British Association of Audiovestibular Physicians

Manual for producing guidelines

Clinical Standards Subcommittee

approved by

BAAP Executive Committee

1st Version: February 2016
This Version: February 2021

Index

Introduction

1.1 British Association of Audiovestibular Physicians [BAAP]

BAAP is a professional association of doctors practising Audiovestibular medicine [AVM]. Its aim is to provide a forum for doctors in Audiovestibular Medicine to discuss issues relevant to their profession. Consultants from any discipline whose practice is predominantly in Audiovestibular Medicine in the British Isles are eligible for full membership of BAAP. Associate membership is open to Staff and Associate Specialists and junior doctors whose practice is predominantly in Audiovestibular Medicine. BAAP has various subcommittees including one on Clinical Standards. Appendix 1 details the constitution of BAAP.

1.2 BAAP Executive Committee

The BAAP Executive Committee is formed of the Officers of BAAP [President, Vice President, Honorary Secretary, Honorary Treasurer and Immediate Past president], the Chairmen of the Audit, Education, Clinical Standards and Publicity and Recruitment sub-committees and the Chair of the Specialist Advisory Committee. The Executive Committee meets at least thrice a year [a quorum is five members with at least two Officers present] and has various functions including making decisions on behalf of the BAAP membership. Decisions of the Executive Committee are made by consensus. In exceptional circumstances, a vote by a show of hands may be used to resolve a difference of opinion. The Honorary Secretary keeps minutes of the proceedings.

1.3 BAAP Clinical Standards Subcommittee [CSS]

The CSS is involved in producing clinical standards and guidelines. The Chairman of the CSS is elected by a secret ballot of the full members at the AGM. The Chairman assembles a sub-committee of at least four members, recruited from the BAAP membership. The Chairman provides a report of the activities of the group for the annual general meeting.

1.4 BAAP Guidelines

BAAP guidelines cover a range of topics of clinical importance. BAAP guidelines are designed to give guidance in the United Kingdom. They could be applied worldwide depending on local availability of clinical expertise, test facilities and resources. The intended users of these guidelines are health practitioners with a special interest in Audiovestibular medicine. The guidelines aim to

- Provide up to date advice on effective clinical practice
- Support staff in improving and benchmarking Audiovestibular medicine services
- Identify audit measures for performance and review of Audiovestibular medicine services
- Promote patient safety and implementation of clinical governance.

BAAP guidelines are based on the best available evidence although this may be of poor quality in many areas of clinical practice. It is hence important that robust methods are followed to develop guidance irrespective of the level of available evidence. The process of formulating these guidelines was reviewed in 2013. The 1st manual was produced in February 2016 to streamline the process of updating these guidelines and toensure that any new guidelines are developed systematically to these processes.

1.5 BAAP guideline manual

This manual details the principles and process to be followed in developing and updating the BAAP guidelines. The aim of this manual is to

- Act as a reference for any future guidelines written by BAAP
- Summarize the guideline making/updating process for all users of the BAAP guidelines
- Collate recent developments into the guideline making/updating process

The Chair of the Clinical Standards Subcommittee is responsible for reviewing and, if required, updating this manual every three years. The writing of this manual has been informed by the Guideline Development Policy Manual of the Renal Association [2010], the British Society for Allergy and Clinical Immunology Guideline Production Manual [2012] , the NICE Accreditation manual 2012 and the NICE Accreditation process manuals –Renewal 2021

[2] Initiation of the guideline making process

2.1 The topic for the guideline

These topics cover the main areas of clinical management of patients with audiovestibular symptoms. The topic of the guideline as related to the clinical setting is detailed within each specific guideline. Relevant healthcare and social circumstances are detailed within the guideline. The topics can be suggested by BAAP members and are evaluated for clinical need, available evidence, available resources and importance in patient outcomes. The topics are discussed at the BAAP AGM [held once a year] and approved by the BAAP membership or they may be discussed in the BAAP executive meetings [held thrice a year] and approved by the executive board.

2.2 The Guideline lead

A guideline lead is proposed by the Chair of the Clinical Standards committee in consultation with the executive committee members. The guideline lead is either a full or Associate member of BAAP and should have specialist knowledge in the area of the guideline topic. Once appointed the guideline lead will be familiarised with the process of guideline development. The Guideline lead is responsible for forming the Guideline group and naming the Guideline authors.

