussed with the teenager to help develop realistic expectations in initial adjustment to listening through the CI and processor. For example, it was explained that, in the initial stages, adjustment to the processor was a gradual process and she may not like the different sound processed through the implant and may feel that her hearing aid was better.

Contact with peers

Opportunities were made for the teenager to meet with CI recipients of her own age and ask questions. During this stage she also went away on a residential weekend with the same peers where she was able to observe the use and maintenance of CI processors and increased awareness related to teenage appearance.

Information about hearing loss, hearing aids and CI

To help understanding regarding her hearing loss, hearing aids and the CI process there was considerable discussion during regular QToD visits to school and during joint visits by the CI keyworker and QToD where she was encouraged to actively question the process. There was also regular contact with parents to get feedback about any questions that may have been raised at home.

Visual materials to support her understanding were used such as audiograms relating to her hearing and CI criteria, use of dummy implant and processor and DVDs. There was considerable discussion about the process of surgery, switch on, early tuning and rehabilitation.

Visual representation of the process

A detailed timeline was drawn up by the QToD with the teenager to explain the process and key dates. This included, future decision making for an initial implant and what might be expected should she wish to proceed to the sequential implant.

Once the decision to proceed was made the timeline was expanded to include more specific dates about surgery, switch on and tuning with the possible timing of a sequential implant (see illustration on previous page). Key decisions were linked to events that would be familiar to her eg by Christmas, the decision for second implant would need to be made. This was a significant resource for her should she raise questions when the visiting professionals were not in school with her.

Baseline listening assessments were carried out to measure progress in the future. There was considerable discussion about the process being her informed decision and that all adults wanted the best outcome for her. There was also

constant discussion with others that it was her own informed decision, given her age and understanding of the process. Following this input which included regular meetings with the family the decision to go ahead with the initial implant was made.

Progress Post implant

All parties continued to work closely. The teenager herself was an excellent user from the day of switch on. The LSA made a detailed diary of her responses to sound following switch on. This included improved responses to speech in the wider environment (eg following speech in the dinner hall after moving away from the table).

Initially she was not convinced of the benefit she was receiving from the implant and processor despite observations in rehab sessions indicating her listening skills were improving. She was therefore given the choice of whether or not to use her contralateral hearing aid as a trial giving her a degree of control about her progress and also showing her that she was able to function very well when listening through the CI alone.

Functional communication skills

Communication skills with others eg ENT consultant, audiologist and key worker were observed to be much more proactive. The teenager was interacting directly with those involved at a variety of appointments where previously questions had been directed through her parents or the QToD.

Understanding of her outcomes

Ongoing tuning appointments prompted discussion with the audiologist that was initiated by her on pre and post hearing levels and how these related to the hearing population as a whole. Joint home visits continued with QToD and keyworker alternating between both parents' homes. Feedback from parents included: better discrimination of high frequency speech sounds than she had been previously unable to access, responding when being called from a distance and showing an increase in interest in news items on TV which promoted increased interaction.

There was some discussion about the benefit of a second implant in terms localisation of sound related to daily living eg traffic and speech in noise in the classroom situation. However in the early stages post implant the teenager made it clear that she did not want to discuss the option of

Distance from speaker: 1m	Pre-Implant 2 x Nathos hearing aids	Cochlear implant (right side) 6 months post implant
Closed set words with lipreading	100%	100%
Closed set words without lipreading	66%	100%
Topic based sentences with lipreading	65%	100%
Topic based sentences without lipreading	57%	93%

a second implant so it was agreed with further use of the time line that the topic would not be raised by the adults but it was clarified that a decision would have to be made close to the six month post implant interval.

Pre and post speech discrimination assessments

The results of a recent speech discrimination assessment carried out by the visiting QToD from the CI team are as shown in table above.

Following sharing the above information with the teenager at six months post implant she raised the subject that she had decided to proceed with the second implant. With further discussion she demonstrated evidence of having thought the process through herself both in terms of being adamant her decision should be fed back to the whole CI team without further need for discussion and how the second surgery could be planned round key events such as Christmas and her birthday.

Conclusions

The process of providing adequate information in an accessible way enabled the teenager to understand the process of assessment and CIs as well as understanding possible options. Collaborative working with professionals and family helped support the teenager in her decision and increased her

awareness that she had an element of control over her treatment and intervention. At the time of the decision for the first implant parents felt that the teenager had made her own informed decision and therefore felt more able to support her choice. By sharing outcomes with the teenager, she was able to understand her own progress and make a decision going forward.

Speed and certainty of the decision of a second implant was easier because of the timeline and very recent memory of the first implant. By giving her the opportunity to make an informed decision she was able to come to the conclusion that she wanted to proceed and take ownership of her own intervention with resulting positive outcomes. ■

References

Cullington HE et al (2017). *United Kingdom national paediatric bilateral project: Demographics and results of localization and speech perception testing*. Cochlear Implants International Vol 18 No 1, 2-22

NHS Consent to treatment 2019, Gillick v West Norfolk and Wisbech AHA 1985



Andrea Dodds is a Qualified Teacher of the Deaf at the Northumberland Sensory Service.

Annabel Caiger is a Specialist Speech and Language Therapist (formally Key Worker North East Regional Cochlear Implant Programme)

Stuart Whyte, University of Southampton's Education Audiologist, expands on Gillick competence

Although working in the University and paid by them, our service is commissioned by the NHS and we have to satisfy their training and clinical audits. So my context is medial treatment for patients at our service if we need to decide if a child can give consent to treatment if parents do not. A brilliant source of information is here: www.cqc.org.uk/guidance-providers/gps/nigels-surgery-8-gillick-competency-fraser-guidelines

"Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines, on the other hand, are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment. By confusing them, we lose crucial details necessary for obtaining consent." Harris J & White V (2018).

Gillick competent A Gillick competent child is a child under 16 who has the legal capacity to consent to medical examination and treatment, i.e. s/he is able to demonstrate that s/he has sufficient maturity and intelligence to understand and appraise the nature and implications of the proposed treatment, including the risks and alternative courses of action. The term 'Gillick competent' is also often used to describe children who are capable of giving consent to other matters requiring their decision without parental consent, i.e. where they are capable of understanding what is proposed and can express their own wishes. It has a wider meaning than the term Fraser competent, which specifically refers to contraceptive advice.

Gillick competence – Oxford Reference

the means by which to assess legal capacity in children under the age of 16 years, established in the case...

Additional reading links

www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years/making-decisions
learning.nspcc.org.uk/research-resources/briefings/gillick-competency-and-fraser-guidelines/

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Martin E & McFerran T (2017). Gillick competence. In A Dictionary of Nursing. Oxford University Press. Retrieved 3 Dec. 2019, from Gillick competence – Oxford Reference

Auditory Brainstem Implant Service

Jeanette Martin, Principal Teacher of the Deaf, describes the ABI Service at St Thomas' Hearing Implant Centre

In May 2013, Guys and St Thomas' NHS Foundation Trust and King's College Hospital performed their first paediatric auditory brainstem implant (ABI) operation. Since then, this service has performed eight more auditory brainstem implant surgeries.

In October 2018 Guys and St Thomas' NHS Foundation Trust and Manchester Royal Infirmary were the two centres in England that were formally commissioned by NHS England to provide a specialist service for ABIs in children up to the age of five years old.

What is an Auditory Brainstem Implant?

An ABI is a surgically implantable device similar to a cochlear implant (CI). The receiver/stimulator package and external sound processor are the same as a CI. What differs is the electrode array and how it is programmed. The electrode array of a CI is placed inside the cochlea. The electrode array of an ABI is a flat paddle shape and is placed directly on the cochlear nucleus, which is situated on the auditory brainstem.

The surgery is more complicated and has to take place in a neurosurgical unit. The programming of the device is more challenging as the cochlea nucleus is not tonotopically arranged like the cochlea so programming for detection and pitch perception can be challenging but it is possible.

Who is suitable?

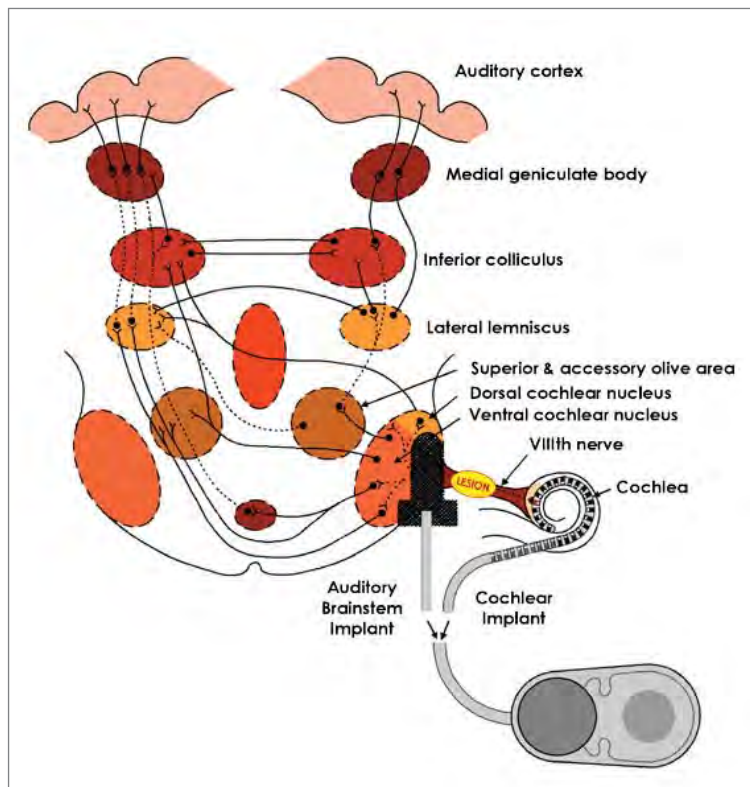
St Thomas' Hearing Implant Centre accepts referrals for children who will follow an assessment pathway to ascertain whether or not a child would benefit from having an ABI.

The criteria for being suitable for an ABI by the NHS is:

- Under five years old and
- Have complete absence of either the auditory nerve or cochlear bilaterally.

When a child is referred to St Thomas' for an ABI assessment there will be several assessment appointments to gather the following information:

- Our specialist consultants and radiographers will review previous scans to be certain that there is no auditory nerve visible. They may request repeat imaging.
- Audiological scientists will conduct behavioural audiological testing. The stimuli may be sound, to be certain that the child is not accessing sound. They will also conduct behavioural testing using vibrotactile stimuli. This is to assess and teach a child how to respond to behavioural testing, this is essential for the post-operative programming of the ABI.



- Speech and Language Therapists and QToDs will assess communication and developmental milestones. They will be looking at non-verbal communication and language skills and functional development.
- The team will be counselling parents throughout this process and explaining the importance of device use, attendance at post operative appointments, commitment to rehabilitation and the use of British Sign Language (BSL) as the primary mode of communication.

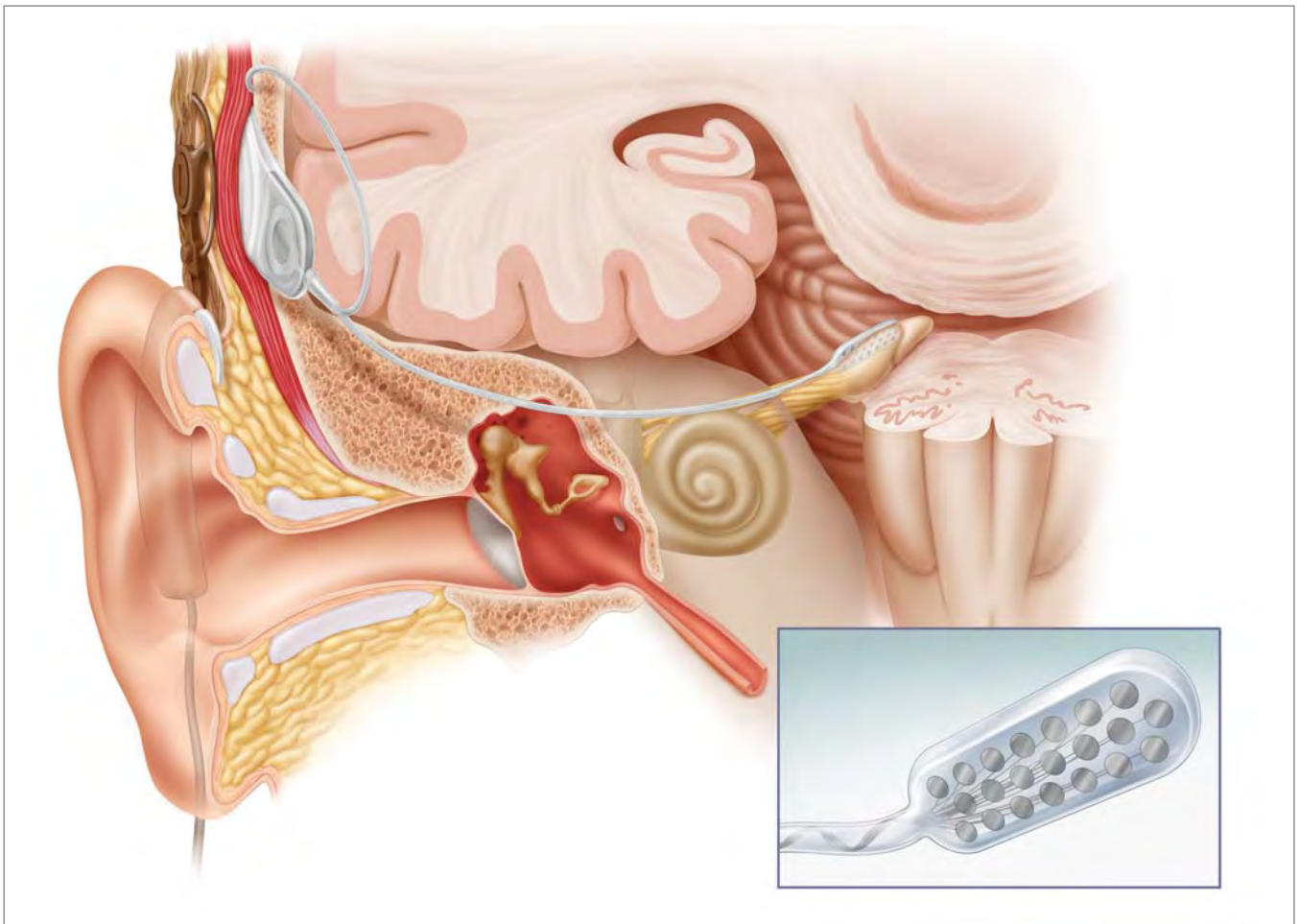
The team will work closely with local professionals to support families through the assessment process to ensure families have all the information they need in order to make an informed decision about proceeding with auditory brainstem implantation.

If our team decides that an ABI is an appropriate intervention and recommends an ABI, the family will meet with the consultant surgeons to be informed about the surgery and can make a decision about whether or not they wish to proceed.

What are the outcomes?

The biggest question for all families is 'will it work?' and the honest answer is 'it will be different for every child'.

Throughout the process the team will inform the family about the possible benefit an ABI might provide their child. ABI outcomes are significantly varied and there is limited data to predict likely benefit.



Of the eight children who have had their ABIs activated at St Thomas', all of them wear their external processors consistently and none of them have rejected their device.

Our outcomes are in line with international data:

- All of our ABI recipients have detection of medium to loud environmental sounds and 7 out of 8 can detect speech sounds.
- Some of our ABI recipients can recognise some environmental sounds and can recognise some speech with lip reading.
- A small number of our ABI recipients have improved speech recognition without lip reading.

We know that ABI outcomes may be limited in terms of being able to discriminate and recognise speech sounds and to be able to use these to produce speech. This is the reason for strongly advising families to use BSL as their primary mode of communication.



Jeanette Martin has worked as a QToD in a Primary Resource Base, as an Advisory Teacher of the Deaf for a Sensory Support Service and as an Implant Centre Teacher of the Deaf. She is currently the Principal Teacher of the Deaf at St Thomas' Hearing Implant Centre and jointly co-ordinates the Paediatric Cochlear Implant and Auditory Brainstem Implant Service.

We also know from experience that the children who have had ABIs with our service have taken several years of consistent device use and rehabilitation to reach detection of speech sounds, so commitment is essential.

In October 2019 Guys and St Thomas' NHS Foundation Trust and Kings College Hospital ABI service won the Groundbreaking Pioneer award at The Sun's 2019 Health awards after being nominated by the parents of our first ABI recipient.

The team were very proud to receive this award and hope to continue to have success in giving access to sound to children with absent auditory nerves.

References

Acknowledgement – The ABI Team (Professor Dan Jiang, Steve Connor, Nick Thomas, Shakeel Saeed, Katherine Wilson, Marsha Jenkins, Sandra Drive, Heather Crofts, Jo Garvey, Chris Rocca)

For further information please see our website

www.guysandstthomas.nhs.uk/our-services/hearing-implant-centre/patients/auditory-brainstem-implants.asp



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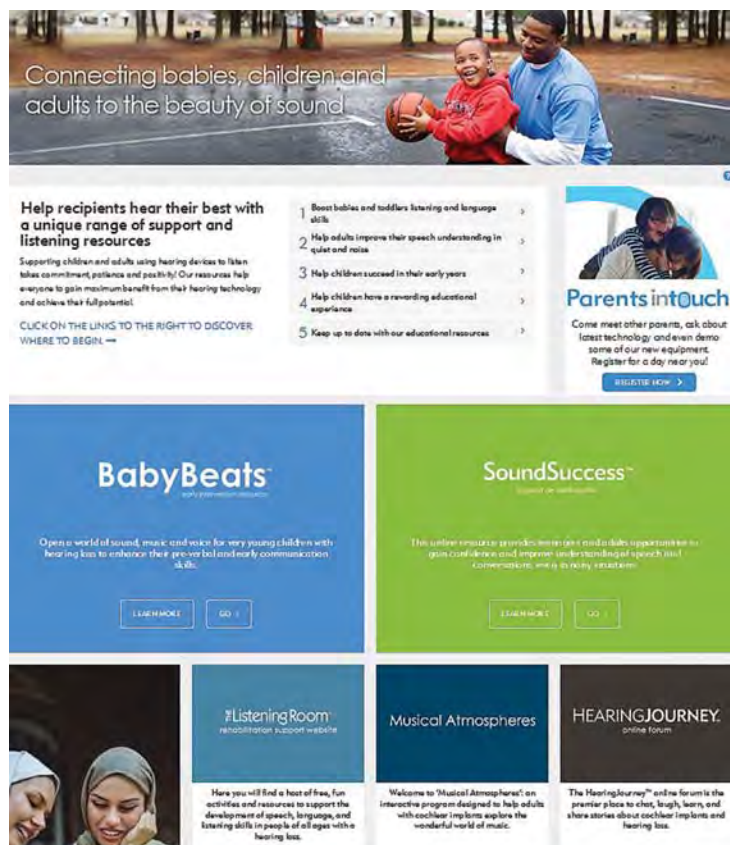
As professionals, once you have registered, you will have full access to our paediatric and adult aural rehabilitation programs, assessment and monitoring resources and counselling tools, **free of charge**. Voucher codes are no longer required.

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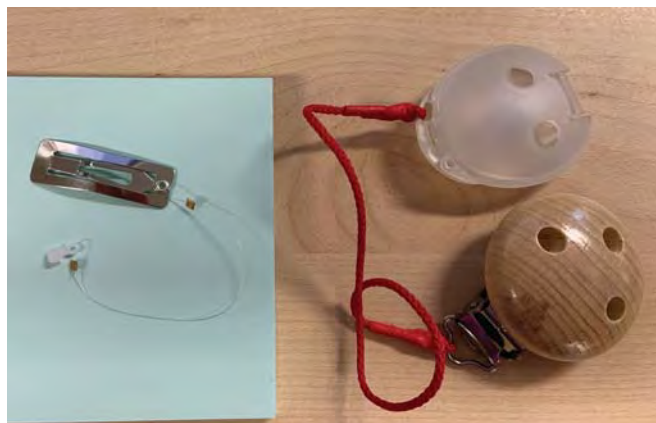
Middle Ear Implants at the Emmeline Centre

Gayle Leeson and Abi Asher offer a practical guide to Vibrant Soundbridge Implants

Undergoing surgery to receive an implant whether it is in the cochlear or middle ear undoubtedly involves a degree of risk for the patient. All implantable devices are therefore only considered when conventional hearing aids are unable to meet the needs of the individual.

For many mild to moderate conductive/mixed hearing losses, the use of bone conduction hearing devices (BCHD) are routinely offered at the Emmeline Centre. These devices are particularly useful when individuals have an air-bone gap of more than 30 dB as research would suggest that they are better aided by bone conduction devices than behind the ear hearing aids. Through the use of BCHD devices on a soft band, percutaneous abutment (pBCHD) or magnet, additional amplification can be offered to patients with atresia, stenosis, chronic ear problems, middle ear dysfunction, otitis externa, earmould allergies and eczema. However, there are limitations. The maintenance of pBCHD can be challenging and not keeping the site clean can occasionally lead to re-implantation. Magnetic BCHDs can require stronger than ideal magnets. The use of soft bands and the more recent innovation of sound arcs with Cochlear Baha devices can be challenging to wear and difficult to maintain adequate connectivity. They aren't always the optimal audiological solution and can be rejected by patients as they become more self-conscious of their appearance.

All patients with mixed/conductive loss who attend our centre for a hearing implant assessment are requested to



Samba hair clip and Samba sleeve

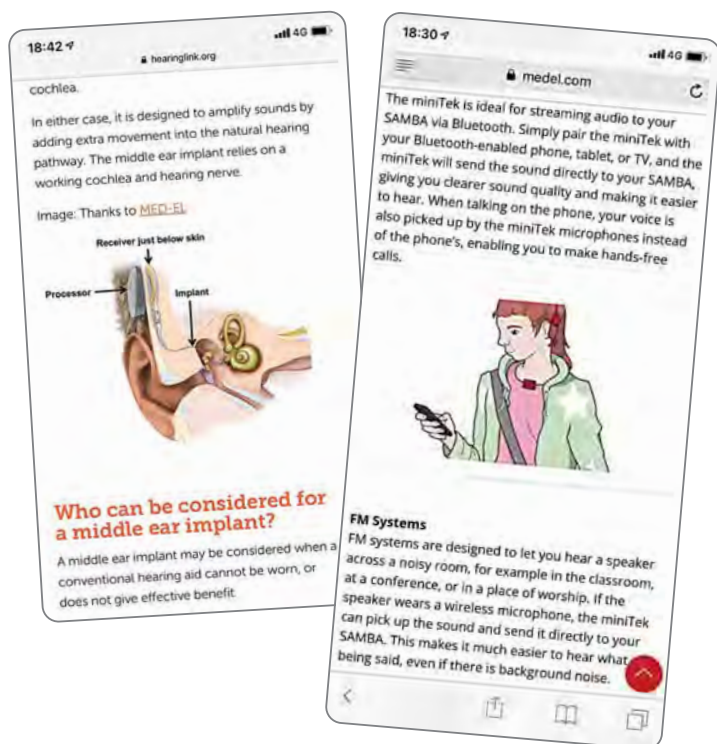
trial the use of a soft band to enable them and us to ascertain the benefits of continued intervention. For some patients, using a BCHD is happily accepted and many continue on a long term basis using such equipment. For others, the alternative of a Vibrant Sound Bridge (VSB) middle ear implant is being increasingly utilised for patients over three years of age. The VSB is suitable for mild-severe sensorineural as well as mild-moderate conductive and mixed hearing loss. Whilst we would view the VSB as our "gold standard" for patients it is not suitable for all eg children with Treacher Collins syndrome often lack the middle ear anatomy suitable for attaching a VSB. Careful consideration is therefore given to each situation on how best to support their hearing.

Middle Ear Implants – Med-El Vibrant Soundbridge (VSB):

A VSB consists of an internal and external component. The internal implant is positioned underneath the skin behind the ear, and at the end of the implant there is an attachment called a Floating Mass Transducer (FMT) which can be connected to middle ear structures. Externally, the Samba audio processor is held on the outside of the head over the implant by a magnet. The external sound processor converts sound waves into electromagnetic signals that can be transmitted to the implant through the skin. The internal implant transforms the signal into mechanical vibrations which cause the FMT and therefore the middle ear structures to vibrate. This subsequently enables signals to be transmitted to the cochlea and activates the hearing process.

Samba processor:

The Samba has five programme slots available, including an adaptive universal programme. Different MiniTek functions require separate programmes, so many paediatric users will have three or four programmes to navigate.



Programme Number	Number of presses on external source button	Audio source available	Beeps heard by user (in ascending musical scale)
1		-	Everyday non-streaming
2	1	Bluetooth phone (if needed)	2
3	2	Any of radio aid/Tek transmitter for TV or headphone socket/background noise/music programmes as needed	3
4	3		4
5	4		5
1	5	Back to non-streaming P1	1

Batteries for the Samba processor can last 3-7 days before they need replacing. Retention clips include a small crocodile hairclip, a snap hairclip, and a large sleeve cover with bodyworn clip. Retention has also sometimes been an issue with the hair clips being easy to break. The Samba sleeve is recommended in younger and complex cases as it is much stronger, or a Samba sports headband that keeps the processor attached during physical sporting activities.

Siemens MiniTek Streamer:

If programmes need changing or if you wish to have wireless Bluetooth streaming to mobile phones, music devices, Telecoil or radio aid systems; this can be achieved by pairing the Samba to a MiniTek streamer. Working out the order of buttons for MiniTek use can be somewhat tricky, but use of the streamer for radio aid or Bluetooth requires programmes 2-5 and so a programme change is necessary in order to begin using it.

To pair with Bluetooth devices:

1. Press and hold on/off button for three seconds to turn on the MiniTek.
2. Activate the Bluetooth function on the chosen device in settings.
3. Press the phone button on the MiniTek for five seconds to prepare the MiniTek for pairing.
4. Search in the menu of the device for other Bluetooth devices.
5. Choose 'RCU connect' to pair the MiniTek and the device.
6. Enter pin code 0000 if requested.

Once you have paired a mobile phone with the device, any incoming calls (heard by the user ringing through their processor) can be streamed by simply pressing the phone button once to answer and again to end. This will take precedence over anything that is already being streamed via Bluetooth from the phone.



Other Bluetooth devices require you to press the external source button on the right to switch to the next audio source (please refer to programming report for specifics for each patient) – see table above.



The streamer needs to be charged and lasts for up to five hours of use. Published literature suggests that the MiniTek is usable on both a lanyard and a body worn clip. Experience and feedback has suggested that the latter clip onto clothes is preferable, as close as is feasible to the processor (on shoulder or collar) with the longer sides of the device kept horizontal ('P' button in this orientation:



This makes the MiniTek quite cumbersome to wear, but if not maintained in this position, the signal has been found to be more unstable.

For audio sources that are not Bluetooth compatible eg TV, and positioned some distance away, a second Tek transmitter can be plugged into the device which then relays the signal to the MiniTek. The transmitter needs to be mains powered or charged in order to function. However, devices can also be attached straight into the streamer using audio cables. For radio aid use, the receiver is connected directly via the DAI port on the bottom of the streamer.

In the current financial climate it is well understood that local authorities may not be in a position to supply radio aid systems to all pupils on their caseload and when prioritising available resources it might be difficult to offer MEI pupils radio aid systems. Although the MiniTek provides access to this facility it is highlighted to parents that its use for this purpose is at the discretion of the local team.

MEI post-implant pathway:

During assessment, if it is considered necessary to investigate other implant options, a CT scan is obtained before the case is taken to our multi-disciplinary team to be discussed. Following surgery, the Soundbridge can be fitted six to eight weeks after implantation. Any former BCHD Softband wearers can go back to this after two weeks as long as it's comfortable and not lying on the scar. Whilst patients might have a period of acclimatisation, regular hearing aid or softband wearers have been found to adapt quickly to listening through their new device. A follow up



Minitek



Minitek position

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appointment is booked approximately four weeks following the initial fitting to check on magnet strength suitability, fine tuning needs and to measure aided listening levels. Between these appointments the Key Rehabilitationist is available to follow-up on local training needs and to complete a baseline functional assessment against which future outcomes can be compared. Once satisfactory threshold levels and speech testing results have been achieved, appointments are carried out on an annual basis with additional appointments available if required.

When working with individuals using a MEI remember these tips:

- Encourage them to say when they do not understand information, particularly during their acclimatisation period.
- Continue to provide access to lip reading and visual cues to support their listening.
- If they now have access to sounds bilaterally, they may benefit from practice to help localise sounds.



Internal and external positioning of VBR



Med-El – Vibrant Sound Bridge (VSB)

- As with all hearing devices it will continue to be difficult to listen in noise. Additional listening devices may still be necessary to support them fully.
- Monitor for any significant change in their listening behaviour as it is possible for the FMT to become dislodged which will affect listening capabilities.

VSB middle ear implants have been used now at the Emmeline Centre since 2010 and so far we have implanted 100 ears in 71 patients. Feedback from patients and families has been positive with reports of improved levels of listening, a reduction in the amount of listening effort needed and greater enthusiasm to wear the equipment. However limited research to date has been carried out on the functional outcomes of BCHD versus VSB.

An initial evaluation of the effectiveness

of amplification offered by MEIs was carried out at Addenbrooke's Hospital in 2018 (Lloyd et al 2018). The Emmeline Centre team compared our outcomes for patients with pBCHD and VSB and a mixed hearing loss. The study compared pre-operative and post-operative unaided pure tone audiograms and most recent soundfield aided thresholds. The research project found that VSBs provided better thresholds in the higher frequencies compared to BCHDs. Results also suggested that VSBs could amplify beyond the bone conduction levels thereby 'over-closing' the air-bone gap by as much as 22.5 dB. This advantage along with the ability for VSBs to offer ear-specific amplification and therefore potential binaural benefits, are benefits that cannot be offered by pBCHDs.

We are therefore very positive about the potential gain offered by using the VSB to help support patients with conductive hearing losses and we look forward to contributing to further research to establish the extent that they benefit patients.

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Lloyd SKW, Donnelly NP (eds). (2018). *Advances in Hearing Rehabilitation*. Adv Otorhinolaryngol. Basel, Karger, vol 81, pp 43-56. Doi:10.1159/000485529

Med-El: *Live, laugh, learn information for teachers of pupils with soundbridge or bonebridge*



Abi Asher is an Audiological Scientist and Lead for Hearing Implants.

Gayle Leeson is Lead Rehabilitationist, QToD, MSc Educational Audiologist. She has worked at the Emmeline Centre for 2 years leading the adult and paediatric rehabilitation teams.

BAHA Service delivery

Emily Brooks and Ying Guo describe a collaborative working multi-disciplinary team approach to BAHA service delivery at the University College London Hospitals NHS Foundation Trust

A Bone Anchored Hearing Aid (BAHA) service was established as part of the Auditory Implant service delivery in 2015. We began to accept referrals for paediatric patients in 2016. There was an increased amount of evidence to suggest BAHA devices on a softband result in significant improvements in quality of life for deaf children and young adults (Ramakrishnan et al 2011). There are a number of profiles where a BAHA on a softband may be considered. These include:

- Single-sided deafness (SSD)
- A conductive loss as a result of a syndrome eg Treacher Collins (Rosa et al 2016), Down Syndrome
- Unilateral or bilateral abnormal middle and or outer ear (microtia and atresia)
- Long term otitis media with effusion (glue ear).

As the demand for BAHAs increased, the department started a Joint Audiology and Implant Centre Teacher of Deaf (ICToD) clinic to assess, fit, review and support

families and their children and young people (CYP). Our patients are mainly referred to the service from Audio-Vestibular Medicine (AVM), Ear, Nose and Throat (ENT) consultants and some from other audiology departments across the UK.

Figure 1 provides a summary of the BAHA service delivery and the case study below provides an example of this:

Case study

Patient D was referred by an AVM in July 2017 for a softband BAHA trial (aged 7) due to permanent sensorineural SSD. His SSD was caused by a hyperplastic cochlear nerve. He was booked into a joint clinic with the Audiologist and ICToD. Prior to this appointment D had never tried any form of amplification.

Initial Appointment:

During an initial appointment, the audiologist completes a hearing assessment and chooses a suitable softband BAHA

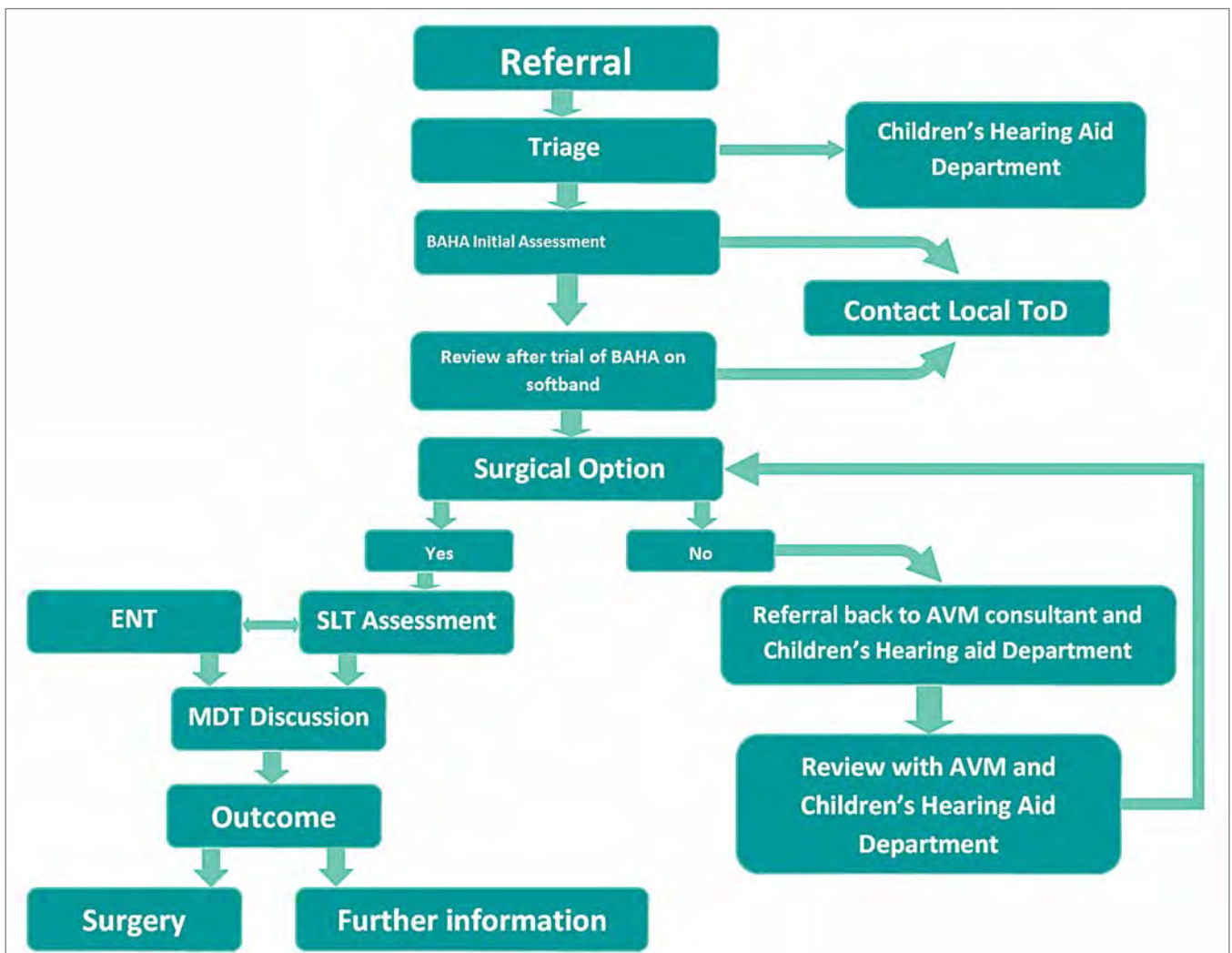


Figure 1

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device. The soundfield detection is normally conducted during the initial assessment. In some cases, it will be done at the follow up appointment; this depends on the patient's compliance.

D was very co-operative during the session; therefore, we completed a hearing test and tympanometry. A more powerful device was chosen due to his SSD. The device was programmed using 'BC Direct' ie measuring D's unaided bone conduction thresholds on the affected side via the software. D was issued with one programme to use in all listening environments, this is commonly the case. The fit and management of the device was demonstrated. The family practised putting the softband on and off to ensure optimum positioning of the transducer. D was then provided with a dry-kit, batteries and a safety line, to ensure the BAHA remains attached to clothing if knocked off. Due to D's cooperation we were able to complete aided detection thresholds at the end of the session. This is completed by blocking the better ear canal with an ear plug and covering the ear with ear defenders. The results are therefore reflective of aided hearing levels with the BAHA. Frequency specific sounds were presented from the loudspeaker, and the minimum detection levels were recorded. The results were then explained to the family.

D was able to hear at the levels below:

	250Hz	500 Hz	1 kHz	2 kHz	4 kHz	8 kHz
Freefield dBHL aided condition Left BAHA alone	25	20	25	25	35	4



We performed conditioning to conduct play audiometry before doing D's hearing test

During this appointment the ICToD gathered background information about the D's school and local ToD team. The parent and D were asked about his school experience and speech, language and communication profile. A questionnaire is used for those patients with SSD which enables us to gather some more quantitative information. In this instance, D was known to local services and consent was given to contact them. Contact can be in various ways: phone contact, letter to the team manager or the use of borough specific referral forms. The information disseminated may include:

- aetiology
- related medical information (if known)
- hearing threshold levels and nature of hearing loss
- device information
- communication development
- general development and details of other professionals involved where relevant eg MSI teacher.

D was fitted with a demo device in the appointment. The family were then invited to a follow-up appointment eight weeks later where use of the device was reviewed.

Review Appointment

The aim of the review appointment is to assess the benefit of the BAHA trial. This is done via self-report, parental report, questionnaires and importantly local QToD feedback. In D's case all reports were generally positive. He was able to localise and his family felt he was more responsive in noisier environments. However, the biggest change was reportedly in his behaviour and self-confidence. This concurred with reports from the local QToD. In this appointment D and his family were keen to



We conducted hearing tests by using play audiometry. D is old enough to press the button as his responds; however he preferred to press his dinosaur instead

proceed with fitting his own device. The trial had been so successful; therefore, D and his mother were keen to be referred on to the ENT consultant to be considered for surgical options.

Next Steps

In this case, D had a speech and language assessment to establish a baseline. They were then reviewed by the ENT consultant who discussed options with the family. The multi-disciplinary team (MDT) discussed his case. It was agreed that D would benefit from proceeding with an implantable device. The device choice is dependent on a number of factors and ultimately rests with the ENT consultant. They base their decision on the information gained from the assessment process as well as anatomical scans.

In many cases families and CYP choose to continue with the softband BAHA and are referred back to the AVM consultant. At any point families can reconsider a surgical option and meet with the Auditory Implant Team.

Our centre has seen over 125 cases with varied aetiology including children with Down syndrome, microtia, single-sided deafness etc. All CYP showed benefit when we tested aided responses. In 90% of cases the CYP, are still using the softband BAHA system. There are a few CYPs who have chosen:

- surgical options
- CROS aids fitting
- to stop using softband BAHA due to no perceived benefit.

Local services may have different criteria for supporting CYP fitted with a softband BAHA. The MDT approach to assessing, fitting and reviewing CYPs ensures the best possible outcomes for them and their families (Nikolopoulos & Vlastarakos 2010). Local services are informed early in the process and have a point of contact to go to for support and guidance. The feedback on the

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Before we conduct speech testing, we use sound level metre to calibrate the speaker

positives and negatives of the CYP's experiences help inform our management and future planning. The contact between ICToD and QToD is vital for patient centred care. Taking an MDT approach to a CYP care and support is much more likely to result in positive outcomes. ■



Emily Brooks is a QToD on the Auditory Implant Programme and has worked on the programme for 4½ years. Emily was previously a QToD with the Westminster Outreach Service.



Ying Guo is an Advanced Audiologist for Cochlear Implant Audiology on the Auditory Implant Programme at the Royal National ENT & East Dental Hospital.

Audiology curriculum

Suzanne Williams, Sandra Barlow and Alice Minett, qualified Teachers of the Deaf, share details of their audiology curriculum, which they also presented at the University of Manchester – 100 years of deaf education conference 2019

When setting up a service-wide document to track the termly outcomes set by peripatetic Qualified Teachers of the Deaf (QToDs) in Leeds, we realised how varied the timings of specific interventions can be. There was a need to ensure that no matter which QToD a child was allocated to, or how old they were when diagnosed, they would receive a consistent program of study that allowed them to develop knowledge and awareness around their hearing loss. This would include those areas that need to be taught specifically outside of the school curriculum. We looked at a range of assessment tools currently in use and worked as a team to adapt and develop our own audiology curriculum, which covers knowledge of audiograms, hearing loss, how the ear works, assistive listening devices, self-advocacy etc. We have now trialled our curriculum for a year and use it widely for target setting and tracking progress.

We strongly believe that children and young people should have knowledge about their own hearing loss, to a degree that is appropriate to each individual and be able to talk about their own hearing with the correct knowledge and understanding. We were aware that peripatetic QToDs were working on audiological understanding but wanted the Leeds staff to have a curriculum document that

showed progression and development over time. This meant that the service was accountable and there was an equity of provision across our three teams. Long term progress would be easier to monitor, particularly when pupils transitioned to a new QToD. It would also give value and importance to those areas, outside of the curriculum and language acquisition, where QToDs can provide beneficial intervention.

After researching materials that were already available, we chose to base our curriculum on the IOWA version. We decided that our audiology curriculum would have 3 areas of learning;

- Knowledge of hearing loss
- Amplification management
- Environmental management.

Each of the areas would be broken down into 4 levels of competency which are basic, emerging, developing and secure. This allows us to track the CYPs progression over time as their understanding and knowledge develops. As a team, we met and discussed each area and the level of competency within that. Finally, we went to trial the document. The overall document provides the QToD with clear achievable outcomes.

Audiology: Knowledge of hearing loss



Date of Visit		21 March 2019		Number		Upload	
Name:		PSS-ID:		TOD		Date of birth:	
NC Year 5		NatSIP: 038		Hearing loss: profound		Type of loss: Sensori-Neural	
School/Setting:							
basic	emerging	developing	secure				
I know that I have a hearing loss.	I know that my device/s help me to hear.	I know that I'm not the only person who has a hearing loss.	I can explain aided & unaided hearing loss.				
I demonstrate an awareness that sound starts and stops.	I can recognise the difference between loud & quiet and high & low frequency sounds.	I understand a basic audiogram.	I can explain my audiogram in terms of speech sounds.				
I know my type of hearing loss.	I know that there are different types of hearing loss.	I can explain my hearing loss.	I can explain the different types of hearing loss & the impact of this.				
I know my level of hearing loss.	I know there are different levels of hearing loss.	I can explain my level of hearing loss.	I can explain the different levels of hearing loss & the impact of this.				
I have a basic understanding of how the ear works.	I can name the main parts of the ear.	I can identify the parts of the ear and their function.	I understand the impact of sounds upon the ear.				
I can show a friend my hearing aids.	I can explain to a familiar adult or child that I have a hearing loss and how to make listening easier for me in class.	I can explain to an unfamiliar adult the nature of my hearing loss and how to make things easier for me in class.	I feel confident to explain the nature of my hearing loss and implications for daily life.				
Date of assessment	Easter 19	July 19					

Audiology: Amplification management



basic	emerging	developing	secure
I accept and use my amplification device/s as directed by an adult.	I can ask an adult for help with my device/s.	I manage my device/s with minimal adult support.	I can manage my device/s independently.
I know that my amplification device/s has different parts.	I have some vocabulary to discuss my hearing device/s.	I know that some parts of the device can be replaced.	I can describe the range of amplification devices used by deaf people.
I can look after my device/s with adult support.	I can store my device/s correctly when not in use.	I can change/charge the battery when needed. I can remove moisture from the hearing aid and/or tube.	I can clean my ear moulds. I keep my device/s in good working order without adult support.
I indicate that I can't hear using facial expression or pointing.	I know and can indicate when amplification devices are not working.	I can ask for help with my device/s when needed.	I can troubleshoot minor issues with my device/s independently.
I indicate that I want to wear my device/s, I sit still when an adult puts my devices on.	I know how to turn my device/s on and off. I can remove my device and/or ear moulds.	I can put on my device/s and/or earmoulds.	I can manage all controls appropriately e.g. Programs, t-coil.
I wear amplification devices consistently.	I understand the advantages of wearing amplification devices in the classroom.	I can explain when amplification devices are not needed and why,	I can use device controls appropriately in various listening situations.
I understand that a radio aid can be used to support listening.	I can make sure that the speaker is using my radio aid transmitter.	I can connect my devices to a radio aid. Independently.	I can explain how a radio aid works and why it helps me.
Date of assessment	Easter 19	July 19	



Audiology: Environmental management

basic	emerging	developing	secure
With adult support, I can sit in the best position in class	I can sit in the best position in class	I know the impact on my listening of sitting in the wrong place	I can explain where is best for me to sit. I can ask to move to a better position.
I know that different things make different sounds.	I can locate sounds in my classroom.	I know the impact that background noise has on my listening. I can ask for help to minimise background noise.	I can explain the impact of background noise on my ability to listen. I can ignore unwanted background noise.
I know when someone is speaking to me.	I recognise when I haven't heard. I recognise when I haven't understood.	I can ask for repetition. I can ask a speaker to look at me.	I can identify & explain barriers to communication. I am skilled at repairing communication breakdowns.
I know that some places are harder to listen in.	I know how the physical environment can affect listening.	I can identify a room with poor/good acoustics.	I can apply my understanding of room acoustics to best suit my listening.
I make good use of equipment with adult support.	I make good use of the equipment I have.	I know about other equipment available to meet my needs.	I know how to request the equipment I need. I know how to use all equipment effectively in different environments.
Date of assessment	Easter 19	July 19	

The charts

In the autumn term of 2018, a profoundly Deaf student was assessed as a baseline using the Audiology curriculum. The student's first and home language is BSL and he is supported in school by a CSW with weekly visits from a QToD and a deaf instructor. The information was shared with relevant school staff, parents and with Audiology to ensure, as far as possible, a multi-disciplinary approach to the outcomes.

Much of the curriculum is personalised and requires teaching in 1-1 or small group sessions with other deaf peers. However, part of the content in the knowledge of hearing loss section lends itself to mainstream classroom teaching. Some initial pre teaching of language took place with this student, which then led to small group classroom based teaching linked to a science topic. This allowed the student to develop concepts, understanding and scientific language in line with his peers.

The grids on previous pages show where the outcomes and targets were identified and how progress over time was tracked. There was no particular timescale set for updating the assessment document, though targets were linked to those set on the child's EHCP.

The impact of this work was that staff, students and parents had a clearer overview of which areas of audiology needed specific work and could then devise targets which were more needs led. Consequently, students were more engaged and so made progress which was more relevant and meaningful to them as deaf learners.

Target setting could be directly linked to EHCPs with a bank of resources becoming more readily available as staff rolled out the curriculum. The curriculum has also been used to support ToDs in training become more comfortable with the functional aspects of audiology in conjunction with their clinical practice.

The audiology curriculum is now being used widely across the team to assess new children to caseload, to set termly targets and to provide a level of accountability and evidence that we didn't have before. It is neatly organised into three sheets of paper, so is a manageable document to track progress over a number of years. It has been used with students with a range of communication approaches and from ages 2-18.



Suzanne Williams is Area Lead Teacher of the Deaf (East Leeds)

Sandra Barlow is Area Lead Teacher of the Deaf (South Leeds)

Alice Minett is Area Lead Teacher of the Deaf (West Leeds)

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Professional Development Groups

Amanda Odell and **Clare Boddy** share details on the Nottingham Auditory Implant programme's professional development groups

The Nottingham Auditory Implant Programme (NAIP) believes that a close working relationship with local professionals and other agencies is essential to ensure that children who are considering or who have cochlear implants and their families are best supported. The team is keen that everyone working with children and families in their care is well informed and knowledgeable about the equipment, use and benefit of implants as well as having tools and profiles to monitor progress.