2.3 The Guideline group

The Guideline lead and the Chair of the Clinical Standards Committee draw up a list of members and a lay representative(s). These members are invited by the Guideline lead to form a 'Guideline group'. There will be between 3-6 members in a guideline group. All guideline group members [except the lay representative] are healthcare professionals with specialist knowledge in the guideline topic. They may be adult or paediatric AVM Consultants, physiotherapists, psychologists, ENT surgeons, Paediatricians, or specialist trainees. Guideline group members may or may not be full or associate members of BAAP. The lay person may be a member of a related charity (e.g. National Deaf Children's Society) or a patient with audiovestibular symptoms or the parent of a child with audiovestibular symptoms. Each member within the Guideline group is allocated a set task by the guideline lead according to their particular area of expertise. The work of the Guideline groups is supported by the Chairman of the CSS.

The work undertaken by the Guideline group members is on an honorary basis. BAAP does not seek external funding for the production of its guidelines. BAAP is funded by subscription of its members. Any administrative support for dissemination of the guidelines comes from BAAP itself.

The Guideline lead determines the 'authors' of the guideline, based on their expertise and knowledge. Named authors will need to have given substantial input to the drafting of the final guideline.

2.4 Conflicts of interest policy

All members of the Guideline group will declare their current and potential conflicts of interest in the acknowledgement section of the guideline. These are taken into consideration when choosing the Guideline group. None of the members of the guideline group will have any financial gain from the recommendations in their guidelines. The guideline group will have editorial independence from any funding body. If there is any overt conflict of interest, this will be managed by discussion at the BAAP Executive meeting. A register of interests will be maintained as necessary. All members of the guideline group will electronically sign the declaration of interests andthe agreement to confidentiality (see Appendix 2, 3). The Chairman of the CSS and the Guideline lead are responsible for assessing and managing any conflicts of interest on the guideline.

Details about declaration of interests of the Guideline Group members will be provided on request. The Guideline Lead will not have any conflicts of interest. If they are found to have any, then the Guideline Lead will be replaced. If any of the other Guideline group members have a conflict of interest, the relevant decision is taken by the other members of the Guideline group, and the member with a conflict of interest is not included in the particular recommendation. In the event that a conflict of interest arises unexpectedly during a meeting, the relevant member will be

excluded from the decision. This is decided by the guideline lead together with the other guideline members.

Currently there is no provision for funding the writing of the BAAP guidelines and the guideline making process is completely voluntary. The Chairman of the Clinical Standards Subcommittee, members of the BAAP Executive board and members of the Guideline Group (including the Guideline Lead) volunteer their time for this work and have no financial remuneration for the same. All members of the Guideline Group and BAAP Executive are hence financially independent. The BAAP Membership fees fund the organisation.

The lay member on the Guideline group is selected from parents of affected children or patients themselves. The selection is made by either requesting individual parents/patients known to the Guideline group members randomly or by requesting Voluntary organisations or local Parent /Patient organisations to put forward names of parents/patients in a random way. The lay member must be able to devote the time to input into the guideline and be prepared to work voluntarily without financial help. The lay member is recruited on a 'first come' basis. The input of the lay member is financially independent. '

[3] The process of guideline development or update of an existing guideline

3.1 The process of guideline development

- The clinical scope of the guideline and the areas to be included and excluded are developed by the guideline lead with help of the guideline group members.

- A timeline for the outline and a first draft of the guideline should be agreed.

- The guideline group performs a literature search to identify and critically appraise the supporting evidence. The guideline group will also consider the cost benefit of the guideline at this stage if this data is available.

- A draft of the guideline is produced following the literature search. Recommendations in the guidelines are linked to the evidence.

- Each member of the guideline group will grade the evidence from the literature searches that they have conducted individually. The grading of evidence will be detailed in the guideline. The grade of recommendation is decided on the basis of the strength of evidence as detailed in the guideline. The guideline authors will review the strength of the evidence and reach a consensus to grade the recommendations in the guideline after a discussion. The guideline draft is circulated to the guideline group to review the strength of recommendations before the first consultation. If there is any discrepancy in the opinion about the strength of recommendations, this will be resolved by discussion and voting within the guideline group. The voting will be decided by a simple majority and these results will be detailed in an Appendix within the guideline. If the

discussion and voting do not lead to a majority decision, the BAAP Exec committee will be invited to intervene by voting and this decision will be detailed in an Appendix within the guideline.