NAIP has two professional development groups which have been established to try and achieve these aims. The Educational Audiology Professional Development Group was started in March 2015 and the Early Years Professional Development Group had its first meeting in February 2017.

The groups are offered to the relevant professionals within the geographical areas generally served by NAIP ie approximately 25 areas/key users.

The groups are scheduled to meet twice each year at Ropewalk House and are free of charge.

Educational Audiology Professional Development Group

This group was set up to provide a regular forum to update local professionals on implant technology and to get some 'real life' feedback on use and any issues affecting the use of the technology.

Educational Audiologists, as part of their role, generally oversee the use of all hearing technologies and assistive listening devices. This group of professionals usually train and disseminate technological information to their teams which include qualified teachers of the deaf (QToD), specialist teaching assistants and technicians. However, not all services have an Educational Audiologist.

Notification of the first meeting, in March 2015, was sent to the Heads of Service and if known, Educational Audiologist for all areas who work with NAIP. While it was stated to be for attendance by Educational Audiologists, Services were informed that a team representative at any level was also welcome with the proviso that the information was disseminated to their team.

Meetings

The meetings have covered a variety of topics and used many different training techniques. The three major implant manufacturers; Cochlear, Advanced Bionics and MED-EL have all offered presentations regarding the developments in their processors ie N6, N7, Sonnet, Naída. The manufacturers have also provided sessions where the group can handle and manipulate the processors which have been particularly popular. Also, they have provided information and training sessions on the use of their wireless accessories in order for local professionals to

support their families in the use and benefit of the new technology. This involved a project on the use of the wireless Cochlear Mini Microphone, led by NAIP, with information and support from the group members. An article was published in Cochlear Implants International on completion of the project.

The meetings have also been used to discuss and debate use of radio aids, their set up and verification. Radio aid policies have been discussed and a NAIP policy developed. There were discussions regarding the implementation of the 2017 NDCS Revised Quality Standards for the use of radio aids with children and the use of radio aids in the preschool population. Presentations were given by guest speakers Wendy McCracken – UK Children's Radio Aid Group, Imran Mulla – PhD on radio aid use in pre-schoolers, Stuart Whyte, Sarah Allen – NDCS project on availability of radio aids for the preschool population and Paul Harris of the Ewing Foundation. Members have found the opportunity to discuss this subject invaluable including the major issue of funding. The meetings have also been a way of informing local services of NAIP practices and any changes made eg development of the spares and repairs service, implementation of the 2019 NICE guidance regarding eligibility for cochlear implantation and development of auditory profiles. Presentations have been given by a range of NAIP staff including QToDs, Speech and Language Therapists (SaLTs), audiologists and other support staff.



We work together across geographical and professional boundaries, enabling us to make the best use of all our skill sets.

Feedback sheets are collected after each meeting giving attendees the opportunity to let us know what information is useful and the best way of presenting information. There is also an opportunity to suggest topics and areas of interest to themselves and their individual services.

Within the meetings there are opportunities to ask questions and discuss issues in a safe and secure environment. The group is aware of the sensitive nature of some of the issues and the need for confidentiality.



Development

Due to time constraints, particularly on local professionals, the meetings are now held twice a year ie in the Autumn and Spring term rather than termly from inception.

Changes in personnel and staff turnover have meant a wider range of professionals now attend. Technicians and QToDs often request attendance if the topics are of particular interest to them. Heads of Service are keen that they have some representation at the group with a view to keeping their service, as a whole, updated. Approximately 16-20 areas are regularly represented at the meetings. Some teachers undergoing the mandatory training qualification for QToDs as well as the educational audiology course also attend to acquire knowledge and experience of the technology.

Early Years Professional Development Group

This group was set up as a forum for sharing expertise not just between the Auditory Implant Programme and the local professionals who work with the children we see, but also sharing expertise between QToDs and SaLTs. Our work is improved if we understand each other's skill set, helping us to understand the best way to work together to meet the children's needs.

In addition to the information we get from hearing the presentations and participating in discussions, we aim to produce materials that support all of our practice

This group provides the opportunity for QToDs and SaLTs to work together.

In some areas of the country there is good practice with QToDs and SaLTs meeting regularly, liaising and using each person's skills optimally. In other areas it can be difficult to

access SaLTs for deaf children, or where the children do have access to therapy but it is difficult for the practitioners of the two professions.

The group has worked together to develop resources; profiles, questionnaires and lists of strategies and equipment that people have found useful.

As Auditory Implant Programme professionals we need to work seamlessly with local professionals, sharing information and ongoing targets. As such we need not only a shared language, but also a shared understanding of what we are looking for and how.

The invitation to the first session was sent to QToDs, Heads of Service, SaLTs specialising in working with deaf children and SaLT Leads. Since then information about the group has spread by word of mouth and we have highlighted it to the local professionals who support our children. We have a core of people who attend regularly, which has enabled us to complete joint projects which have run over more than one meeting.

Meetings

These have covered a range of topics:

- babble
- the development of speech production
- speech
- listening development
- play
- useful strategies for working with children with complex needs.

Much appreciated. I feed back to team!

Most definitely will impact on my own practice

We have had presentations to introduce a topic, both from members of the Auditory Implant Programme and from local professionals and we have also had external speakers

Really informative and interesting

to present on their specific areas of expertise. Many of the sessions have been workshops, with everyone contributing as well as, practical sessions and case studies.

Through the group we have taken the tools NAIP were using to monitor speech production – the questionnaire looking at early development of babble, and the scale looking at how babble then develops into intelligible speech – and adapted and refined them so that they are user-friendly and provide useful information. We have been able to test their reliability and validity through practical sessions at the meetings. We are looking at further long-term projects similar to this.

Our recent topic on complex needs has allowed those of us who only see children with additional needs occasionally, to draw on the expertise of group members who have specialised in that area. It highlighted the wide variety of different complex needs that we come across when working with deaf children. Many people in the group shared tips and resources that they have found helpful in different situations. Drawing in the outside expertise of the paediatrician provided a context for many of the difficulties and challenges these children face.

Inspiring – encouraging thinking about working in different ways beyond the usual way of working because of time pressures

Development

Group members complete feedback forms at the end of each meeting and there is no shortage of suggestions for topics and ideas for ways in which the group could be moved forward.

We encourage local areas to send two to three members of staff, the same staff, where possible. That way they can discuss ways in which issues raised at the group can be cascaded to their local setting. Consistency helps not only to ensure the

continuity of the ongoing projects, but it also encourages everyone to contribute. Ideally there would be a SaLT representative and a QToD representative from each area, although the thinner spread of SaLTs means that that is not always possible. In the near future we are planning to run a topic on different models of working together as professional groups.

We are outgrowing our room, but if we expand to a bigger space we need to be careful not to lose the vibrancy and sense of belonging that we get from the current group.

Will enable me to support others more

I enjoy liaising with like-minded people and catching up with ideas

All brilliant

Both groups continue to be well attended and attendees are particularly vocal about the benefits of the groups. We have heard that local service users are asking other Auditory Implant Programmes to provide something similar. As well as the opportunities to learn and develop tools to monitor and manage progress of children with cochlear implants, they report that these groups also benefit their wider practice with children and families using hearing aids. They also report that regular opportunities to meet, discuss and share information and ideas with professionals from other areas is particularly useful.



Amanda Odell is a NAIP Advanced Specialist in Communication – Speech and Language Therapist.

Clare Boddy is a NAIP Advanced Specialist in Communication – QToD and Educational Audiologist.

Increase your skills

Check the BATOD website calendar for courses that expand your knowledge and skills as a QToD, ToD in training, audiologist, speech and language therapist or support staff.

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Feedback on a radio aid study

Stuart Whyte, University of Southampton Auditory Implant Service, summarises his radio aid study

The aim of the study was to test the validity of electroacoustic verification of radio aid systems coupled with cochlear implant (CI) sound processors and to examine the rationale of proposed protocols for Phonak Roger design-integrated receivers for CI.

The University of Southampton Auditory Implant Service radio aid study (Whyte, 2019) considered the validation of proposed electroacoustic verification protocols for design-integrated radio aid receivers coupled to cochlear implant sound processors. The United Kingdom (UK) Children's Radio Aid Working Group (formerly the FM Working Group) in collaboration with the UK National Deaf Children's Society have published standards and guidance on amplification systems used with hearing aids and auditory implant sound processors (UKCRAWG, 2017). In the United States (US) adaptations of the American Academy of Audiology guidelines for hearing aids have been proposed for implant sound processors in peer-reviewed research (Nair, Sousa, & Wannagot, 2017; Schafer, Musgrave, Momin, Sandrock, & Romine, 2013).

It is important that when hearing aids or auditory implants are coupled with radio aids, an appropriately qualified individual ensures that the whole system provides the desired benefit. However, the approaches by the UK and the US to achieve the balance or 'transparency' of the combined systems differ. The traditional approach of the UK, built on work associated with the NHS Modernising

Children's Hearing Aid Service programme, was first produced as guidance in 2006 and published in 2008. The original US work was published in 2013 and followed up by an article in 2017. It only uses test signals of 65dB and allows transparency within 3dB.

The study looked at the two approaches to determine which is most effective. The balance or electroacoustic transparency is demonstrated when the hearing instrument analyser outputs of the sound processor on its own and then coupled with the radio aid are equal to within 2dB in the range 750Hz, 1kHz and 2kHz.

Measures of output at the implant electrode level and electroacoustic responses of contemporary CI sound processors were conducted with their design-integrated receivers at different gains.

The current UK and US electroacoustic test protocols for radio aid receivers coupled to CI sound processors were used. Measurements were conducted in the laboratory with the CIs and their design-integrated receivers to determine transparency, where suitable inputs to the CI and to the CI and radio aid, give equivalent outputs.

Results

Changes in the gain of the radio aid receiver resulted in corresponding changes in implant output at the electrode level. This was found to be similar in the electroacoustic output of the processor shown by the test box response curves. To avoid compression effects in the SONNET, CP1000 (N7) and CP910 (N6) processors 55dB signal levels were used as a maximum and a maximum of 65dB for Naida CI.

Naida CI Q90 and Roger 17 example

Figure 1, left, and Table 1, on next page, show the curves and data for the Naida CI Q90 and Roger 17 set at EasyGain 0 and -2.

Curves 1 and 2: 65/65 EasyGain 0 are within 2dB but the radio aid is just louder:

Offset calculation = -1.7dB [average of values at 750Hz, 1kHz, 2kHz]. Note RMS of -1.

Curves 3 and 4: 65/65 EasyGain -2 are also within 2dB but the radio aid is just quieter:

Offset calculation = +1.7dB [average of values 750Hz, 1kHz, 2kHz]. Note RMS of +1.

As with the hearing aid procedure, you can run a "Reality Check". For example, speech usually reaches the child's ear at 65dB at a metre. However, the transmitter is worn at 15-20cm below the talker's mouth and the sound is greater at that distance, so the input to the radio aid is approximately 80dB.

Curves 5 and 6: 65/80 at EasyGain -2 show a

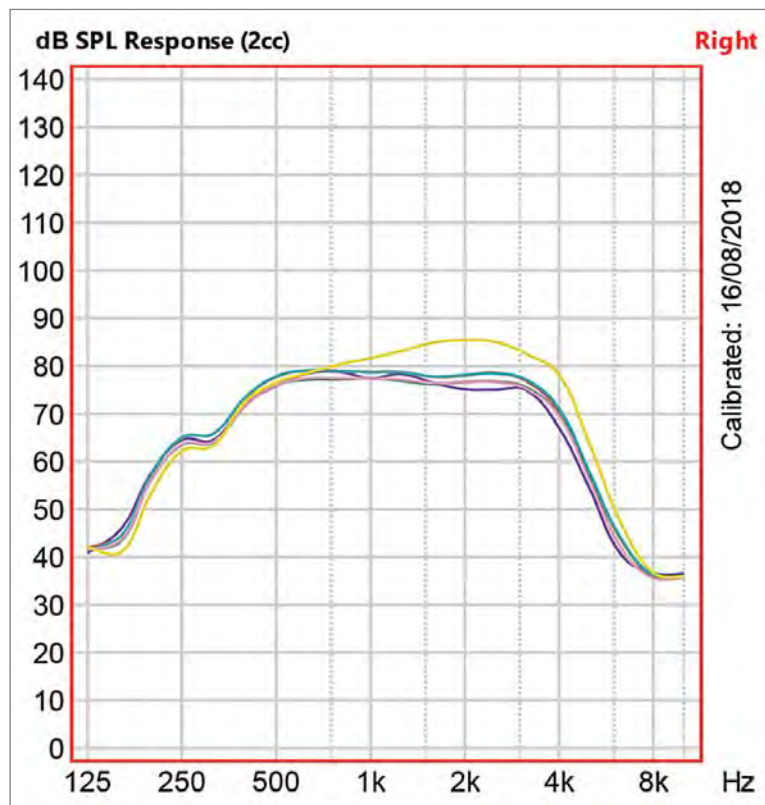


Figure 1

FreeStyle Table Right (2cc)								
Right	250	500	750	1K	1.5K	2K	3K	4K
Curve1	65	76	79	77	77	75	75	67
Curve2	65	78	79	79	78	78	77	71
F2B 1	0	-2	-1	-1	-1	-3	-2	-3
Curve3	65	78	79	79	78	78	77	71
Curve4	64	76	77	77	76	77	76	70
F2B 2	2	2	2	1	1	2	1	1
Curve5	64	76	77	77	77	77	76	70
Curve6	62	77	80	82	84	85	83	78
F2B 3	6	8	13	12	12	10	10	9

Table 1

Device combination	SPL to processor	SPL to radio aid	Connevens test lead *
MED-EL SONNET & Roger 21	55dB	55dB	DCTEST 4 & MTD adapter
Cochlear Nucleus 7 & Roger 20	55dB	55dB	DCTEST 4 & mono adapter
Cochlear Nucleus 6 & Roger 14	55dB	55dB	DCTEST 3
Cochlear Nucleus 5 & Roger 14	65dB	65dB	DCTEST 3
Advanced Bionic Naida CI & Roger 17	65dB	65dB	DCTEST 4

Table 2

*www.connevens.co.uk/productSearch.do?query=dctest&Search+Button=

frequency offset of -5.3dB (RMS -5). However, to show the reality of wearing a transmitter in use with an 80dB input we use the F2B values (feature to benefit). Here the Gain offset [750Hz, 1kHz, 2kHz] is -11.7dB (louder). But it is not really about crunching numbers – it is important to use common sense and look at the shape of the curves! Above all, it is essential that speech in noise tests are used to validate the fitting.

Test signal values

Table 2 shows the recommended values for Phonak Roger design-integrated receivers for cochlear implants.

Conclusions

Although the test box curves only indicate the microphone output, this has been shown to correspond at the implant electrode level. Initial results show that suitable signals of equal intensity presented to the sound processor and the radio aid transmitter are appropriate for design-integrated receivers coupled to CI sound processors, a modification of the US approach.

The protocols need further validating with speech in noise testing to provide more evidence that the desired benefit has been achieved and that the user is satisfied with the quality.

Similar investigation needs to be undertaken with other ear level receivers and with receivers coupled by electromagnetic induction to the telecoil of the processor.

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Stuart Whyte is Chair of the UK Children's Radio Aid Working Group.

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X-linked deafness

Rachel McOmish provides a summary of the audiological and surgical considerations associated with X-Linked Deafness

What is X Linked Deafness?

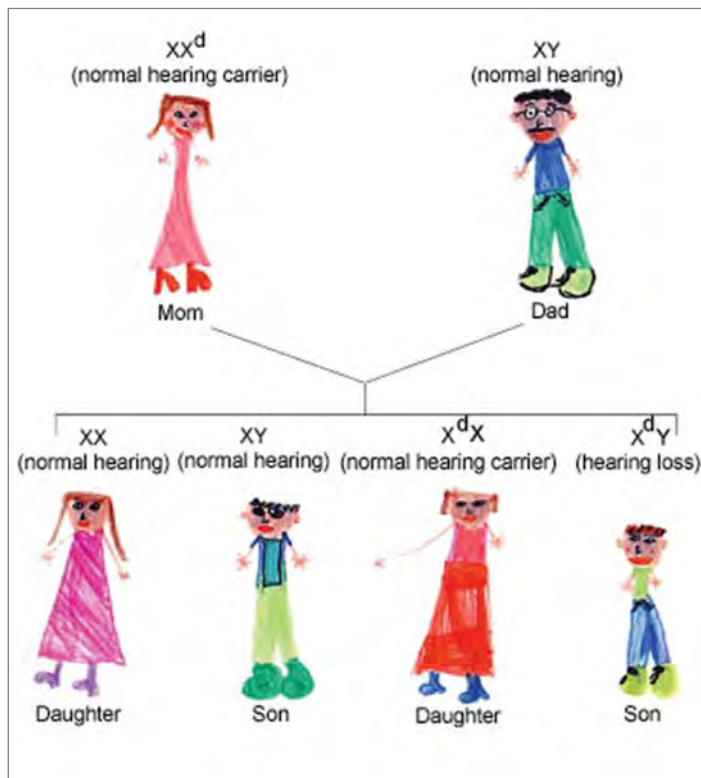
X-Linked Mixed Deafness (DFN3) is a rare congenital disorder. The presentation of symptoms may occur at birth. The disorder predominantly affects males, since it is inherited in an X-linked manner. The hearing loss is characterised by a progressive conductive and sensorineural hearing loss and a pathognomonic temporal bone deformity that includes dilatation of the inner auditory canal and a fistulous connection between the internal auditory canal and the cochlear basal turn, resulting in a perilymphatic fluid 'gusher' during stapes surgery (summary by de Kok et al, 1995). As a result, diagnosis can cause confusion to the clinician as the patient presents with a mixed hearing loss, often with normal middle ear status on tympanometry testing. Cochlear implants (CIs) are increasingly utilised for treatment in this population.

Who do we have under our care with this type of deafness?

The Royal National ENT Hospital has five children, aged 2-8 under our care with the diagnosis of X-linked deafness. All five children were considered to be suitable CI candidates. In view of the surgical considerations and complexities, extra counselling regarding expectations, risks and surgery were discussed with the parents and caregivers of the children.

What are the surgical considerations?

Due to the complex anatomical anomalies the following



Philadelphia Children's Hospital

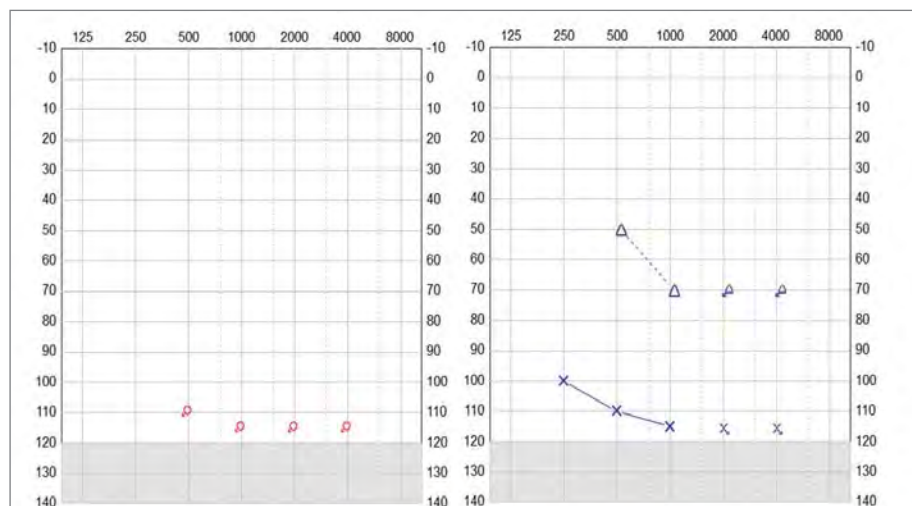
are surgical considerations that needed to be carefully discussed with the multidisciplinary team (MDT) and the patient's family before surgery:

- Risk of meningitis
- Intra-operative imaging required for surgery
- Choice of implant/array
- Lack of modiolus
- Cerebrospinal fluid (CSF) 'gusher' (leakage) during surgery.

Case Study: NS

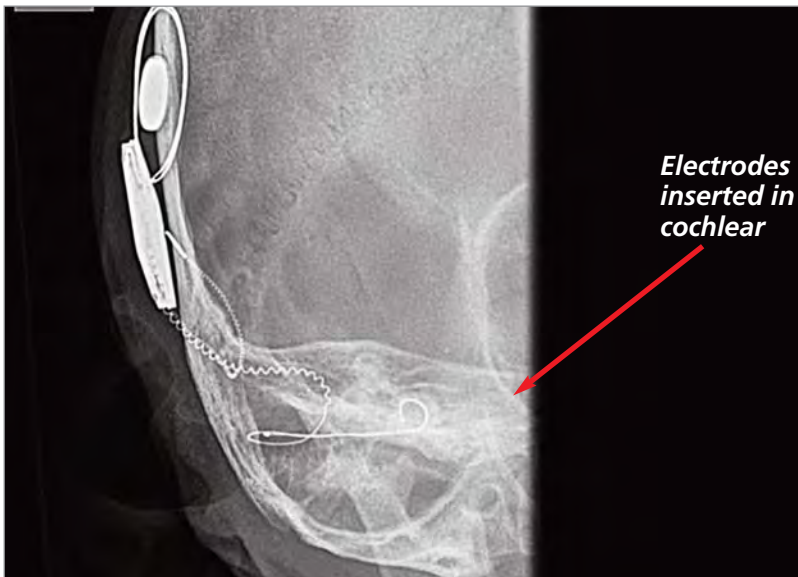
NS was a 4 year old boy who presented with a mixed profound hearing loss which was identified on the newborn hearing screening. He was issued with bilateral hearing aids at 4 months of age, however these were deemed to provide very limited benefit. He was then issued a Bone Anchored Hearing Aid (BAHA) on a softband to help overcome the conductive component to the hearing loss; however he did not show benefit with this device and rejected wearing the band.

NS had a complex medical profile



ABR	2kHz AC	4kHz AC	1kHz BC	2kHz BC	4kHz BC
RIGHT	>90	>90		35	25
LEFT	90	80	>40	>45	40

Hearing thresholds and ABR results from patient NS



Stenver view X-ray: all electrodes were inserted, despite a very difficult surgery

and presented with additional needs in addition to his hearing loss. NS had a diagnosis of autism spectrum disorder, significantly delayed speech and language and delayed motor milestones. He had been assessed by two other CI Centres, and they had deemed him not to be a suitable candidate due to his additional needs. His parents then requested a third opinion at the Royal National ENT Hospital.

He was assessed by the MDT and a further review of his computerised tomography scan (CT) revealed the diagnosis of X-linked deafness. The complex anatomy on his CT scan explained the large conductive component to his hearing loss. On his CT scan it showed gross abnormalities in the middle and inner ear structures, which give a 'false' bone conduction result and may confuse even the most experienced clinician when looking at his pure tone audiogram. This example highlights the importance of a MDT approach, as without the in depth discussion of the scan results with the ENT consultants this patient may have been incorrectly diagnosed.

The MDT agreed that NS was a suitable CI candidate as the BAHA and hearing aid trial had demonstrated that he did not obtain adequate benefit to soft sound. The surgical and rehabilitation team counselled his parents regarding realistic expectations post implant (especially due to his additional needs and older age of implant); as well as the surgical considerations as listed earlier.

It was advised that NS have staged sequential implantation to minimise the risk of meningitis. The surgery was successful, although great care had to be taken as there was a large gusher during surgery. NS had one night in hospital to ensure that there were no surgical complications, however he went home the next day and bounced back very quickly post surgery.

His switch on was four weeks post implant and the talented surgeon had managed to ensure that all the electrodes were functioning, despite NS having incomplete partitioning of the cochlea.

Outcomes

Three months after switch on, his parents reported that he was now making sounds with gestures, showing some situational understanding, responding to his name when his father called it, he was more engaged and he responded to music. His parents were very happy with his progress and requested to proceed with a sequential implant. NS had the surgery eight months after his first implant was switched on.

Interestingly, NS's younger brother, aged 1 year, is now under assessment for CIs at our hospital.

Learning points

X-linked deafness is certainly a very complex form of deafness. There are many considerations to make when the child is under assessment. Surgical planning is also very important due to the increased risk of a CSF gusher which is a meningitis risk.

As a team, we often feel that a CI assessment is like trying to complete a jigsaw puzzle. We cannot finish the puzzle without all of the pieces in place and when we work together as a MDT we achieve the best outcome for our patient.

We are pleased that NS has had such a positive result with his CIs. Whilst he has additional needs, in our team this is not a reason not to proceed with implantation (and certainly a full MDT assessment is always warranted). For children with known additional needs, expectations counselling is very important, however benefit from CIs comes in many different forms. NS's parents report that post implant he is much more 'engaged' in the world. To see him so much calmer and happier in our sessions is a real joy.



Rachel McOmish is an Advanced Audiologist at the Royal National ENT Hospital, London, mainly working with children and young people. After nearly a decade working in Australia in the public, private and not-for-profit charity sector as a Specialist CI Audiologist, she moved to the UK. She has a special interest in emerging cochlear implant candidacy, working with patients with special needs and early intervention.

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de Kok YJ, van der Maarel SM, Bitner-Glindzic M, Huber I, Monaco A P, Malcolm S, Cremers FP (1995). Association between X-linked mixed deafness and mutations in the POU domain gene *POU3F4*. *Science* (New York, N.Y.), 267(5198), 685–688.

Images

Philadelphia Children's Hospital, www.nidcd.nih.gov

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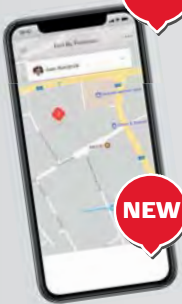
CI Technology and Rehab Resources for Teachers of the Deaf

MED-EL shares the latest cochlear implant product news including new app technology designed specifically for teachers of the deaf, parents, and guardians.

NEW

AudioKey app for iOS and Android

With the new AudioKey app you can change settings, 'find my processor' to an exact location, and check advanced hearing stats including accessory use – all directly from your Android or iPhone.



NEW

Guardian Controls only with MED-EL

The AudioKey app "Guardian Role" is also the only app that allows parents and teachers to pair multiple audio processors with their phone to check children are hearing their best.



NEW

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The compact remote control also includes an integrated processor check and link monitoring tool.

NEW

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NEW

AudioLink

This all-in-one wireless device can be used as a remote microphone, for making calls and listening to music, or docked next to the TV.

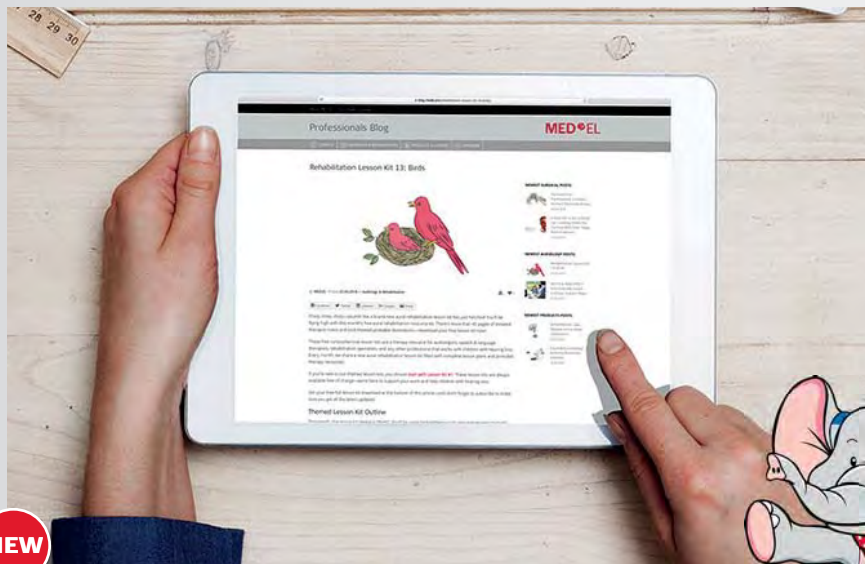


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<https://go.medel.pro/SONNET2>



SONNET 2. Made For You.

Strengths and Difficulties Questionnaire

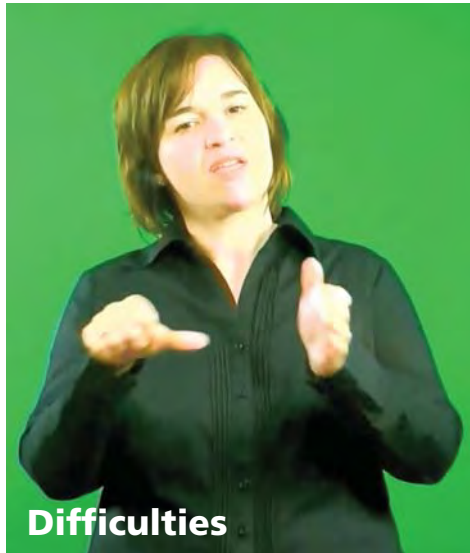
Richard Ogden describes how access to mental health is improved for children and young people by translating the Strengths and Difficulties Questionnaire (SDQ) into BSL

Mental health is a big issue nationally right now. It is constantly in the news, and the reported levels of mental health problems among children and young people are rising.

Rates of mental health problems are even higher in the Deaf community: by some estimates, two or three times higher than among hearing children. Deaf children with mental health problems can access generic Child and Adolescent Mental Health Services (CAMHS) provided by the NHS. But this can be challenging because children whose first language is

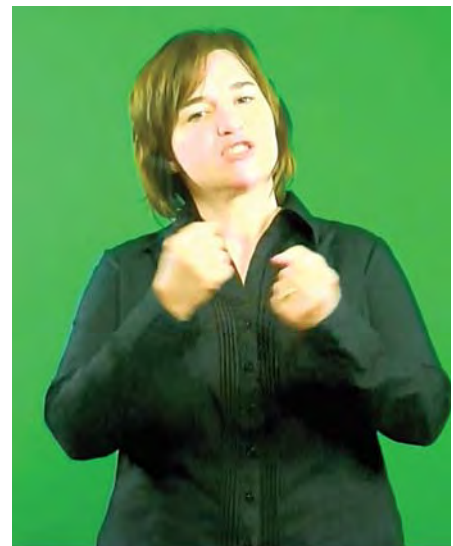
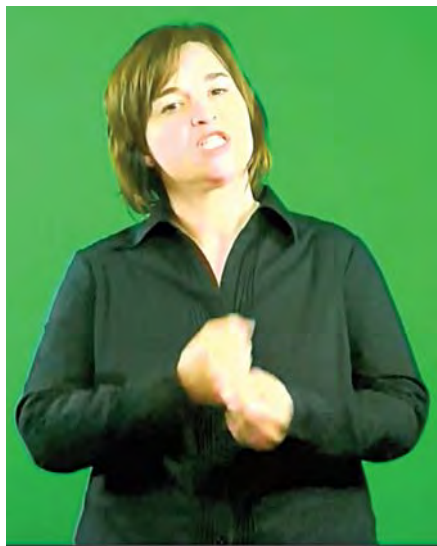
British Sign Language (BSL) may not have easy access to an interpreter who has the necessary skills. There has been until recently no validated mental health measure for children and young people in BSL, which has meant that clinicians could not screen Deaf BSL-using children for mental health problems, nor monitor their progress while they were being treated or supported.

The Strengths and Difficulties Questionnaire (SDQ) is commonly used to assess what kinds of problems a child has. It is a self-report questionnaire, initially developed to improve the detection of child psychiatric disorders. There are three versions: one for children and young people, one for parents and one for teachers. The SDQ can also be completed at the beginning and end of treatment to



assess how well the treatment has worked. The SDQ is widely used, and has now been translated into over 80 languages, but until recently it was not available in any sign language, meaning that access for Deaf children and parents whose first or preferred language is BSL was very limited. This situation has now changed thanks to the translation of the SDQ into BSL; it is being widely used by Deaf children, and their carers and teachers.

The translation process involved a team of Deaf and hearing professionals working together. Because the SDQ is a clinical tool, the translation process was more complex than it typically is for more everyday things in order to ensure that the translation would be accurate and as reliable as the written English version. First, the English





'sickness', and we had to decide whether this means 'vomiting' or 'feeling unwell': the only way to be sure was to ask clinicians how they use the question.

At the end of this process we evaluated the questionnaire, to check whether the translation was reliable and produced the same results as the English version. It did, so we can be sure that we have a robust translation that works properly for Deaf people.

This was the first time the SDQ has been translated into a sign language. Since

our work, teams in Canada and Norway have translated the SDQ into American Sign Language and Norwegian Sign Language using the same methodology. Currently, 9/10 of the National Deaf CAMHS are using the BSL version of the SDQ. The numbers of people who use it are relatively small, but the impact it has on the Deaf people concerned is big, because it improves their access to mental health care. A similar translation method is being used to translate other diagnostic tests into BSL, as part of a bigger drive to provide Deaf children with good mental health support.

Having a BSL version of the SDQ gives Deaf children and their families better, more suitable access to mental health care. The translation process was also very rigorous. It is being used again to develop other translations: there is one in progress for a test for autism.

The translation process brought up lots of interesting cultural and language issues. In English, the questions have just a few words, like "Steals from home, school, or elsewhere". The written English version has no facial expression or intonation: it's just

words on a page. Some changes had to be made for the questions to work in BSL. For example, in the BSL version for 11-17 year olds, YOU has to be added when the question is signed; in the version for parents and teachers, the same question is signed in the third person, S/HE. The signer also has to produce a facial expression: in the case of asking about stealing, it was important not to make the answer 'no' more likely, for example by frowning and expressing disapproval. In other cases, it wasn't clear what the English question meant exactly: for example, one question asks about



The York team has made a video about the translation process, and you can find it on our web page (www.york.ac.uk/sdq), along with leaflets about the translation process, which you are free to download and distribute. You can also follow us on Twitter: @SDQinBSL



Richard Ogden is a professor of linguistics at the University of York. While his primary research interest is in conversation

analysis and phonetics, he has an interest in sign languages and gesture. He has been part of a wider team involved in translating the SDQ and another diagnostic tool into BSL.

Ovingdean Hall Foundation update

Claire Simons outlines the opportunities from Ovingdean Hall Foundation for deaf young people and their teachers

Over the past seven years, a small grant-maker has made a big difference to charities and teachers working with deaf children.

Ovingdean Hall Foundation (OHF) funds scholarships for teachers training to become Teachers of the Deaf and makes grants to UK charities supporting deaf children.



OHF evolved out of Ovingdean Hall School for deaf children which closed in 2010 as a result of declining pupil numbers. Trustees set up a foundation to build on the school's legacy and to continue to benefit deaf children and the teachers who support them.

OHF's Trustees have worked with 25 charities and not-for-profit organisation. They have funded research and training bursaries, audiology equipment, theatre, music and sports days, refurbished facilities and contributed toward new-builds.

Training opportunities

OHF has focused on preparing the next generation of professionals who work with deaf children. They offer five scholarships per year for teachers to train to become Teachers of the Deaf (ToDs). OHF's **Con Powell Memorial Scholarships** are managed by **BATOD** and named after their first president. They are aimed at teachers whose local authorities are not obliged to support them financially.

The scholarship programme re-opens in January 2020, and more details can be found on OHF and BATOD's websites.



OHF has worked with **Auditory Verbal UK**, a charity which teaches deaf babies and toddlers to listen and speak using a parent coaching programme, based around play, called Auditory Verbal Therapy (AVT). OHF has funded bursaries for Teachers of the Deaf and Speech and Language Therapists to train in this innovative, family-centred early intervention approach.

"A true gift." said one student of her bursary.



Access to the arts

Music and drama were key areas of the curriculum at Ovingdean Hall School, and OHF has continued this work by collaborating with theatre and music charities.

OHF has a long partnership with **Mousetrap Theatre Projects (MTP)** and helped to develop their *Playmakers* projects. This is a scheme where deaf school children



work with drama practitioners and playwrights to produce their own play, which is then performed by a company of deaf and hearing actors at a London theatre. "When *Playmakers* was piloted, OHF provided funding and advice," said Gayle Bryans, MTP's Deputy Director. "Their support over a number of years has helped us develop it into an enormously successful project."

OHF now supports their popular Stageseen theatre days for deaf children. Each event takes place at a London theatre and includes a drama workshop exploring character and themes, a backstage tour and a matinee performance which is either British Sign Language interpreted or captioned.

OHF has also supported **Polka Theatre** to adapt four shows, including *The Borrowers* and *Wind in the Willows*, for deaf children. In 2019, OHF supported their programme in schools, *Polka40*, which celebrated 40 years of the theatre. OHF specifically supported a class of 19 pupils at the hearing impairment unit in Rushy Meadow Primary to create their own short play, inspired by props, costumes and workshops from Polka theatre and practitioners.



OHF has recently started working with **Music and the Deaf**, a charity which is committed to enriching the lives of deaf children through music. OHF's grant enabled the charity to deliver musical inspiration days to 114 deaf children, with 80% saying that they were keen to continue playing music.



Bringing deaf children together

Over the past few years, OHF has supported **The Ear Foundation's** activities holidays for deaf young people, funding places for those who might otherwise struggle to attend.



Trustees also support the leadership course for young deaf adults, with participants going on to help lead the activities holidays. One young person said, "You have truly changed my life by giving me a wonderful opportunity to be a leader. It has been so inspiring."

OHF has helped to fund events and training for deaf children organised by sports charity **Panathlon Foundation**. They have brought deaf children



together to enjoy activities such as boccia, swimming, ten pin bowling, multisports and leadership training, while building communication skills and confidence. "The backing of OHF has been instrumental to the rapid growth of events and participation numbers," said Tony Waymouth, Chief Operating Officer. "Find out more at www.panathlon.com or contact me at tony@panathlon.com"

Please contact these charities to find out about theatre, music and sports events for your deaf pupils.

Research

OHF is supporting a pioneering seven-year study into the performance of deaf children at school. The data collection is being carried out by **National Sensory Impairment Partnership (NatSIP)**, working in partnership with the Consortium of Research into Deaf Education (CRIDE), University College London and City – University of London. Pupils will be tracked across their school years, with the aim being to improve education outcomes for deaf children.



OHF is encouraging the next generation of professionals working with deaf children by funding a number of research grants for students on the MSc in Audiology and Deaf Education programmes at **The University of Manchester**. Dr Kai Uss, teaching and programme lead at the Manchester Centre for Audiology and Deafness, said the funding, "will promote the training of the future leaders in audiology and associated services across the country." The grant is facilitated by James Mander, the audiologist at our partner charity Ewing Foundation.



Supporting mental health and wellbeing

OHF has a long relationship with **SignHealth**, having supported their Domestic Abuse Service for three years. OHF funded the salary of a Young People's Violence Advisor (YPVA), who was herself deaf, to deliver workshops and one-to-one sessions to d/Deaf young people, helping them to stay safe online and in relationships. OHF is now helping to fund an Advisor to support d/Deaf women and girls in Sussex who have experienced or witnessed abuse.



Helping charities to grow

OHF has helped other charities grow their provision for deaf children and their families. It has supported a number of projects at **The Elizabeth Foundation**, including the development of a new hearing test centre. OHF has also supported their new national online home learning programme that gives information and practical support to families.



OHF has also funded the building or refurbishment of spaces for living or learning. They sponsored rooms within the new centres at **The Ear Foundation** and **Linden Lodge School**, a music room and library at **St John's School for the Deaf**, a sensory room at **The Seashell Trust**, an IT suite at **Hamilton Lodge School** and contributed toward the **NDCS's** Listening Bus.

Furthermore, by providing the funding for pilot projects at Mousetrapp and AVUK, OHF has helped these charities to secure funding from other grant-makers.

Reducing isolation

All of these projects have the unifying aim of reducing the isolation deafness can bring to deaf children, their families and the professionals who support them.

OHF also retains links with its former students' reunion committee and continues to be supported by a community of kind and loyal donors. Former Ovingdean Hall School staff member Jonathan Coe also supports OHF as a grants advisor.

OHF has built on the legacy of Ovingdean Hall School, continuing its aims and ethos, and now has an identity and impact of its own. If you would like to find out more, please visit www.ovingdeanhall.org



Claire Simons, carries out fundraising and communications for Ovingdean Hall Foundation (OHF). OHF is managed by Ewing Foundation, a charity which supports the professionals who work with deaf children.

BATOD Magazine Archive online



Did you know that there are copies of all the BATOD magazines on our website going back to 1999?

These are invaluable for historians, researchers and students but also of great interest to the readership at large. Have a look through and see how things have changed – and what has stayed the same! Search 'magazine'.

www.batod.org.uk ▶ Information ▶ Publications ▶ Magazine ▶ and pick a year!



Con Powell Scholarship

Karen Taylor outlines the Co-ordinator role

The Con Powell Scholarship was started in 2013 by the Ovingdean Hall Foundation working with the Ewing Foundation. The aim of the scholarship is to attract new people into the profession.

BATOD co-ordinates the scholarship on behalf of the Foundation which provides the funding and working with the Ewing Foundation which gives ongoing support including providing mentors for each of the successful candidates. I have had the pleasure of co-ordinating it for the last six years and in that time we have awarded 37 scholarships – some for a year, some for two years, depending on the application. The scholarships have been awarded across a range of course providers including Mary Hare (University of Hertfordshire), Birmingham, Leeds and Manchester. But we would welcome candidates from other course providers as well. The funding awarded covers the cost of the tuition fees for the course.

The scholarship is only awarded to candidates who are not eligible for funding elsewhere and would otherwise have to fund the course themselves. This means that candidates currently working as a Teacher of the Deaf employed by a Local Authority or educational setting are not eligible.

Application process

Candidates apply via an application form anytime from the end of January through to the end of May. Application forms are on the BATOD website – the form is updated annually. A number of current BATOD members (scrutineers) shortlist the applications and last year, for the first time, we interviewed all those shortlisted before making a final decision. Candidates are notified by the middle of June. BATOD then liaises with the course providers and pays the course fees direct to them.

Ongoing support

Each successful candidate has to become a BATOD member and provide a termly report for BATOD and The Ewing Foundation. This provides really useful information and feedback on a regular basis. They receive ongoing mentoring during and after the course. They also have email contact with the Coordinator as necessary.

Reflections

We are delighted that the majority (over 85%) of the successful candidates have become Qualified Teachers of the Deaf.

BATOD has provided regular evaluations to The Ewing Foundation who have also carried out their own evaluation of the course;

- Candidates were very positive about the Con Powell sponsorship, with comments like “It has changed my life”, “I am in my dream job now” and “It made all the difference”.
- The sponsorship allowed them to avoid borrowing money or re-mortgaging their house
- Access to a mentor was appreciated and they all

thought this extra personal training was extremely useful and of great benefit although only one was aware that this could carry on after graduation.

- One student also identified that meeting with other Con Powell students during small group meetings was very useful in comparing experiences and the setting up of networks.

More recently, we have also taken on board feedback from candidates, the BATOD members who shortlist candidates and course providers resulting in the following changes:

- we have slightly changed the application process to make it more robust by interviewing candidates as well as shortlisting
- the length of time to apply has been extended to give as many candidates as possible the chance to apply before the courses start in September
- further promotion of the scholarship eg website and video
- increasing the number of scrutineers (BATOD members) who shortlist the applications
- updating the forms eg the application and shortlist forms
- tracking the students after two years to see if they are still in jobs.

We will continue to monitor and evaluate the scholarship process on a regular basis.

The future

The number of applications is rising each year.

Last year was the first time we interviewed the candidates who were shortlisted for the scholarship and we were impressed with their quality and the range of applications we received which is hugely encouraging for the future of the profession.

Please support the scholarship by promoting it in your area as it is a very positive way to recruit new blood into the profession.

It is a lovely project to be involved in and I have thoroughly enjoyed my time as Co-ordinator. As I have now retired, I will be handing over to Steph Halder, who will be taking over the role of Co-ordinator from April 2020. We are also looking for BATOD members who would like to join the group of scrutineers to help shortlist candidates and potentially support the interview process. If you are interested please email me at cpschol@batod.org.uk



Karen Taylor is the Con Powell scholarship co-ordinator.

Con Powell

Helen Martin shares how the impact of Con Powell in her life has come full circle

Our friend Kumkum paid us a visit last week. I was introduced to Kumkum 30 years ago by Con Powell, who was one of my lecturers when I was training to be a Teacher of the Deaf (ToD) at Oxford Polytechnic in 1986. In among his lectures about the width of ear mould tubing, auditory training units and Widex bodyworn hearing aids, I remember being captivated by his descriptions of his work in a school for the deaf in India, along with Sue Lewis and Ivan Tucker. Con's role was pioneering, as his interview on Radio 4's Today programme at the time testified.

After I graduated from the course, Con's last words to me were: "If you ever want to look at deaf education in India, do get in touch!" It was an offer too good to refuse. Kumkum Jalon was the Headteacher at The Oral School for Deaf Children in Kolkata. She too trained as a ToD at Oxford Polytechnic, and I first met her while she was doing the Educational Audiology Masters at Manchester University. I had just started working as a ToD in Manchester. With Con's support and encouragement, I went to Kolkata in 1988 and taught in the Oral School with Kumkum for six months. I returned two years later, with my husband for another six-month stint.

It was a life-changing experience for both of us, and we still have a strong connection to the school, staff and pupils. Two of the original ToDs, who were working in the school when I first visited, have retired this year, and several of the pupils, who are now living and working across the world, keep in touch with us via social media.

I remain indebted to Con for broadening my professional and personal horizons, not to mention facilitating some amazing experiences and lasting friendships. Sadly, Con died, but 32 years after he inspired me, he is providing the same support and encouragement to other aspiring ToDs through the Con Powell Memorial Scholarships programme. Earlier this year I became part of the Ewing Foundation, which, among other things, coordinates and administers the Con Powell Memorial Scholarships. These are bursaries available to qualified teachers who wish to train as a ToD but may not be working for a Service or in a



Helen Martin and Kumkum Jalon

school for the deaf, and, as such, have neither access to funds nor professional support from their workplace. As part of the scholarship, Con Powell students on ToD courses are given access to a mentor (through the Ewing Foundation), who provides practical support to them throughout the course.

So, the Con Powell Memorial Scholarship students also have much to thank Con for: through him, they can widen their professional horizons just as I did, and, in doing so, continue the work in deaf education about which he was so passionate. ■



Helen Martin is the Senior teacher for the Deaf and Hearing Support team with City of York Council. Since September this year she has also been doing some work as an Education Advisor in the North for the Ewing Foundation.

Singing and Signing in Wiltshire

Ian Sharp provides an insight into meeting the needs of a toddler group in the rural county of Wiltshire

There have been many articles in BATOD reporting on the benefits of music ('Using music to support communication development' by Julie Hughes, BATOD March 2018) when working with deaf children and their families and rightly so. A Qualified Teacher of the Deaf (QToD) now for 20 years and a life-long lover of music, it has been like a magic ingredient to children I have worked with in achieving a focus both with a wide range of individuals and alike. What is it about music that brings a smile to faces and draws them together? Music, in one form or another, features in all cultures it seems, at the centre of ceremonies, rituals, group gatherings and parties. Perhaps somewhere deep within human evolutionary history we have been pre-programmed, just as we have been to develop speech and language skills, to be drawn together as a group by rhythm, melody and song.

Wiltshire is a large and mainly rural county and like everywhere, as one cohort starts school another is born. Bringing deaf children and their families together then is a perennial challenge. This year we have refocused on how we do this with recently diagnosed and pre-school children. Given the distances that some families need to travel, it is pleasing to announce that we have been successful in establishing a sing and sign group with regular attendees.

As many readers will appreciate such a group needs to cater for a wide range of hearing need and communicative development. In order to provide a welcoming atmosphere and to support such diversity, sessions, in the early stages, were well supported by other QToDs in the team. This way families had someone they knew to meet on arrival and

introduce them to others. Also attending throughout each session has been a member of the deaf community, Sally, who signs. Her skills have been used to sign the lyrics to the songs that the group sings.

Our setting has been the spacious and modern, central library attached to County Hall in Trowbridge. Not having been to a public library for a while I now realise that parent/toddler singing groups are very much a part of the library's remit these days. And what a great development this is as it brings life to a wonderful public space. Not only then is it absolutely fine to make a good amount of noise in the library, it is also great that our families can do so publicly too. So often we hear stories of passers-by staring at the hearing aids on little ones, making the parents feel uncomfortable. During our singing sessions we 'own' our corner of the library and at the same time, are more than happy for others to watch and even join in. A few days after our first session, our librarian, who had posted on Facebook that our group had started up, received the following response 'This is great. Shame it wasn't around when my daughter was a pre-schooler!'

Sally, our signer, needs a special mention here as she is almost entirely reliant on the lip-patterns of the teachers sitting opposite her for keeping in time with the guitar and lyrics as they are sung. Discussion inevitably develops at some point over which signs to use in songs such as 'Twinkle, Twinkle Little Star' because there are so many signed versions. This, however, all becomes a part of developing the group's deaf awareness as parents come to realise that there can be several signs for one object, just as there are in English.



The singing part of the session tends to last around 30 minutes as attention spans wander if we go on longer. In terms of song choice, we have stuck to the classics children's songs such as 'Ba, Ba Black Sheep', 'The Wheels on the Bus' and 'Old MacDonald had a farm' and use related toys to bring the lyrics to life visually. While there are plenty of newer songs to sing, using ones everybody knows means people are not having to work hard to recall both lyrics and signs at the same time. Interestingly, we have a Japanese mother attending with her child, who commented that while she has only recently learnt the English lyrics to 'Old MacDonald', there is a Japanese version that she used to sing as a child.



Before you know it, everyone is joining in, adults staring at Sally in order to keep up with the signs as well as trying to sing at the same time. Children sing and shake shakers, and babies probably thinking 'What on earth is this noise!'. We are all too busy laughing at ourselves to be self-conscious.

As well as the use of the wonderful library with plenty of parking close by, we also have an atrium with a cafe set between the Council House and central library. As we know, singing and especially signing can make you very hungry and so the session now extends to include a cup of tea with cake afterwards. On a serious note though, this extension is much needed for families that have had to travel but even more valuable is the opportunity it gives to develop relationships, information and experiences.

Music is fun, its rhythms encourage movement, its melody creates atmosphere and when accompanied by lyrics, it often tells a story. The combination of these elements stimulates our emotions and this we find exciting. While it may not be a language in itself it certainly makes listening and noise-making fun. What a great way then to encourage little ones to play with their voices and listen to others. ■



Ian Sharp is a Qualified Teacher of the Deaf in Wiltshire.

Searching for a QToD?

Job vacancies can be advertised on the BATOD website at a cost of £280.00
(with reduction for early payment)

If you have to re-advertise the same post, the cost is reduced to £170.00

Teaching Section – Situations Vacant

www.batod.org.uk/jobs

one of our most popular pages – especially on a Monday with hundreds of 'hits'!!!

On the Jobs page, scroll down and click on 'Submit your listing' and your advert should appear very soon afterwards **AND REMAIN VISIBLE** until after the deadline!

Your email address can be an active link so potential applicants can contact you directly

Value for money advertising 

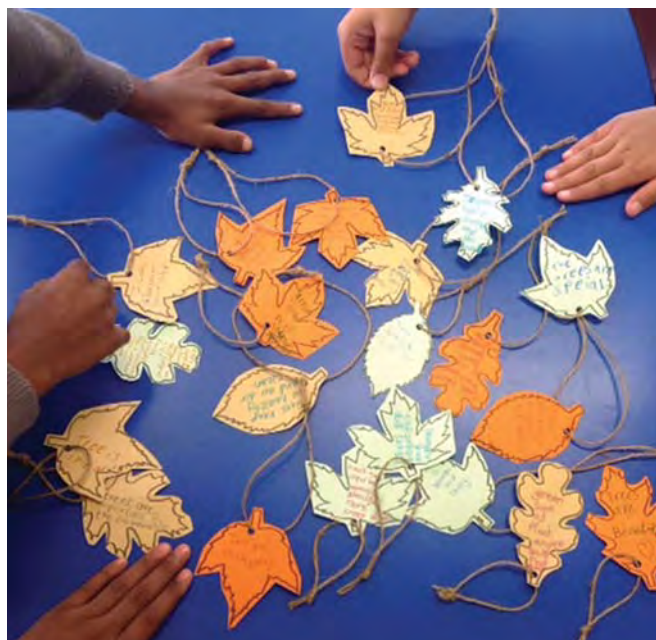
A tool to promote positive social interaction

Leanne Chorekdjian-Jojaghian, a Global Learning Programme Accredited Lead Practitioner, qualified at Level 1 in Forest Schools, shares her experience of using outdoor learning as a learning tool

Many have cited the benefits of providing children who are deaf with personal, real life and diverse experiences (Marschark et al 2002), which have the potential to develop not only vocabulary (Knors and Marschark, 2014) and support language acquisition but to also improve literacy outcomes (Albertini and Schley, 2011). Real life experiences can also fill gaps in world knowledge due to a lack of incidental learning as a result of deafness (Arfé et al, 2015; Knors and Marschark, 2014; Convertino et al, 2014; Albertini and Schley, 2011). We at Kingsbury Green Primary School are lucky to have ample green space for children to play in and explore freely. We are also lucky to have the amazing resource that is Fryent Country Park on our doorstep! Thus, it would be a crime not to take advantage of all this outdoor space.

For the last five years, I have run an extra-curricular club called the Eco-Champions at the Kingsbury Green Primary School. The club shows concern for society by undertaking projects to build awareness of global issues on a local scale. The club includes children across mainstream (Reception to Year 6) as well as children from the Total Communication Base (TCB – a resource base for children who are deaf). The Eco-Champions started as a club to draw together children who wanted to bring about positive change linked to sustainable development in their school community. However, over the years whilst continuing to be a very much pupil-led group to steer positive change linked to the environment and sustainable development, it has begun to simultaneously facilitate positive integration opportunities to develop social skills and communication with mainstream peers for the children in the TCB.

Kingsbury Green Primary School educates 680 pupils, 17 of whom are deaf children. The school has embedded



global learning across the whole curriculum, with a focus on critical thinking, empathy, hard work and intellectual and physical agility. I have found that providing immersive, practical and memorable experiences not only engages children in their learning, but also develops language and provides the foundations for future learning.

The projects undertaken previously have been linked to the Sustainable Development Goals, but this year we applied for our Eco-Schools Green Flag accreditation, so we focused on the topics suggested by them. Through inquiry-based learning, we collaboratively discuss potential projects as a group. Children take the lead on the project while I facilitate and support them to steer their actions in the right direction. I also support them to risk-take, think





- different angles and perspectives using technology (cameras/iPads)
- Carrying out leaf identification and a mini-best hunt to develop their knowledge of trees and the biodiversity of insects and animals in the school environment to develop empathy, but also raise awareness of habitats
- Completing journey sticks of their walk around the school grounds: children collected their favourite leaves/feathers/seeds etc and retold their journey to peers
- Making a school trail around the grounds: children went out in groups to explore their favourite areas and give them exciting names. This trail was shared with classes across the school so they could go and explore the grounds for themselves
- Tree dressing: children cut out paper leaves and wrote

creatively, and to evaluate their actions. Discussion with peers is enabled through the use of radio aids, practical resources and total communication, so the club is fully accessible for the children who are deaf.

Projects include:

- Composting uncooked food waste for use in the school garden
- Reducing the use of single-plastic bags and plastic bottles
- Campaigning and fundraising to swap conventional micro-plastic glitter for more expensive biodegradable glitter
- Reducing electricity consumption and wastage by switching off lights and projectors when not in use
- Encouraging classes and teachers to reuse and recycle paper
- Collecting and recycling batteries
- Encouraging others to use re-usable plastic bags and straws to create products which have a longer life.

This year we worked towards the Platinum Award for the Woodland Trust's Green Tree School Award and Eco-Schools Green Flag Award. In order to achieve the Platinum Award for the Green Tree Schools award, the children undertook a variety of outdoor activities which included:

- Visiting the school environment to explore and experiment with

messages showing their love and appreciation for trees. They hung them on a small tree on the path leading out of school to raise awareness of the importance of trees to the rest of the school community passing by

- Tree champion challenge: they created characters with superpowers from natural resources collected from across the school environment.

For the Eco-Schools Award, children had to:

- Complete an environmental review, which highlighted areas around school to address through actions
- Decide on actions to complete around school (collecting



litter and paper recycling, monitoring the use of reusable water bottles and reducing energy waste by turning off lights)

- Raise awareness by informing the school community of these actions through assemblies, outreach sessions, displays and contributions to the newsletter
- Monitor progress towards these actions through data monitoring sheets and creating graphs, which were shared with the whole school
- Evaluating the impact of their actions and next steps to ensure the actions were successful
- Creating an Eco-Code, which would support children and teachers around the school to remember the actions
- Discussing their actions and learning on their journey to becoming an Eco-School with the Eco-assessor.



Due to the collective hard work, determination, resilience and perseverance of the Eco-Champions, we successfully achieved both a Platinum Award for the Green Tree Schools Award and have just achieved our Green Flag Award for Eco-Schools. The activities and shared goal of promoting sustainable development and a love for the environment provided organic opportunities to develop meaningful social interaction and communication for deaf children and their mainstream peers, which go beyond typical functional language such as asking for directions

etc. I would encourage others to unlock the potential that outdoor learning and these award schemes have for not only imparting knowledge about the environment but also for developing natural peer-to-peer relationships. ■

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Leanne Chorekdjian-Jojaghian is the Leader of the Total Communication Base at Kingsbury Green Primary School. She is currently working towards an MA in Education Studies (Hearing Impairment) at Mary Hare.

Working Together

Sara Brierton, QToD and Becky Frewin, SaLT, provide a summary of the journey to creating their localised joint working guidance between Teachers of the Deaf and Speech and Language Therapists

Collaborative working between QToDs and SaLTs has been a hot topic of late. On 14 November 2019, a good practice guidance document drawn up between RCSLT and BATOD was published along with an accompanying editable document.

Prior to this, services in Peterborough and Cambridgeshire had been working on our own, localised version. The need for this was driven by several factors including:

- newly qualified ToDs in post understanding the relative roles of both professions
- parents requiring clarity on the different roles.

Representatives from the Peterborough Sensory and Physical Support Team, Cambridgeshire Sensory Support Team, and local NHS and independent SaLTs met to devise a document which would serve to make our respective roles clear for multiple audiences:

- Families of deaf children/young people
- New members of those services who authored the document
- Local education and health services
- Children's Hearing Services Working Group (CHSWG)
- Any other relevant parties.

The document needed to be concise, clear and relevant to all of the audiences, as well as easily accessible to the high percentage of families with English as an additional language (EAL) in both authorities but particularly in the Peterborough area.

We met several times, during which we discussed roles that were specific to each profession, as well as those which fell into the remit of both. After some time, we decided to order the roles chronologically, thinking about how we work together from diagnosis, through the early years, into school, HE and FE settings.

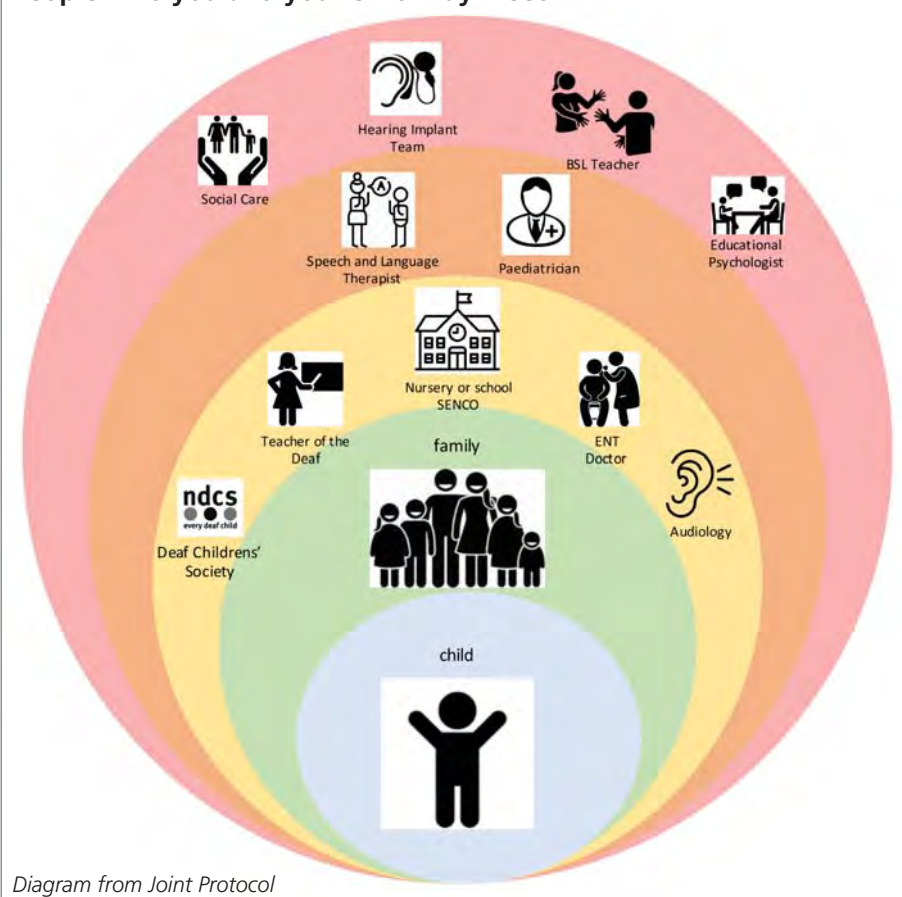
It became apparent that the two professions were working within a context of a much wider 'pool' of professionals who may come into contact with a family. We devised a pictorial representation of the other professions that may work with a family and this can be used particularly with the EAL families in the locality. So, a document that began by intending to outline the joint working of two services in fact now also puts these two services within a wider context in a more family friendly and accessible way.

The document was shared with a group of parents, and parents in Peterborough were also asked before the process began what they wanted to know about how the services worked together. The document was also shared in the CHSWG forum with both other professionals and parent representatives.

Some general comments and reflections from the working party include recognition that professionals often want to use their own jargon and vernacular and are inclined to be over verbose. Having recognised this what started as quite a wordy document got cut down progressively over time to what is now quite a tight and short two sided document that only contains just over 500 words. We began with 2000-3000.

The process also revealed that there can be considerable overlap in the two roles and thrashing out who did what was often hard! All the more reason, we concluded, to need to try and explain this as clearly as concisely as possible and to work closely together to do so.

People who you and your child may meet



► Continued at bottom of next page

Reflections: one year on

Sarah Armstrong reflects on her first year in role as Chief Executive

At the time of writing this, it has been just over twelve months since I joined the Ewing Foundation, and it feels like a really good time to reflect on that first period. I can sincerely say that I have received the warmest of welcomes from all directions! Having met a number of QToD professionals at many events, I feel part of a highly supportive community and I thank you all for having made me feel so welcome.

From within the Ewing Foundation, I see the partners with whom we work closely, like BATOD, who share a commitment to improve outcomes for deaf children and young people and I feel privileged to be a part of it. When I joined, I was very fortunate to join a highly experienced and well established team with a range of audiology, technical and teaching skills. However, as some very valued members of our team were in the process of retiring, I have spent considerable time on recruitment to ensure we continue to have the skills and experiences needed to meet the demand we face. This work continues so please do watch this space!

In addition, as I have learnt more about the sector, I have begun to think about our short term and longer term future. Our charity has a long and successful history supporting the professionals who work directly with deaf children and young people. Our contribution has helped raise achievement and inclusion levels for deaf children

EWING FOUNDATION for deaf children

and young people in special schools, services and mainstream provision over recent decades. We now need to prepare for our future, and we have begun to think about our next strategy and what professionals will need from us. We also need to ensure we continue to make the best use of our resources. This is where you come in... if you have thoughts and ideas, I would love to hear them, so please do get in touch via saraha@ewing-foundation.org.uk

Finally, I want to wish you well for 2020 as I am sure it will be another year full of learning, changes, and some challenges. I look forward to meeting more of you during the year and sharing our collective progress. ■



Sarah Armstrong is Chief Executive of the Ewing Foundation.

► *Continued from bottom of previous page*

Mutual respect of our relative training experiences and knowledge bases was also essential, as we discussed who did what, when and why. Within this, choosing words carefully was essential. All services are bound by certain referral processes and ways of working some of which are beyond our control but we need to be able to explain these to families. Families should not need to be concerned by details such as how local authority boundaries and health service CCG areas don't always match amongst other anomalies but just want the best for their child.

For the professionals concerned all agreed that a major benefit of the process has been strengthening relationships across a) the locality and b) the professions. Getting together to look at creating the document also allowed time to discuss ways of working, shared service issues or training opportunities and has led to further training now being set up for a wider group of SaLTs in Peterborough covering all areas of sensory impairment.

Feedback on the document has been positive so far with one parent at CHSWG commenting that she wished a document like that had existed when her child was younger so that she understood the relative roles of the two professional groups and all the other professionals that may become involved.

The document will need reviewing as time goes on but for now represents a positive step forward. We also look forward to using the recently published guidance from the consultation on joint working between Teachers of the Deaf and Speech and Language Therapists as this too may yield areas we need to consider further or develop. ■



Becky Frewin is an Independent Specialist Speech and Language Therapist. Sara Brierton is a QToD and Manager of Peterborough's Sensory and Physical Support Team.

The good practice guidance document

drawn up between BATOD and RCSLT can be downloaded from the BATOD website:

www.batod.org.uk/collaborative-working-between-qtod-and-salts-best-practice-guidance-has-been-published



Looking through the archives

Paul Simpson takes us back through the archives to a range of articles on 'cochlear implants'

I have been looking through the BATOD magazine archives (www.batod.org.uk/information-category/publications/magazine) for articles relevant to this edition on auditory implants. They show what huge changes have occurred in the world of audiology and auditory implants since the time of our first archived edition on the website in 1999. In the January 1999 edition (page 6), they were mentioned in a list of different hearing aids and instruments being described in a report of the 'national evaluation of support options for deaf and hearing-impaired children' by Fortnum and Summerfield. And in the year 2000 there was only one reference to cochlear implants in an article on page 48 about an advanced speech and vocabulary trainer. How times have changed!

Clearly audiology is a vital element in the work of every QToD and the magazine aims to keep colleagues up to date over time with changes and developments in the hope that they will stimulate members to undertake further CPD in this area. This could be through further reading, internal CPD activity and/or conferences provided by BATOD and other organisations. The website CPD area and calendar are useful places to make sure you are aware of what is going on in this area.

It is informative to look at emerging facets of the subject over the years. In 2004 (May, page 16) Carina Newman wrote about a workshop she had given on the increasing digitalising of cochlear implants and hearing aids and in November (page 31) colleagues from the Ear Foundation wrote about a conference in which one of the topics was

what children really hear with aids and implants.

In 2008 the January edition was devoted to Cochlear Implants and former president of BATOD Sue Archbold, who is still a key figure in the world-wide field of cochlear implants, contributed a most interesting overview of the then current situation. It is interesting to see what has changed over the years since she wrote that overview.

Other articles in this special edition looked at using cochlear implants in a school where BSL is used, bilateral implantation, use of radio aids and what happens when the cochlear implant goes wrong along with several contributions from families, young people and a teaching assistant.

The profession has become more and more aware of the importance of listening to the student and family voice. Page 12 of the January 2012 edition and page 35 of the November 2019 edition contain articles

from young people describing their experiences. On page 38 of the 2012 edition there is an account of one of the Ear Foundation's European gatherings of young cochlear implant users which included representatives from Norway, Finland, Turkey, Belgium and the UK.

During recent years there have been a number of editions devoted to cochlear and other types of implant. The January 2015 edition on the subject of Bone Conduction Hearing Instruments was so popular that we made a unique version of it just containing the BCHI-relevant articles. You can access and download that edition here:

www.batod.org.uk/wp-content/uploads/2017/11/BCHISpecial0115-1.pdf

Other interesting relevant articles include one in September 2018 on the subject of cochlear implants with radio aids and the value of carrying out electro-acoustic checking.

Also, on page 45 of the September 2018 edition, Alexandra Wheeler shared an update on the current issues then, which provided an overview of a range of aspects of this field.

We are always looking for new articles and if anything you have read looking back over the years stimulates you to write about current issues related to this topic, any proposed articles would be warmly received by

Teresa Quail, the Editor, at magazine@batod.org.uk



Paul Simpson is the National Executive Officer of BATOD and Editor of BATOD Magazine from 2007 to May 2019.

Using animojis to support story telling

Suzanne Williams provides an overview of the Leeds Service animojis project which she also presented as a poster at the University of Manchester – 100 years of deaf education conference

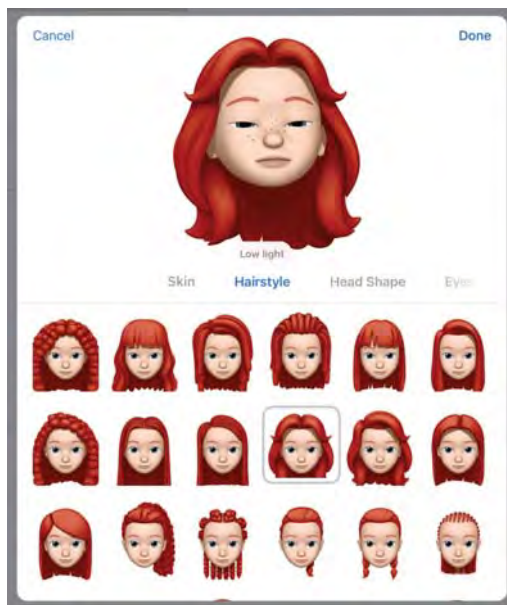
Facial recognition software now allows for more realistic animations that imitate real human facial expression, historically this was only available at huge expense and used in films and other media. However, Apple's animojis allow facial expressions to be replicated on to animated faces easily on your own hand-held device (the iPad Pro and newer iPhone X). This makes it possible to easily create video animations in the classroom and at home. The technology tracks a person's eyes and mouth and maps this on to a character on the screen. So, you are able to control a character and record this as a video.

"Nowadays, deaf children are also considered 'digital natives' and this could make interactive storytelling an even more effective strategy for them, but unfortunately, we noticed that there is not an established methodology to make use of interactive storytelling through the use of ICT."¹

Technology is adapting faster than we would probably like to admit, and we have an opportunity to harness its potential within deaf education. The combination of this new technology and the internet could open up a whole new world of shared resources in deaf education. As QToDs, we continue to have limited access to BSL video resources to support teaching and learning, and in some areas of the country limited access to BSL. Facial recognition technology could be harnessed and embedded into the curriculum in a way that makes learning more accessible for Deaf students using BSL or Sign Supported English.

So how did we use animojis?

Our animoji project began with a small group of deaf year 7 and year 8 students attending our HI secondary resourced provision setting. We explored the book 'Ranvir Cannot Hear' by Genevieve Yusuf, a story that follows a deaf elephant, who sets out to find his hearing. Although this book is aimed at primary aged children, the 'song-like' structure and vocabulary provided a rich text that would challenge all students in different ways. The range of characters also allowed us to focus on drama and movement and build confidence in performance techniques. Over a half term



period, we examined the story page by page, predicting what might happen next; investigating some of the language and cultural references (including the highland fling).

Alongside this, we started to retell the story, through sequencing activities, drama and oral/BSL retelling. We encouraged our young people to recall key information and to develop confidence to speak/sign in front of peers. At this point students then worked one-to-one with a level 6 BSL qualified Communication Support Worker to retell sections of the book in BSL. For some students this provided an opportunity to teach specific BSL skills. While for those that use primarily BSL it was an opportunity

to introduce topic specific BSL signs and think about the way meaning is conveyed from English.

Next, we supported students to design their own animoji face on an iPad Pro. When creating your own character, you are taken step by step through the process choosing each feature from a wide range of options, from face shape to eye colour and more. Being able to immediately see your selections on the screen led to much amusement with moustaches and elaborate beards being tested.

With the animojis saved and ready to use, we then videoed their re-telling of the story. This consisted of one adult holding the iPad at head height approximately 1m from the young person to record a video. Students later had the opportunity to watch and review their own video before performing a final version that was later edited using the iMovie. Videos were used to self-assess the students' use of BSL and Non Manual Features and to determine their ability to remember and re-tell a simple story.

We sent the final video to the author, Genevieve Yusuf, who was thrilled to hear about our use of her book and enjoyed watching the students' video version.

Using the iPad Pro in class was a novelty, it engaged and motivated students; less confident students were happier to video themselves with an animoji face than





without. Though there were a few challenges, the first was creating the optimum angle for the iPad Pro camera. It was difficult to get this right, as you need to use the front facing camera, the student can see themselves on the screen but the person holding the iPad cannot. When the camera distance was too great, the animation disappeared. When the angle or distance wasn't right the hands moved out of shot easily. So, it was important to play around with the angle and distance before recording anything. The overall look of the final videos was really effective, though some signs were concealed by larger hair or faces, a consideration that would need to be made when choosing future character features. Furthermore, using BSL fluently but not too close to the face was challenging for those students with more delayed language skills. They quickly forgot that signs that cover the face made their animated face disappear and when this happened it was a distraction to the flow of storytelling. The best way to combat this was to produce signs that start at the face a little to the side, and to turn the face slightly towards the hand, this created the illusion of signs in front of the face without blocking the face recognition software and losing the animation completely. This was a skill that most students could develop in order to make videos more effective. However, it was more time consuming and frustrating on our first attempts.

Overall though, the project was enjoyable and the benefits far outweighed the logistical difficulties. The videos were more effective at recording evidence and tracking progress in BSL skills than using photographs as they could be watched later, by a range of professionals and by the students. They recorded how a child signed, including their movements, position and the accuracy of handshapes, whereas stills only provide a quick snapshot and rely heavily on notes taken to accompany them. Students that would usually be self-conscious to speak in front of others enjoyed the novelty of creating and watching the animojis. The animojis were really engaging to watch. Our deaf students can be reluctant to watch BSL videos with adult interpreters, preferring live BSL to on-screen. With this in mind, animojis could potentially be used to create more

exciting BSL stories for social media and online. The videos are anonymised, students are unrecognisable as their animations, and so this would also allow for the sharing of students' work with less concern for the safeguarding issues around videos. Though we did take steps to ensure that school badges and uniforms were not identifiable in the final videos, as clothes are not masked in any way, they will be clear to see. Imagine a bank of videos on YouTube created by deaf children that could be used in settings across the country.

Animojis are already available to use on the iPhone X and newest iPad pro devices and can be used to create videos in the messages app. Though some other phone developers are also beginning to develop their own face-recognition technology. Researchers at Brigham Young University, Utah have taken this a step further and have developed the concept of what they call 'handimojis' which would use current facial recognition technology and map it to animate hands. If Apple and other technology providers were to take this idea on board, this would allow for both animated hands, faces & bodies in the future. cfac.byu.edu/school-of-communications/byu-students-touch-hearts-with-handimojis-creation-for-deaf-community



Suzanne Williams is Area Lead Teacher of the Deaf, Leeds

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- 1 Flórez Aristizábal L, Cano S, Collazos C (2017). *Using Storytelling to Support the Education of Deaf Children: A Systematic Literature Review*. Marcus A, Wang W (eds) Design, User Experience, and Usability: Understanding Users and Contexts. DUXU 2017. Lecture Notes in Computer Science, vol 10290. Springer, Cham

Embarking on a Teacher of the Deaf career

Cheryl Livingstone gives us an insight into the start of her journey as a qualified Teacher of the Deaf

It's hard to believe that just over three years ago I hadn't even heard of a Teacher of the Deaf and, here I am now, writing an article for BATOD as a newly qualified one.

At that time, I was teaching in a mainstream primary school with a young girl with a recently diagnosed moderate to severe mixed hearing loss. I had no previous understanding of deafness, its potential impact or how best to support a deaf child in the classroom. I had started the new school year with a mind full of the misconceptions of what deafness meant and how hearing technology worked. Then, in came a ToD, a role I previously didn't know existed, to help make sense of the child's deafness and develop her spoken language. It was through getting to know the ToD and a year working with the child that sparked an interest in me training for the role. My most vivid memory was the look on this girl's face after being given a radio aid for the first time. The surprise and delight she showed was as if she had never truly heard me clearly before.

As I was working full time, my only option for training as a ToD was to take on a distance learning course over two years. Luckily, Manchester University had a space available for that year and speaking to Helen Chilton helped to further fuel my interest in pursuing the subject of deaf education and I was eager to start as soon as possible. To take the place on the course meant funding myself and it needed the support of my school in order for me to attend and be released for the 24 days a year needed on campus and on placement. Fortunately, the management at the school I worked at were very supportive towards what felt like a very last-minute decision to take on a university diploma. And so just like that, it all began: a new class at school, a new university course and also weekly BSL classes. I quickly learnt how much you can actually squeeze into a week when you put your mind to it!

The first days on campus were both fascinating and terrifying at the same time. The course started with the unit on Language Acquisition, which I found the most interesting of the units. The most memorable part of the induction days though was an introduction to audiograms and having a go at pure tone audiometry with our peers. Having had no experience of this before, I was both intrigued and overwhelmed at the thought of progressing on the course. It was reassuring that the other students I met on the course, whatever their previous experiences, had similar feelings and that the course tutors were there at the end of a Skype call or email to help when needed.

The first term rushed by and soon my first placement was upon me. I was given a place at Peterborough City Council (PCC) with the peripatetic ToDs and a specialist communication and language therapist. Up until that point, the course felt very much like something I was reading, learning and writing about outside of my normal

day job. Suddenly, all that learning became relevant on placement. The biggest learning curve was how different the needs were of the deaf students I met, particularly added to by the diverse cultural and ethnic population of the city. I suddenly realised that there was no 'this is what it means to be deaf'.

In the May of my first year, a job as a peri ToD became available at PCC, which I was successful in getting. Having taught in mainstream education for ten years, it felt the right time for a change and I was so excited to get to apply the skills and learning that we'd covered on the course so far. I was also very aware that there was still so much to learn and also that my breadth of experience of teaching was limited to early years and key stage 1. I requested (with much trepidation) to be placed at a secondary school with a resource base for my second placement and was given a place at City Academy Norwich. The experience was invaluable for learning the importance of developing students' personal understanding of their deafness, having deaf role models and peers, and daily checks to ensure optimum use of their hearing technology. It also presented the question of how I, in a peri role, can best support this with teaching staff and deaf students in mainstream education.

Fitting the course studies into evenings and weekends and writing assignments in school holidays meant the first year was non-stop. I think it was adrenaline and motivation that got me through. Following this, working as a peri ToD, which was a stark contrast to most of my working life so far, made the course more manageable in many ways. The course was no longer in isolation to what I was doing. My caseload helped me in developing a deeper understanding of the theory covered and the audiology management was no longer something I dreaded but instead became more interested in.

Having now been in the role for just over a year and being qualified for a few months, I feel very lucky to work with such amazing students and professionals. As a teacher, you often say that no two days are the same, but working as a peri teacher, with babies to young adults, all with different levels of deafness, needs and backgrounds, every day certainly is unique. There is always a new challenge and, of course, there is still so much more to learn!! ■



Cheryl Livingstone is a recently qualified ToD now working at Peterborough City Council.

Musical Tots

Sarah Angove gives us an insight into a community-based toddler group in South Wales

One of the challenges presented when trying to sustain a pre-school group for deaf children is fluctuating numbers and a generally small cohort. One of the ways around this is to open up the group to other children. In this article, one such group is described, although its origins were quite different.

The "Musical Tots" group has been running in the Bethel Baptist Chapel, Penyrheol, Caerffili, for fifteen years. Initiated by the pastor's wife during her maternity leave in the hope that enthusiastic participation in action songs would lose the baby bulge, it was quickly handed over to me on her return to work. The format was calmed down and restructured but has remained fairly constant since.

As an experienced QToD I was keen to enable greater accessibility and participation by deaf children and their families. In those early days I had become friends with the mother of a deaf girl the same age as my toddler and encouraged her to come along. The considerations put in place for her daughter have ensured that many more deaf children have been able to come along and quickly feel part of the group during subsequent years.

The format of the session has remained similar:

- 10:30 start, singing
- 10:50 counting the hands up for teas and coffees, then story
- 11:00 refreshments
- 11:10 singing
- 11:30 finish.

We have found that these timings seem to work best. I always finish on time as many are then going to collect an older sibling from nursery. The central ethos is informal and welcoming, so sometimes families join us later in the session.

Considerations to allow full participation include:

- visual links to the songs through pictures. These are laminated and simply attached to a felt board by the children using velcro. They can physically choose their favourite song from a basket of pictures. The board is low enough for the children to reach easily and the pictures cut with rounded edges to prevent injuries
- objects of reference are used for some songs, such as rubber ducks for the AB "Quack, quack, quack" song
- words for the songs are



projected onto a screen above the felt board. This enables parents and carers to sing along and to feel included even if they are new to the group or the song is unfamiliar. This has also helped deaf parents to follow and to join in

- BSL signs are used instead of actions for the songs. The amount of BSL has varied according to the needs of the participants, but many of the songs are routinely sung with a significant SSE accompaniment
- recorded music (including some tracks with singing) is played through the chapel's sound system to ensure it is clearly audible.



The group continues to receive support from the chapel, so no room hire costs are incurred. This could be replicated by using your own facilities. As part of his role in the community, the pastor, Andy, has continued to manage the music and computer files many years after his own children have left the group. Again, this could be replicated in your own setting by delegating this role to a member of staff or an older student. We provide tea, coffee or diluted fresh juice and fruit for the children from our own resources,



but families contribute an occasional packet of biscuits. This enables us to provide the group free of charge which is important for some of the families attending.

Due to the length of time that the group has been running, a core group of childminders has developed. They have attended over many years with different children and are very familiar with the format. This has been a strength of the group and has led to greater consistency. One of these, currently without a baby to mind on a Friday morning, will step in to lead the group if necessary. Another recently was seen to calmly and competently replace a dislodged speech processor on one of our implanted children being already familiar with the device from previous participants. Their familiarity with deaf children, despite having little direct experience, can help parents of deaf children joining the group feel less anxious or self-conscious.

The songs used are a mixture of traditional nursery rhymes, recent children's songs and some specially created songs such as the Advanced Bionics, "Neptunes" collection. We greatly appreciated the donation of a batch of these CDs from AB a few years ago. The MP3 files are copied from a variety of sources but are usually from recordings that we own and are covered by the chapel's PRS licence. Some tunes were not available and were recorded for us by a talented ten year old who has

subsequently gone on to a career in music. The music files are embedded in powerpoint slides selected from picture icons on the title page. The presence of someone managing this aspect of the session enables a seamless flow from one song to the next. Action songs encourage the deaf children to join in. Favourites include "Row, row, row your boat" "Dingle, dangle scarecrow" and "Sleeping bunnies". As our group is in Wales, we also include a range of Welsh nursery rhymes such as "Clap, clap, un, dau, tri" and "Mynd ar y ceffyl".

Refreshments are provided in a separate room and reliably prepared by volunteers from the chapel. Whilst the provision of refreshments is not essential, the opportunity to talk and share experiences is. Occasionally we have information presented during this break such as resources about Fair Trade fortnight or a Comic Relief fundraising stall. If you had a larger number of deaf children attending maybe you could extend this time and include a speaker or perhaps a visit from an audiologist to take earmould impressions.

The advantage of this group and probably the reason for its longevity is due to its voluntary status. I have led the group for fifteen years through several different professional roles always keeping my Friday mornings "free for Tots" and supported by the commitment and dedication of Wendy, Andy and Tracey with many others along the way. There may be opportunities for you to work in partnership with a local group or perhaps start a group in collaboration with your local children's centre, Flying Start team or Portage service to establish early listening, attention skills, awareness of songs and music, but above all, enjoyment. Have a go.



Sarah Angove is a QToD working in South Wales, who represents Batod Cymru on NEC.

“...but what about generalisation?”

Casey Jackson shares details of a project using ‘smiLE’ Therapy, conducted collaboratively with colleagues; Tim Meaden (QToD), Lisa Salter (Specialist Teaching Assistant) and deaf students

What we did

We used smiLE Therapy (Schamroth, 2015) to encourage generalisation of communication skills to the mainstream classroom. Our specialist provision supports deaf students with mild to profound hearing losses within a mainstream secondary school.

All of our students are hearing aid and/or cochlear implant users and communicate using spoken English. Many have additional needs and other spoken languages or British Sign Language at home.

SmiLE Therapy develops functional communication skills for real-life situations using a test-teach-test model. The therapy was first created for use with the deaf population but is now used with clients with a wide-range of communication profiles and ages across a variety of settings.

We have successfully completed modules such as ‘clarification skills’ (CS), ‘requesting and refusing an item in an office’, ‘work experience’ and ‘interview skills’. Many of these modules prepare our older students for overcoming the social isolation commonly experienced by deaf people in the workplace (Action on Hearing Loss, 2013).

We share the students’ successes, evident through their before and after videos and record forms, with mainstream school staff and parents. Sometimes we share them at Education, Health, Care Plan meetings to bring success tangibly to the meeting in a lively way.

The challenge

Comprehension monitoring is vital for our deaf students in mainstream education. Here, they must learn to listen

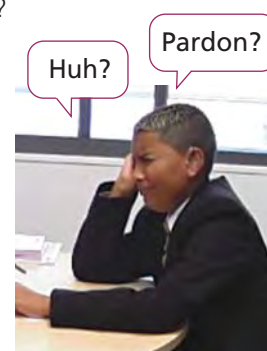


actively where there are likely increased communication challenges, due to noise in large classrooms untreated acoustically where the vast majority of students are hearing. Schamroth & Lawlor (2015) cite NDCS’s (2012) report that 85% of school-aged deaf children attend mainstream school.

Our service is committed to promoting student self-advocacy, as deaf adolescents can lack assertiveness in communication (Wauters & Knoors, 2007). SmiLE Therapy embodies this ethos and the use of CS facilitates this.

Our students might seek clarification generally in the provision, eg “pardon?”, “huh?”, but we wanted to teach them to make more specific requests:

- Can you say that louder please?
- Can you say that slower please?
- I need to lip read please
- What does that mean?
- Can you break that down please? (for lengthy spoken information)
- Other (often relating to equipment – eg requesting that the teacher mutes the radio aid transmitter).

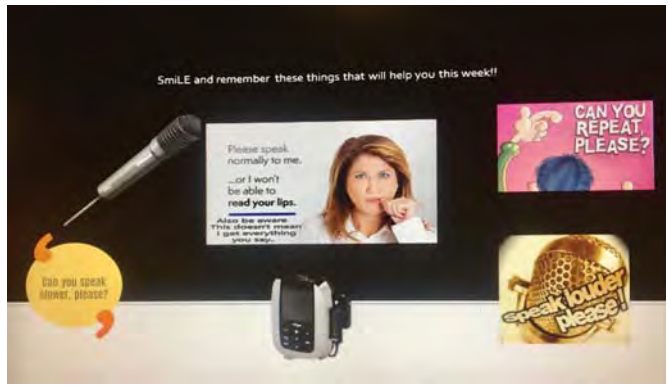


Our students learned to use these CS in our provision with fellow deaf peers and staff who know them well.

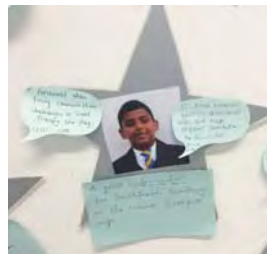
Our challenge was to establish use of CS in the mainstream school, a known difficulty for deaf adolescents (Silvestre et al, 2007).

What we’re already doing...

- In-class recording: our team logs students’ use of CS or missed opportunities in the mainstream classroom on the support sheet kept at the front of each file taken into lessons. I inserted a box on the existing sheet to make recording quick and easy for my colleagues,



- reduce paperwork and most importantly, encourage collaborative working, so that SALT aims become integrated with general mainstream lesson monitoring
- Fixed agenda item at weekly support team meeting: this regular, structured forum for discussion means we share observations and 'keep alive' developing skills
- 'Superstar' wall: we record smiLE Therapy successes on speech bubble post-it notes on the 'Superstar' wall, which celebrates students' academic and extra-curricular successes
- TV monitor: We have smiLE Therapy-themed slides on rotation on a screen, visible to all staff and students walking through the centre. This is a constant reminder to students to take their developing skills into the mainstream.



Why use smiLE Therapy?

I love that smiLE Therapy has fostered collaborative working between professionals in my setting to maximise the benefit to our students.

Tim, Lisa and myself were trained in smiLE Therapy so that we were collaboratively empowered to deliver the programme. I have completed the full Practitioner Training, expanding our range of modules and best advising the team.

We've involved all of our colleagues, many as 'actors' in our filmed communication tasks. This joint working is particularly valuable as historically, SALT provision primarily used the traditional 1:1 model in a small room. The profession in the UK has seen a shift away from this model (Law et al, 2002), resulting in more holistic intervention. My colleagues and I possess improved understanding and respect for each other's roles, integral to a collaborative approach (Wilson et al, 2015).

What we're developing...

- Data collection: data from the record sheets is being collated to identify patterns in use of CS or missed opportunities, eg in specific lessons or with specific staff members. We use this to tailor our work with each student to meet their individual needs
- Mainstream assembly: we promote 'hearing awareness' alongside 'deaf awareness' regularly. Our collaborative success with CS generalisation will be part of this.

The future...

- We plan to use these systems for other communication skills targeted in smiLE Therapy. This could include skills such as varied greetings and appropriate small talk.

What staff say

Tim Meaden, QToD:

"smiLE therapy has added an exciting new dimension to our provision and had an immediate positive impact on the well-being of the deaf young people involved..."

Our students are equipped with clarification strategies to use in situations where communication may break down through missed information or misunderstandings. On a practical level, this has empowered them to be assertive and take responsibility for explaining their communication needs, but on a much deeper level I think this is helping them to construct an identity as a deaf young person, incorporating hearing loss in a positive way. Explaining their communication needs and deafness builds their internal resources and develops a more confident sense of self for future interactions..."

The Rowan Hearing Support Centre (HSC)
Young Support Service
In-class Support Overview Sheet

Student(s):	Date:	HSC Staff:
Subject:	Teacher:	Topic:
Lesson Aim(s):		

Student's strengths

Progress during the lesson

What the student found challenging

Basic Access Strategies

Urgest information to be shared with senior HSC staff: Yes / No

		Seeking Clarification					
		Yes			No		
Sought clarification when needed?	With:	Peer	HSC staff	Teacher	Peer	HSC staff	Teacher
	(please tick or write student's initials if more than one student in lesson):	Louder					
	Slower						
	Lip read						
	Meaning						
	Break down						
	Other (e.g. equipment)						

Clarification Skills (CS) in the mainstream					
Date	Yr group	What does that mean?		Other	
		Not used	Used	Not used	Used
SPRING 2018					
30.01.18	12	Confirmed he understood when asked by teacher but showed his lack of understanding when started work.		Did not tell teacher that the transmitter was muted the whole time she was speaking, when questioned as to why he didn't say anything he responded with "I could hear you crystal clear".	
02.03.18	7				Politely asked his partner to start again but wearing the transmitter and said "thank you".
07.02.18	12		Asked for meaning of 'route'.		
08.02.18	9		Asked for meaning of a word as soon as teacher had finished addressing the class.		
15.03.18	10				Couldn't see the writing on the board because teacher wrote in green pen. Asked teacher to change the colour.
22.03.18	11	Refused to ask teacher for the meaning of a word in science.		Did not want to ask teacher if they were allowed to use a calculator or not	
23.03.18	11			Did not tell teacher that transmitter was on mute while he was teaching	
SUMMER 2018					
17.04.18	9				"Can you mute the FM please?"
19.04.18	10				Asked teacher to turn mic around as teacher had put on transmitter back to front
27.04.18	7		"Can you repeat what you said about what 'oakum' means?"		

Sessions are enjoyable for students and staff. In the context of a fast-paced secondary curriculum delivered in the bustle of an inner-city academy, sessions provide a rare opportunity to slow down and, through role-play, dissect and explore the minutiae of social interactions in a way that is not usually possible in a normal school day... particularly valuable as the development of 'Theory of Mind' is a known area of risk for deaf adolescents...

This innovative practice still feels new and fresh, as the potential for developing exciting units based on social situations relevant to our students seems endless."

Lisa Salter, TA:

"smiLE therapy is invaluable in encouraging our students to seek clarification and better access mainstream lesson content when support staff are not present."

What students say

SmILE Therapy has taught me the importance of approaching intervention with a functional mindset. It bridges the gap between the 'safe' therapy session and the potentially daunting world beyond education. It gives our students an opportunity to develop vital communication skills at each 'stepping stone': smiLE Therapy sessions, generally within the centre, in the mainstream class and outside of school – on public transport, in shops, further education and the workplace. SmiLE Therapy is giving our students the communication skills and resultant confidence needed for life beyond school.

If the teacher is not clear, ask, ask and ask!

This will help in Year 8 because you have new teachers and new lessons.



Casey Jackson is a Specialist SaLT (deafness) with the Rowan Hearing Support Centre at Southfields Academy, Wandsworth Hearing Support Service.

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Supporting deaf children for 150 years

Ann Bradbury reflects on the school's 150 year history

St John's Catholic School for the Deaf has been teaching and supporting deaf children for 150 years. As the school begins its year-long celebration of this momentous anniversary, Head Teacher Ann Bradbury looks back at the history of the school from its founding principles to its present day successes – and looks to the future of educating deaf children.

To mark the beginning of our year of celebrations we held a very special Bishop's Mass, marking the start of 12 months of events we'll hold to mark the occasion.

More than 150 invited guests – including many past and present pupils and their families – gathered together in our chapel to celebrate our foundation 150 years ago by St John's Catholic School for the Deaf in Boston Spa, near Wetherby, by Belgian priest Monsignor Desiree de Hearne.

After working with a family of deaf children in his parish

and discovering how limited their educational opportunities were, he decided to found a school to meet their needs. The school, the only one of its kind in England, was dedicated to St John of Beverley who became Bishop of Hexham and York and who, legend has it, taught a deaf and dumb boy to speak without a miracle.

He began the school at Handsworth Woodhouse (the rent was £20 a year and rates £40 – how times change!) and it was first opened with just two girls as pupils as St John's Institution for the Deaf and Dumb.

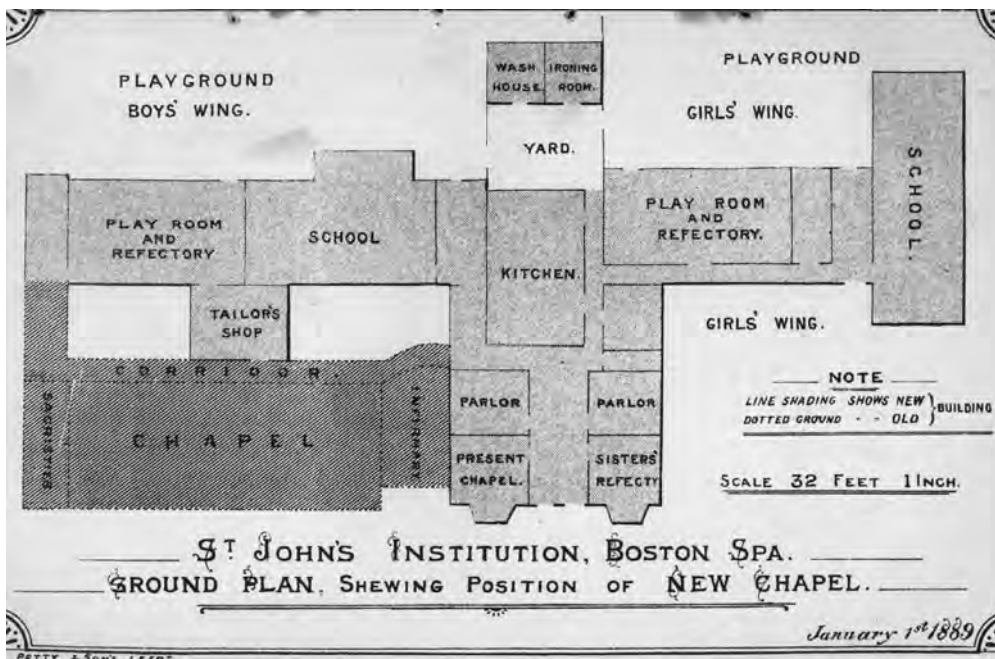
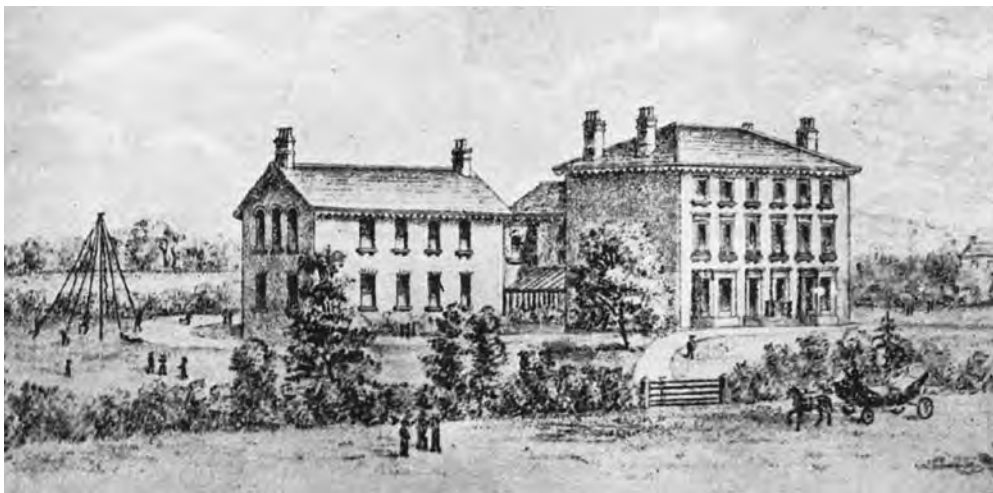
Within a year, the school's growing roll of 14 boys and girls had already outgrown its capacity and by the end of 1874 there were 41 children in the school – which had been originally designed and furnished for just 12. It was time to move.

A new building was found in Boston Spa in 1875 – the

building was said to be in the healthiest district in England thanks to it being built on magnesium limestone. That year, 47 children moved to their new school and were taught using a combination of "natural signs, articulation and the single-handed alphabet".

Their curriculum in some ways did not differ too much for the traditional national curriculum we see today – it included English, Arithmetic and Geography, and as you would expect from a faith school, Christian Doctrine and Scripture History, as well as articulation. As we today look more at vocational options for those students who choose them, they were a large focus of the school's work back in the late 1800s.

Boys were: "further prepared to take situations as printers, carpenters, shoe-making, tailors and gardeners", while girls were taught, as was the custom at the time (although would cause a rightful furore now!) 'ordinary' household



work, laundry work, plain and fancy needlework – “according to their capacity”.

We see from many of the letters the school received from former pupils at the time that they indeed went into paid work in these professions, with others taking work in mills and factories and earned salaries broadly commensurate with their hearing peers.

The school continued to grow throughout the end of the century and into the next after the Education Act (1893) made it clear that the education of deaf children was compulsory, while before many had received no teaching at all.

St John's continued to be extended, with improved and extended facilities eventually seeing more than 200 pupils supported. In 1883 farmland was bought and produced milk, bacon and other foods, allowing the school to be self-sufficient.

A turning point in how the children would be educated came in the 1880s. Until that time, the school used the combined method which was used more than the manual alphabet. In 1880, the Milan Congress decreed that the Oral Method was to be used in all education for the deaf – with the theory that if deaf children could learn using sign language then they could learn through speech.

Class sizes were reduced to eight or 10 children in each, which led to an increase in the number and training of teachers at the school. Our historical records show that



Teachers of the Deaf were, if they were college trained and had 19 or more years' experience, received an annual salary of £195. A first-year TOD would receive £110.

Photographs from the time show children on their first beach holiday (provided by the school), playing football, hockey and netball, doing gymnastics, making artificial flowers and much, much more. It was clearly a very diverse timetable!

Moving forward, while the school was largely unaffected by the First and Second World Wars, it was after this that some monumental changes took place at St John's. In the 1950s, boys were not taught separately from girls, as had been the case. There was a more inclusive curriculum for girls and hearing aids were introduced for use in classes in 1951.

Technology and other education changes continued and between 1956 and 1975, there were significant moves. In 1958 the first public examinations were taken by children at St John's. The experiment was a success (although all failed the English O Level they sat) and the school rearranged the classes to include a new GCE class. In the 60s and 70s, it became usual for pupils to sit between two and 10 GCSEs each.

Induction loops and other up-to-date audiological equipment was provided as well as speech training, as the school continued to use the Oral Method of communication, as we broadly still do today.

Today the school still supports children who are deaf. We also support those who have multi-sensory and communication difficulties, including





achieve a happy and successful adult life.

“As a governor of the school for the last seven years I have witnessed the outstanding work being done by all the staff in teaching, guiding and supporting our pupils in developing all their talents to the full.

“I have seen the amazing changes that have come about as our young people develop their language and communication skills, and the confidence with which they leave this school as they take their place in the wider world.”

He is entirely right. We now, as the school did

young people who have an autism spectrum condition. We continue to offer both day and residential placements and our children, as they did throughout our history, learn in a wide range of subjects, academic and vocational, and are supported by in-house audiology, speech and language therapists and Teachers of the Deaf.

Our focus remains supporting our young people to gain the skills and confidence they need to do well in their lives away from school, to embrace their talents and provide a foundation which they can rely on in difficult times. The children themselves build a community and friendships that transcend distance.

As we saw at our celebratory Mass, and we see throughout our historical records dating right back to the 1800s, former pupils keep in touch with us, and each other.

Then they too regularly visited and wrote. They still do – although sometimes via email, text or Facebook and Twitter now too of course. Past pupils come to our events, they speak for us at professional and other gatherings and they tell us about the great things they have gone on to achieve since leaving St John’s.

They told us then and they tell us now about how what they learned, not just academically, has helped them be better prepared for their lives. We hear a lot that time in our residential service helped them learn how to cook and wash up, good skills to have indeed!

We’re proud to say they feel an affinity with St John’s and we’re extraordinarily proud of each and every one of our former students.

Speaking at our celebratory Mass, Reverend David Arblaster, the Vice Chair of Governors at St John’s, said: “Then as now, the school gained a national reputation for providing an education to support young people to

back when it was founded, have extremely high expectations for our young people.

I would like to thank families, past and present, for sharing their children with us and allowing us to be such large parts of their children’s lives. Our students continue to inspire us and make sure no two days are ever the same – I firmly believe they teach us far more than we could ever teach them.

In this most special of years, I’d like to particularly thank our staff team for their endless optimism and relentless hard work supporting our young people to flourish in their future lives.

As I’ve looked back over the 150 years’ worth of records, photographs, memorabilia, letters and others we have amassed as a school in our proud history I see several themes which are much the same now as they were 150 years ago.

St John’s has always been blessed with specialist, supportive staff determined to go the extra mile to do their very best for our young people. We have had the privilege of supporting young people dedicated to learning and most importantly, to enjoying life and all it has to offer. And we have truly formed an enduring community which we are all a part and of which, we should be and are, rightly proud. ■



Ann Bradbury is the headteacher of St John’s Catholic school for the deaf in Boston Spa, West Yorkshire, a residential and day school for pupils aged 3-19 years with sensory impairments or communication difficulties.



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(Ofsted 2019)**

Why Choose St John's?

St John's has a proven track-record in supporting deaf and hearing-impaired children and those with complex communication difficulties to achieve outcomes that support success in the real world. Our residential and day options offer flexible support for children who are deaf, have communication difficulties or are affected by multi-sensory impairment.

An autism-friendly environment, St John's is inclusive and welcoming and a place where children thrive among their peers supported by in-house audiology and speech and language therapy. Our sixth form provides an excellent preparation for students moving into the next phase of their lives.

Our care is officially "outstanding"- again!

"Outstanding" Residential Care"

"They are relentless in their drive to ensure that children learn skills and gain qualifications to be able to live fulfilled lives"

"Parents say that they are amazed at the progress and the skills children acquire"

Ofsted 2019



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STUDENTS WHO PROGRESS TO FURTHER EDUCATION, EMPLOYMENT OR TRAINING



10

YEAR 11s AT THE SCHOOL SECURED AN AVERAGE OF 10 QUALIFICATIONS EACH - RANGING FROM ACADEMIC SUBJECTS TO MORE VOCATIONAL OPTIONS



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Connevens – technology made in the UK!

Richard Vaughan summarises some new technology designed and manufactured by Connevens

Connevens is a company whose foundations are built firmly on the manufacture of electrical and electronic equipment. In the 1960s we were the first British manufacturer of Language Teaching Laboratories and since the 1980s we have been the only company to design and manufacture radio aid systems for deaf children here in the UK.



Connevens language lab testing in 1967

As we approach our 60th anniversary, manufacturing remains at the heart of what we do. We have diversified over the years to offer a wide range of other products and services; however, we believe our manufacturing basis gives us a unique understanding of technology's journey from conception to production to customer satisfaction. Whilst we now supply equipment from many suppliers made all over the world, here is a small selection of the varied products designed and manufactured by Connevens in Merstham today.



Bertha and Ken

BabbleGuard Classroom Noise Indicator

Our aim when designing BabbleGuard was to produce an effective device that was very quick to set up and easy to use. It is a beautifully simple solution to encourage young children or students to keep the classroom noise at a comfortable level, promoting concentration, listening and learning. Using a sophisticated sound sensor, BabbleGuard has an LED bar which changes colour using the traffic light colours green, amber and red to reflect the level of sound in the classroom. Please do get in touch if you'd like to borrow one to try in your classroom.



BabbleGuard



Lion Intelligent Hearing Aid Loop Indicator Sign

Our newest manufactured product is the Lion loop indicator sign, aimed at helping to ensure that hearing aid loops in public places are working well whenever they're needed. Lion is both a test device, assuring staff that the loop is working, and also a visible reassurance to deaf people that the venue has an induction loop that is active and available for use.



Lion Intelligent Hearing Aid Loop Indicator Sign

Classroom and Hall SoundField systems

We have been manufacturing Soundfield Systems for many years now. Most popular is the Swift Digital hyper-wide dispersion flat panel speaker unit, which is now available with the SwiftConnect to enable easy integration with existing classroom AV equipment. We also have the IR Classmate+ multi-speaker classroom system and a range of systems for school halls. If you'd like more information about



Swift Digital with SwiftConnect





Ewing SiN Toolkit

Connevans soundfield systems or a demonstration, please email phil@connevans.com

The Ewing Foundation for deaf children SiN (Speech in Noise) Toolkit

We always value the opportunity to work in partnership with other organisations with specialist knowledge and expertise, so we were particularly pleased to develop the SiN Toolkit with The Ewing Foundation for deaf children. Designed for Teachers of the Deaf, the Toolkit is supplied

with the Manchester Picture test and word lists and provides measured and repeatable results on a child's ability to hear speech; with or without their hearing instrument/s. Rather than a clinical test, the toolkit is designed to be used in real-world every day school settings.

New ideas are always welcome!

If, while you've been reading this article, you haven't been able to stop your mind wandering to that life changing gadget that you've always wished existed, why not drop us a line and let us know? We can't promise to bring the idea to reality overnight (the product development road isn't always a straight, high speed one!) but every exciting new product that rolls off the production line started with one good idea!



Richard Vaughan is the Customer Support Manager at Connevans Limited.

BATOD membership: developing professional world partners in deaf education

BATOD is a professional body which offers a 'community' of dialogue and information. If a UK-based BATOD member has an established involvement with a developing world project, they can make a recommendation for the head teacher of the school for the deaf or teacher in a deaf resource base associated with their project to be registered with BATOD as an online 'overseas special member' at no charge to either member.

- BATOD has an expectation for the overseas special member to submit an annual magazine article or information for a blog post. BATOD encourages the overseas special member to be the author/co-author of the article submitted.
- The BATOD overseas special member must have internet access in order to access the online resources which may be of interest.
- Online members can access the five magazine editions/year in the electronic version. The BATOD magazine frequently features articles about deaf education from across the world. Thus, our special overseas members can share with and learn from UK and other worldwide professional peers in deaf and deaf related education.



BATOD cups – where have yours been?

Let us know where your BATOD cup, bottle or latest BATOD Magazine has been round the world.

We can't promise to publish them all in the magazine but send them in and they might also turn up on our Facebook or Twitter pages.

Kindly provided by Tiffany Moorcroft from Barford Top campsite in Leicestershire



Parent talk

Marie Ange Nimpaye shares her parent experience on raising two deaf children in Burundi

I'm the mother of two beautiful deaf children, a daughter aged 13 and a son aged 4 years old. When my daughter was born, I did not realise that she was deaf until she was 1 year old. It was the same with my son. During the first year I kept talking to my children in the normal way, but at some point I felt that something was amiss because they would not pay attention to my voice. At this time I had no clue about deafness as there was nobody who was deaf in our family.



With no audiology, children's service or information on deafness, I struggled at first to accept that my children were deaf. I did not know what to do or where to look for help or information. It was very depressing. But I became accustomed to it and accepted that my children are deaf. I still struggled to communicate with them though as I didn't know any sign language and there was no support groups or information for parents of deaf children. We had to make up our own signs to try to communicate, but it was not full communication, just basic things.

There were times when my daughter would get angry with me. She was so frustrated that I couldn't understand her. I couldn't understand why she was unhappy, or what she wanted. I was upset too.



The situation was no different with my son. I struggled to bring up two deaf children in my home without any support from the government at all. There was no social or health service to support us, I felt helpless.

Things started to change when my daughter was five years old. I learnt that there was a school for deaf children, in the capital Bujumbura, called Ephphata School for Deaf. I went there with my daughter and I was happy to enrol her there. It is a boarding school, which means that she has to stay there.

My daughter would only come home during the school holidays (Christmas, Easter and summer). I started to notice changes in my daughter. When she returned for her first school holiday, I was surprised to find that she could write words and numbers (mom, dad, 1+3=4,) like the other children in the neighbourhood. It was obvious that she was trying to talk to us using sign language, but the problem was that no one at home could understand her or reply to her. Neither I, nor my husband, nor either of my other children could communicate by signs. This meant that the frustrations continued for my daughter and for us.

One day, a teacher at our daughter's school told us that there is sign language training for parents of deaf children. My husband was very interested in this training and he started to attend this sign language training.



After this training, my husband could communicate with our daughter in basic sign language (greetings, express some basic needs, etc). My husband's understanding of basic sign language has made our daughter much more attached to him than to the other members of our family. Our daughter felt comfortable with my husband. Both could communicate easily and tell each other stories. It



comforted our daughter. I found myself using my husband as an interpreter between our child and the rest of the family. However, my husband and our daughter taught us some signs that allowed us to communicate a little with her and also her little brother.

Later, with funding from an association called 'Aurora Deaf Aid Africa', training was organised for parents of deaf

children, which I attended. With the signs learnt in this training, I can easily communicate with my daughter using these signs. And this has contributed to the development of both of our children.

Thanks to the sign language training received by my husband, and later by me, communication is no longer an issue in our family. Our daughter now feels accepted and comfortable in our family. We now have another deaf child in our family, and we communicate with him in sign language too, and it works well. I benefited greatly from the sign language provided by Aurora and it brought me together with other parents which make us feel like a peer support group, we help each other. I would recommend the sign language training to other parents who have deaf children.

I am also one of the founder members of a new parents association called the Association of Parents for the Education of Deaf Children in Burundi (APEES Burundi). Through this organisation we hope to spread awareness of deafness and be a valuable source of support for parents of deaf children across the country. We also hope to raise the issue of the needs of deaf children with the Burundi government to ensure they provide for the education needs of deaf children, and recognise and provide for their wider rights.



Marie Ange is a mother of two deaf children and is one of the founder members of a new parents association called the Association of Parents for the Education of Deaf Children in Burundi (APEES Burundi).

Translation by Chris Kubwimana the Founder & Director of Aurora Deaf Aid Africa. In August 2019, Aurora Deaf Aid Africa joined forces with DeafReach, with a view to full amalgamation during 2020.

FEAPDA Congress 2019

Paul Simpson shares a summary of the 2019 FEAPDA* congress

The FEAPDA congress takes place every two or three years. 2019 was to see only the second ever congress in the Balkans since the federation started in 1969. FEAPDA is keen to expand its membership and in particular into the eastern parts of Europe. The congress started on Friday 27th September and lasted two days and the theme was “preparing deaf learners for life and independence”.

The eve of the congress usually includes a sight-seeing tour and indeed a group of delegates was escorted round the heart of Skopje and had a most interesting visit.

At the same time, the FEAPDA committee, along with the keynote speakers and a representative from each participating country, were driven to meet the president of North Macedonia (the name having recently changed from Macedonia). Having handed in our phones at the door – not a liberating experience for me – we were ushered into a large room where the President, sitting in front of three



flags – Macedonia, NATO and the EU flag conversed with us for about 45 minutes mainly asking questions and trying to determine (photo of meeting) how best he could advance the course of deaf education in his country. During the discussion two strong proposals were made – institute neonatal screening and ensure that deaf children have properly qualified Teachers of the Deaf through the development of a mandatory qualification.

After a modest dinner by the riverside we retired to bed. Next morning Alison Weaver, FEAPDA President, and me (now Vice President), went to the studios of Macedonian TV to appear on breakfast TV. A first for me! In a bilingual discussion lasting about 20 minutes we were interviewed about the congress and deaf education in Europe. It was a useful and enjoyable experience – questions and answers being translated in and out of the Macedonian language. Anyway, we made our points about early screening and working with families and it seemed to go down well. We await the link to the website to see what it was really like!

The congress itself got under way with the first of four excellent keynote speeches. It was delivered by Aleksandra Karovska, assistant professor in the Department of Special Education and Rehabilitation, Faculty of Philosophy, University Ss. Cyril and Methodius,

* *Fédération Européenne des Associations de Professeurs de Déficients Auditifs – European Federation of Associations of Teachers of the Deaf*



Skopje-Macedonia. She provided a stimulating overview of the issues arising from the theme of the whole congress.

This was followed by some excellent paper presentations to the whole group. These covered a range of topics and started with a contribution by Emmanouela Terlektsi, well known to us though her leading of the ToD training course at Birmingham University, who did an interesting presentation about research into interventions to support the social emotional skills of deaf children to become independent learners – known as a rapid evidence assessment.

This was followed by a paper from Cecilia Nakeva von Mentze from Sweden who spoke about reading ability and working memory in school-aged deaf children who are deaf using cochlear implants and/or hearing aids which was a 30 month follow-up on computer-based phonics training.

This was followed by a strong appeal from two deaf former school for the deaf students, Hristina and Aleksandar, as special schools in Macedonia are possibly under threat from a proposal to make educational fully inclusive and close all such schools. We made it clear that in our view a 'mixed economy' is best placed to respond to all the individual needs – mainstream inclusion with support but specialist provision as well. Indeed, this is what happens in most European countries. Italy briefly introduced a period of full inclusion, but we understand this has not worked well and now special schools may return.

Further presentations came from Romanian colleagues who adopted a rather novel approach – the first section of their talk was a travelogue about Romania encouraging us all to visit! This was followed by a presentation from Serbia



about the role of careers guidance and counselling in a vocational school for deaf students.

The second keynote was a stimulating presentation from Manfred Hintermair from Germany on the topic of identity and development. Dr Hintermair is now retired but for many years was Professor of Psychology at the Department for Special Education at the University of Education in Heidelberg, Germany. His research interests have always centred round family socialisation and deafness, and socio-emotional development of deaf children.

Another member of the strong UK delegation delivered the next paper presentation. Martina Curtin spoke about her work with smiLE therapy. Martina is a practising Speech and Language Therapist currently studying at City, University of London. She used some excellent video to support her talk which was very well received.

This was followed by another Romanian presentation entitled "being deaf in an inclusive Europe" which was the last presentation of the day.

The first day ended with a choice of four interesting workshops – Christina Wurzer talking about the German dual system of vocational and training embedded in a real-life environment, our own President, Steph Halder, on promoting independence through technology, Martina Curtin building on her earlier presentation and Susanne Keppner, also from Germany, talking about professional training for deaf students at schools for the deaf.

Whilst the other delegates had a well-deserved rest, the members of the FEAPDA council, representing each member country, had no such luck. The council meeting discussed changes to the constitution – mainly to expand the membership of the federation to include individual institutions, not just associations (mainly because there are fewer associations today) so as to be welcoming to all countries in Europe (not just the EU, fortunately for the UK!) – and some discussion on voting arrangements within





the council. The other discussion related to the next congress and we were delighted that colleagues from Estonia offered to arrange the 2021 congress which will take place in the autumn.

In the evening, after another sightseeing tour of Skopje, we went to a restaurant and enjoyed a congress dinner of Macedonian music, dancing, food and drink which was very enjoyable if rather noisy!

Although some delegates didn't make the start of the second day – for some reason! – the third presentation came from UK's Martin McLean, Education and Training Policy Advisor from the National Deaf Children's Society, who made an interesting presentation about careers and higher education drawing on both his personal and professional experience.



This was followed by FEAPDA council member Amelia Mozetic Hussu from Slovenia who talked about preparing deaf students and young people for life and independence in their country.

An interesting look at self-advocating in higher education was the topic of the presentation from Greece which was followed by a presentation from North Macedonia colleagues about their school for the deaf.

The final keynote lecture came after lunch – which, as it had been the day before was a delicious range of

Macedonian delicacies.(photo) It was delivered by Leo de Raeve from Belgium and looked comprehensively at issues related to independence development as they affect all ages and phases.

We then heard from another member of the UK delegation, Catherine Walker, talking about resilience skills for life after school for young people with mild and moderate hearing loss.

The next presentation came from Maarten Rencken, a PhD student from Belgium, and looked at training expressive vocal use which was a most interesting and stimulating presentation.

Before the closing ceremony there was the opportunity to attend a final workshop – one about inclusion and the education of deaf children in the 21st century and two follow up workshops from the earlier presentations by Catharine Walker and Martin McLean.

The closing ceremony was led by Alison Weaver in her role as FEAPDA President and consisted of giving grateful thanks to all the organisers including the sign and spoken language interpreters who had worked assiduously throughout the conference.

Once again, a FEAPDA congress had been a great success and fulfilled its objective to ensure that Teachers of the Deaf from across Europe can exchange good practice and learn from each other. We look forward to the next congress in Estonia in 2021. ■



Paul Simpson is the National Executive Officer of BATOD

Together we are stronger!

The **BATOD East committee** reflects on their regional CPD and sharing of good practice day

Building on the success of the previous year's regional training event, it was decided to continue and develop the concept of regional collaborative working by holding a second regional event in the western side of the East region. The event 'Developing good practice for working with deaf children, their families and schools' allowed delegates to network, share some best practice highlights from their own services as well as receive updates on a range of topics including technology, regional services, Deaf CAMHS and the specialist hearing implant centre at Addenbrookes Hospital.

Hertfordshire service hosted the event and undertook the lion's share of the administration necessary to book delegates and speakers supported by a small planning group from around the region that started meeting approximately six months before the event took place. The CPD day was attended by many delegates from services including Hertfordshire, Cambridgeshire, Peterborough, Norfolk, Suffolk, Luton, Bedfordshire and Essex. By choosing to use speakers able to offer their time without cost and to facilitate workshops using staff from within local services, it was possible to keep the delegate costs very low, something that we believe encouraged such a positive



turnout from the region. CPD is at a premium these days with many Local Authorities (LAs) discouraging or disallowing costly training. The response and feedback from the East region event suggests this is something delegates continue to want and value.

The event opened with a keynote presentation from Ian Noon, Chief Policy Advisor at NDCS, on the issues and challenges facing Teachers of the Deaf. He used available data from sources such as the school census, CRIDE and the BATOD ToD survey 2019 to look at three themes; raising achievement for deaf children, wider issues facing deaf education and raising the quality of the workforce. The presentation was thought provoking and highlighted issues such as 41% of LAs in England planning to freeze or cut budgets to specialist services to deaf children. Further keynote speeches then followed by Steph Halder, BATOD president and Lesley Reeves-Costi & Sarah Shields, Headteachers at Heathlands from September 2019 who talked about the offer at Heathlands school for deaf learners.

Following the keynote speeches delegate chose from a series of workshops on topics including Deaf Children Don't Need Phonics lead by Heathlands staff, the work of Deaf CAMHS, the work of the regional hearing implant team at the Emmeline Centre in Addenbrookes hospital Cambridge delivered by Gayle Leeson, Lead Rehabilitationist. Additional workshops were led by practitioners from Cambridgeshire, Hertfordshire and Peterborough on themes



such as Baby Beats, Theory of Mind Resources and Deaf Studies Curriculum resources. The regional committee also snuck in the necessary regional annual general meeting at lunchtime allowing many delegates to attend without having to travel to a separate event- this also led to the regional committee doubling in size!

The event was then rounded off with some updates from several of the main implant and hearing technology companies and a short presentation on a project in Africa being supported by some of the delegates in attendance.


The feedback from the day indicates that delegates really valued a rare opportunity to network with other ToDs but also to meet face to face and make connections with some of the agencies they deal with such as Deaf CAMHS. Delegates commented that you never stop learning and even in topic areas that you think you know reasonably well there are always new approaches to learn or different ways of doing things that you may not have considered. The presentation on Theory of Mind and activities supporting this from Hertfordshire was particularly well received.

So, beyond offering a varied and interesting program what did we also learn from the day? Several things come to mind, it is always important to review and evaluate what you are doing and going beyond your own authority boundaries gives another perspective on this. Organising a regional event sounds onerous and the committee know that at one point the idea was almost shelved but actually all agreed that ultimately the event had been hugely worthwhile. Keeping things relatively low key and pooling knowledge and experience allowed this to happen and did not leave one service with having to provide all workshops. Having one service host the event clearly helped but others were able to support and may take on the hosting responsibility next time- yes- we have been discussing doing it again! Watch this space...

No service is an island and there is a certain strength in



knowing that your neighbouring authorities are likely facing similar challenges to you and hearing what creative solutions they have come up with often provokes thought. What is more and more important, all services have areas of strength and it is good to be able to share and promote these. So – this is a challenge to other regions out there – consider it – could a regional cross border event work for you? If the Eastern region experience is anything to go by, we feel it could be something worth exploring.



Sara Brierton, Malcolm Sinclair and Claire Gamon are BATOD East committee members

Role of a proof reader

Thinking about volunteering as a proof reader for the BATOD magazine?

Corinda Carnelley and **Mary Gordon** share their thoughts on the role

Mary: Proof reading can be fun! Be reassured – it does not spoil it when you get your copy of the ‘tweaked’ final version of the magazine through the post with everyone else because proof reading is reading word by word with your antenna set to checking mode so you don’t really take in the articles in the way you do when reading.

Corinda: At its most simple, the role of the proofer is to pick up any spelling mistakes or grammatical errors before the magazine goes to print.

Personally, I feel it’s a chance to comment on things/articles/statements that may seem unpleasant, outrageous, or simply wrong. As a QToD working at the chalk face – so to speak, some articles submitted by people who are not so familiar with the day to day challenges of educating deaf children, need to be disputed, or flagged before they cause offence – or worse, the magazine to be consigned to the recycling bin before being read.

It’s a second opinion for the editor to consider. (You have not to mind awfully much if the editor chooses to ignore your opinion!)

Mary: You are looking for flow and for glitches in the flow. These can be anything from an ‘orphan heading’ (google it!) to an accidental extra letter space between two words, to a simple typo. American spelling can cause a problem as many people’s home computers default to US English. A quick google will also give you the UK spelling but you will save a lot of time if you set your computer on UK English each time you start proof reading! If the author is American or Canadian you will use their USA spelling – the role is to help the article have internal consistency.

Some words in English have two permitted spellings (each in UK English) eg focused and focussed – but for some of these BATOD has a House Style! For that example BATOD prefers ‘focused’.

Corinda: The worse thing about proofing is the incredibly short timescale involved. It is usually necessary to read the entire magazine, proof, comment and upload said comments within the space of a week – and if it happens to be a busy week either at work or socially, something has to give.

Mary: Just before a magazine goes to bed, the proof reading needs to be done. It can take a good while (several hours) to do a chunk of the magazine but it does not have to be done all in one go. I highly recommend saving frequently! I have lost all of my corrections and additions in a huge chunk of magazine once after several hours work! It only has to happen once!

Corinda: As previously stated, I am a grammar geek and there is nothing I find more satisfying than replacing a comma with a semi-colon, or noticing that a list of bullet points has some full stops at the end of some statements and none at the end of

others. (Yes, geek is the correct noun!) I also sometimes suggest alternative words – ‘challenging’ twice in one sentence – I don’t think so!

Mary: Proof reading is a skill most teachers have by dint of constantly correcting spelling or grammar in their pupils’ work. It is not demeaning for the author! Every famous or otherwise author has a proof reader and an editor! It is a very well known fact that no-one can proof read their own work! Those who try come a cropper! Your brain does not see your own mistake but it sees what you meant! Therefore proof reading includes articles written by articulate academics, the Magazine’s Editor’s own words, the BATOD President’s words etc. It is unfair to a contributor to let a mistake or an error go through! Everyone has the right to good proof reading!! Advertisements also need to be proofread! Absolutely anyone can make a mistake!

Mary: The suggestions for corrections which you make are not cast in stone and the magazine Editor has the final say. You may notice things which the other proof readers have not noticed! This can be very valuable! It is not a competition! Your corrections or proofing points will not be shared with the other proof readers as they go from you directly to the Editor.

Tempting though it is to change an article completely from the author’s style to your style, that is both time consuming and unfair to the author!! However if there is a lot of repetition in an article you can suggest other ways of expressing the phrase so that it enhances the article and makes it easier to read! The author is likely to be very pleased but may well not notice!! Sometimes there are space constraints on a page so if you can suggest a way of losing few words or lines from the original article that can be most helpful.

Corinda: If you are picky to the point of geekiness, this is the job for you. It’s also a great chance to get out the red pen – usually banned in schools these days for something less confrontational!

Mary: It is a flurry of activity for a few days. It can be busy but all the rest of the month/ year you will not be needed to do any! You will have the satisfaction of knowing you have mucked in and helped. It will also greatly hone your proof reading skills which could be useful in other aspects of your life outside BATOD!

If you are interested in this volunteer role please contact Teresa Quail, Editor via batd_aneo@icloud.com



Corinda Carnelley is a Peripatetic teacher of the deaf; London Borough of Croydon.

Mary Gordon is a (recently) retired peripatetic QToD in Belfast.

Meet the team behind the BATOD Magazine

The collaborative efforts of a range of professionals are key to the education of deaf children and young people. Similar collaborative efforts are fundamental to the creation of each BATOD magazine. Meet the current team behind the magazine. Maybe you are interested in one of our vacant roles. Expressions of interest are welcome. Please contact Teresa Quail at batod_ane@icloud.com



Editor:
Teresa Quail
Leads on the content of the magazine



Commissioning editors:
Heather McClean,
Liz Reed-Beadle
Encourages some contributors to write articles for you to read



Production manager and artwork:
Rosi Hearnshaw
Prepares the pages ready to go to the printer

Proof readers:
Corinda Carnelley, Emma Parker, Mary Gordon, *vacant post*
The invaluable team that check all the pages to spot spelling or grammatical errors



Advertising manager:
Teresa Quail
Persuades companies to place ads in the magazine which helps to cover costs



Reviews panel editor:
Joanne Kelsey Taylor
Co-ordinates the review of books to help you decide what's worth buying



Proof readers for audiological specific items:
Stuart Whyte, Liz Reed-Beadle
When specialist education audiologist knowledge is required



BATOD treasurer:
Carol Thomson (*vacant post from March 2020*)
Balances the finances



New roles
Archive feature page co-ordinator:
Paul Simpson
Technology section feature page coordinator:
We welcome Jeanette Hender to this role, commencing 2020.
Social media feature page coordinator:
We welcome Helen Devereux Murray to this role commencing 2020.



President:
Steph Halder
Ensuring that the Magazine follows BATOD's ethos



Journal 'Deafness and Education international':
Rachel O'Neill
The 'other' publication

Magazine distributor:
Menzie's Response
Gets the Magazine out to members

Printers:
Wealden Print
From artwork to printed magazine

There is typically a think tank Skype call for each edition from which an array of professionals are suggested as potential authors to be commissioned. I would like to thank this edition's think tank volunteers: Conor Mervyn, Stuart Whyte, Steph Halder and this edition's commissioning editor, Liz Reed-Beadle for their input.

Also, the BATOD team is much wider with NEC representation from the 8 regions and nations. Details of each area can be found on the BATOD website About Us section.

BATOD has a guest spot at each NEC. If you would like to attend as an observer please contact your BATOD region/nation Chair

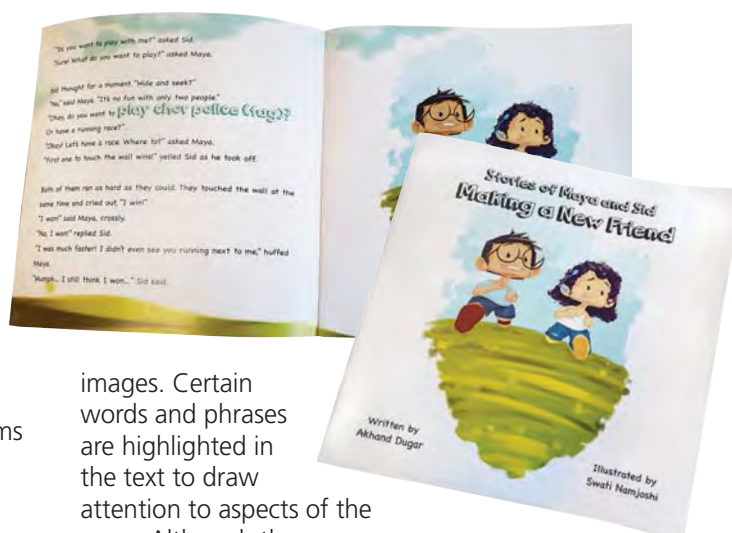
Steering group consists of the President: Steph Halder, President Elect: Lesley Gallagher, Past President: Stuart Whyte, NEO: Paul Simpson, Treasurer: Carol Thomson, ANEO: Teresa Quail and a different NEC member as a guest at each meeting.

As David Couch retires from the role, our new consultant will be Stuart Whyte.

Review

Stories of Maya and Sid Making a New Friend

Author Akhand Dugar
Illustrator Swati Namjoshi
Date unknown
Publisher Listening Together
ISBN 978-1-7335923-0-7
Price Including details of site licences, test forms etc. \$9.99/£4.99 per book (seen on ebay)
Reviewer Joanne Kelsey-Taylor, ToD, IPaSS Hull



Meet Maya, a girl full of energy and adventure. She is profoundly deaf and wears bilateral cochlear implants. She is very knowledgeable about her deafness and her technology. In a sunny park in India, Maya meets Sid, a curious boy.

Maya and Sid talk about hearing loss, and how Maya can still listen!

I enjoyed reading this books and believe it would suit primary aged children, probably up to about Y4? I felt the story offers the opportunity to enter into a discussion with children about hearing and hearing loss. Although it talks about cochlear implants I do believe it can lead to conversations about other hearing technologies used by other children, if these are used in the setting or just to highlight there are different technologies in use.

Content evaluation

The book is a good size to share with a small group of children around a table or carpet circle. The illustrations are colourful and engaging, but also simple

images. Certain words and phrases are highlighted in the text to draw attention to aspects of the page. Although there are some Americanisms in the book these can be altered if you feel it is necessary. I think I would use the book in PSHE style sessions and Deaf Awareness with hearing peers to open a discussion about deafness and differences. I liked the book and will use it with some of my mainstream classes.

As I said I feel it is useful for younger children maybe to Y4. I feel the images used would be more engaging to this age group as opposed to older children. Older children may find it useful for ideas if they are looking to write a piece about deafness for a younger audience.

This story is short, it took me about 10 minutes to read, but in a classroom setting it would take longer as it would lead to discussions about hearing loss, technology used and other differences in the class. I have used a similar text with success for his style of lesson.

Summary – marks out of 5

Quality:	4
Value for money:	4
Educational usefulness:	5
Overall:	5

Classroom/ workplace evaluation

The parents (with children under 5) with whom I shared this book felt that it was too 'wordy' to read to their children with CIs. They did like the explanation of the CI and the brain though.

Isaac gets his BAHAs fitted!

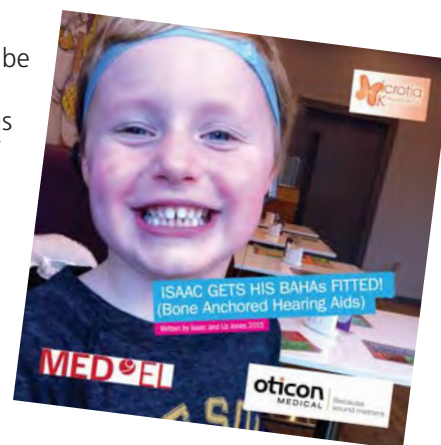
Author Liz Jones
Date 2015
Publisher Microtia UK
Price £3.00
Reviewer Joanne Kelsey-Taylor, new book review editor for BATOD

This is a beautifully presented little book written for young children who have microtia and their families. It is ideal to support children to become aware of their ears by thinking about the similarities and differences between themselves and other children and adults.

Each page has a clear photograph on a bright background with accompanying child friendly language. It would generate much discussion when shared with a young child.

I think this little book would also be ideal to use in nurseries / schools with the peers of young children who have microtia.

As suggested at the end of the book, it certainly provides inspiration for families and professionals to create similar, personalised photo books for hearing impaired children to support their self-awareness.



Review

SignSpell

Author(s) Signature
Date 2013
Publisher Signature
ISBN Each book has a different number. There are 12 books in the set
Price The resource is available in three sets:
 SignSpell small £499 +vat,
 SignSpell medium £899 +vat (comes with 4 sets of books and 4 sets of flashcards),
 SignSpell large £1299 +vat (comes with 8 sets of books and 8 sets of flashcards)

(see the website for further details)

Reviewer Joanne Kelsey-Taylor, QToD, IPaSS Hull

Zip and his friends are called home to planet Zee.

Join them as they get ready for the journey home, discover the problems of preparing a spaceship for blast-off, and learn signs for emotions.

Watch out for Goober!

SignSpell is a resource to help develop language and communication in primary age school children. Friendly aliens use aspects of BSL to support emotional and kinetic learning, helping children learn different ways to express themselves. There is access to 340 signs online which are accessible on a range of devices.

The pack comes with books, flashcards and teacher resource pack. There is an online learning tool, which I was unable to access. There are fun and interactive ways to learn. This can be used both in school and at home. I felt a signing club at school would be a good environment for this resource to support a deaf child, who uses signs, to communicate with their peers or as a fun way to learn something about how Deaf people communicate.

It is important to remember that the signs used in the book will vary in different regions of the country. Our Deaf Instructors were a little confused by some of the signs which they didn't recognise. However the illustrations are clear and simple, but I believe staff using it will need a BSL user to support them with the signs as I truly believe that signing instruction should be delivered with the support of a signer to ensure that signs are taught accurately. The books will act as a reminder once this support has been sought.

Children are offered the stories with the signs followed by interactive and repetitive activities allowing time for practice. The activities/lesson plans are both clear and well structured. Children will soon become clear about how the sessions work as they tend to follow a similar format-recognition, repetition, recall and reuse.

There are 12 topics covered including: Zip and the Rainy



Day; Zip and the Party; Zip at the Seaside; Zip at the Supermarket; Zip and the Outdoor Adventure etc. These lessons cover themes including fingerspelling, greetings, numbers, colours, school, animals, transport, emotions and the weather.

I also feel that if a school has a Sensory Resource Base and the signing students wish to hold their own signing club this would offer a very good structured resource to support them covering topics over a term. This will also develop their communication skills and confidence in their own Deaf Identity.

I enjoyed looking at this resource and feel with some adaptation to include local signs alongside these signs would be useful and also show that signing, like speech, has its regional semantics.

I feel that the Service I work for could use this for some of our Deaf Awareness sessions using our regional signs. Our own graphic visualisers will help to create graphics of our signs to use alongside the books.

Summary – marks out of 5

Quality	4/5
Value for money <i>(expensive initial expense but once bought can be reused)</i>	4/5
Educational usefulness	5/5
Overall	4/5

Our new reviewers



Joanne Kelsey-Taylor is a QToD at IPaSS Hull and is our new book review editor co-ordinator.

Member of the review team

Hannah Morgan, Senior Specialist Teacher for Hearing Impairment, Integrated SEND Team, Buckinghamshire.

Regions and nations

Enables members to see what is happening in the other nations and regions

BATOD Northern Ireland
28 August 2019
Beyond diagnosis – Developing the professional toolkit for meeting the needs of sensory impairment profiles
Presentations on the BATOD website

BATOD Cymru
21 October 2019
Promoting health and well-being in deaf education

BATOD Scotland
16 May 2020
Title to be confirmed
Dr Kai Uus
Premier Inn, Glasgow
batodscotland@batod.org.uk

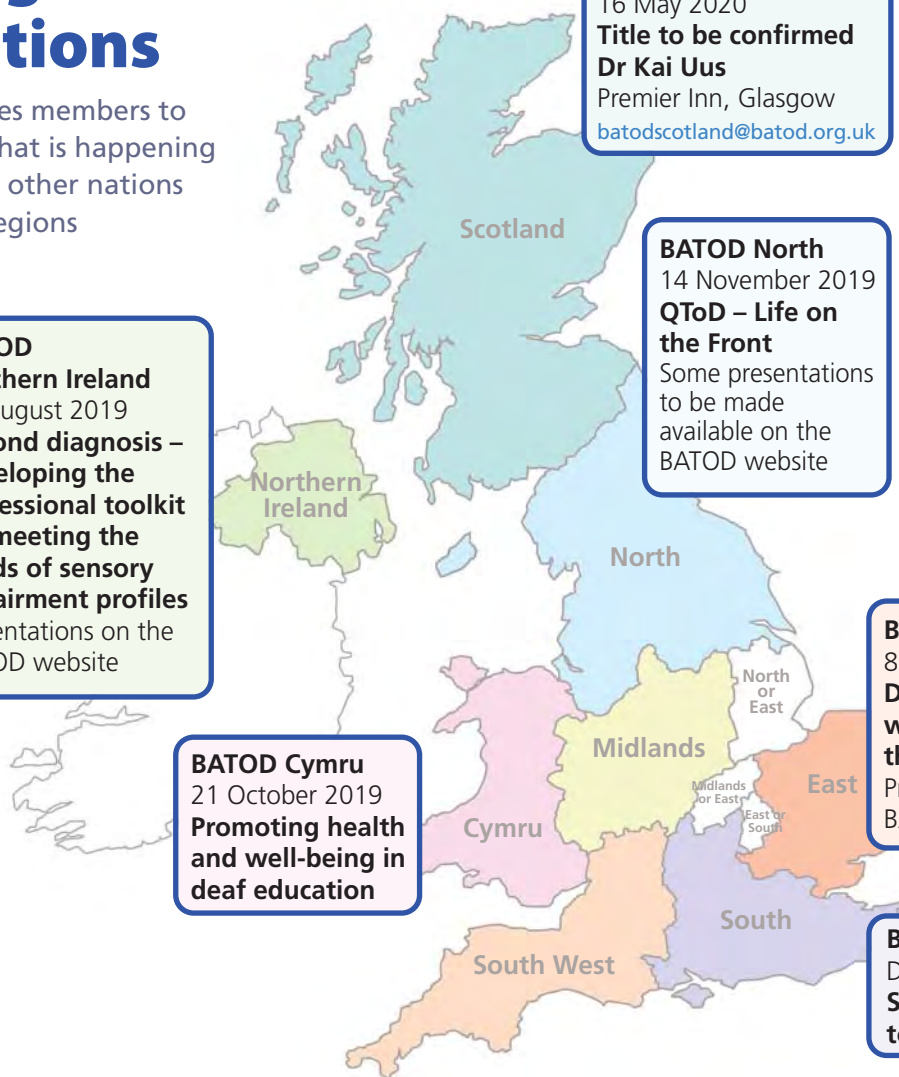
BATOD North
14 November 2019
QToD – Life on the Front
Some presentations to be made available on the BATOD website

BATOD National
14 March 2020
Frank Barnes School
Researching the future
Booking form now open!

BATOD SIG
6 November 2019
York
Deafness and Autism
We will announce when presentations are available on the BATOD website – watch this space

BATOD East
8 July 2019
Developing good practice for working with deaf children, their families and schools.
Presentations available on the BATOD website

BATOD South
Date to be confirmed
Supporting access to the curriculum



BATOD was there representing you...

Between the NEC meetings, members of BATOD attend various meetings that are of particular interest to Teachers of the Deaf. This list is not exhaustive. Your representatives at the meetings listed (as known at the time of writing) included: David Couch, Sue Denny, Steph Halder, Derek Heppenstall, Teresa Quail, Paul Simpson, Tina Wakefield.

Date	External participants	Purpose of meeting	Venue
November			
1	Institute of Apprenticeships	Meeting re SIMQ	DfE, London
5	Ofqual	Development of accessibility guidance	Ofqual, Coventry
6-8	Kentalis	Teaching Deaf Learners Conference	The Netherlands
21	University of Hertfordshire	Programme committee meeting	Mary Hare School
21	Ewing Foundation	GLADE Study day	London
December			
4	National SEND forum	Regular meeting	London
5	Phonak	Education Workshop	London
13	NatSIP	Reference group	SENSE, London
17	NDCS	Regular meeting	NDCS, London

Please inform the National Executive Officer, Paul Simpson, if you know of any meetings where you feel representation on behalf of Teachers of the Deaf would be of benefit. Although there is no guarantee that BATOD would be able to attend every meeting, situations could be monitored and the interests of ToDs represented.

BATOD membership

BATOD activities are funded from your membership fee and some advertising income. Colleagues who share your Magazine and Journal also benefit from BATOD negotiations with government and other influential bodies – but they are not contributing! Persuade your colleagues to join BATOD and you will receive 10% of their membership fee as an ‘introduction fee’.

Full details of membership are available on the website and new members are able to join online at www.batod.org.uk

ToDs in training will be entitled to a £20 reduction in annual membership fee. This applies for the two years of the course.

The BATOD Treasurer may be contacted via treasurer@batod.org.uk

Officers of Nations and Regions

Northern Ireland batodnireland@batod.org.uk

Chairperson: Clare Bateson
Secretary: Rebecca Millar
Treasurer: Margaret-Anne Christie

Scotland batodscotland@batod.org.uk

Chairperson: Jean McAllister
Secretary: Hazel Kellachan
Treasurer: Elaine Harris

Cymru batodcymru@batod.org.uk

Chairperson: Jayne Taylor
Secretary: Lisa Whitney
Treasurer: Rhian Gibbins

East batodeast@batod.org.uk

Chairperson: Claire Gamon
Secretary: Liza O'Donnell Thorpe
Treasurer: Becca Citroen

Midland batodmidland@batod.org.uk

Chairperson: Angie Wootten
Secretary: *Post vacant*
Treasurer: Helen Cooper

North batodnorth@batod.org.uk

Chairperson: Claire Jacks
Secretary: Trish Cope
Treasurer: Sandy Goler

South batodsouth@batod.org.uk

Chairperson: Majella Williams
Secretary: Lisa Durrant
Treasurer: Heather Latter

South West batodsouthwest@batod.org.uk

Chairperson: Helen Maiden
Secretary: Jo Saunders
Treasurer: Sarah Wardle

BATOD contacts and Magazine Distribution

Articles, information and contributions for the Association Magazine

should be sent to:

BATOD Assistant Executive Officer: Teresa Quail
Email: batod_aneo@icloud.com Tel: 07506 400280

Association information and general queries

Contact: Paul Simpson
Email: batod_neo@icloud.com Tel: 07506 400270

Advertisements for the Association Magazine

should be sent to:

Teresa Quail, BATOD Advertising Manager
Email: advertising@batod.org.uk Tel: 07506 400280

BATOD Magazine distribution by:

Lynne Harris, Menzies Response, The Boulevard, Orbital Park, Ashford, Kent TN24 0GA

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For full guidelines for submissions and abstracts of papers published in the Journal, plus any other enquiries related to the Journal, please contact Rachel O'Neill Email: rachel.oneill@ed.ac.uk

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