- The first draft of the guideline is open to consultation for 4 weeks. Consultation is open to membership of BAAP, stakeholder representatives and the lay representative/s. The stakeholders and lay representatives are identified by the guideline group with input, if necessary from the Chair of the CSS and the BAAP executive. These members/groups are invited by email to submit responses to the consultation to the Guideline lead.

- The responses to the first draft, once received are discussed with the Guideline group and Chairman of CSS and incorporated in the guideline draft where appropriate. Expert advice is sought from other groups (e.g. ENT surgeons, Paediatricians, Physiotherapists, Psychologists] as necessary.

- The Guideline lead will send the final draft of the guideline with a summary of the key changes following consultation to the Chairman of the CSS within 1 month of the deadline for receipt of comments on the first draft.

- The final draft of the guideline is circulated by the Chairman of the CSS to the BAAP executive. At least two members of the BAAP executive will read the final draft of the guideline in detail and provide feedback to the Chairman of the CSS and the Guideline lead. A second draft of the guideline is then prepared by the Guideline lead. As a part of the external review, an expert in the field will be invited to scrutinize and comment on the second draft of the guideline. The expert reviewer will be chosen after discussion within the guideline group and will be required to declare their conflict of interests. Should there be any conflict of interest, their review will not be considered and an alternate expert chosen. The comments of the expert reviewer will be reviewed and agreed by the guideline authors before inclusion in the final draft of the guideline. If there is concern or disagreement over the comments of the expert reviewer, the other members of the guideline group will be invited to vote on inclusion of the comments by the expert reviewer. The vote will be decided by a simple majority. Under exceptional circumstances where no consensus can be reached, the opinion of a different expert reviewer will be sought. The choice of the second expert reviewer will be made after discussion within the guideline group. A similar process will be followed for inclusion of their comments in the guideline.

- A final draft of the guideline is prepared by the Guideline Lead following feedback from the expert reviewer and is sent electronically for approval to the BAAP executive committee.

- The final version of the BAAP guidelines are published on the guidelines page of the BAAP website with the notice of the date of publication and planned review. The BAAP membership is informed electronically of the date of

publication of the guidelines. The guideline will be submitted to NHS evidence for publication

- A summary of audit measures is identified within each BAAP guideline. These measures may serve to indicate quality improvement of services.

3.2 The Literature / Evidence

BAAP guidelines provide clinical guidance on patient management based on the best available evidence. The literature searches will follow these principles:

- The guideline will have a defined search strategy which is published in anabbreviated form in the final guideline

- The dates covered by the literature search are stated clearly in the finalguideline

- Reference searches are run with appropriate key words provided by the Guideline group. The search will also include data on cost benefit if available. The keywords are published in the final guideline. These are guided by questions using the PICOT format

  - Population to which the question applies
  - Intervention (e.g. or diagnostic test, exposure etc.) being considered in
  - relation to thispopulation
  - Comparison(s) to be made between those receiving the intervention and those who do not receive the intervention
  - Outcome(s) i.e. any effect caused by the intervention
  - Timeframe (optional)

- The literature searches are carried out by the members of the Guideline group themselves. Where available, librarians may be requested to perform literaturesearches

- The literature search will involve, as a minimum a search on Pubmed, Medline and Embase and a review of Cochrane Library Database and Clinical Trials database. All relevant RCTs, systematic reviews and meta-analyses will be reviewed. Articles not available in English or only available in abstract forms are excluded. In many areas in Audiovestibular medicine, high quality evidence is not available and many recommendations may be based on observational studies. This evidence will be included. Evidence from case reports and review articles is generally excluded. In exceptional situations, if it is included, this will be detailed with the reasons for inclusion, in the search strategy in the final guideline. Where relevant, guidelines from other relevant national and international organisations will be reviewed e.g. British Society of Audiology. The literature search will include data on cost benefit of the guideline

- After the initial literature search, the reference list is scanned by a member of the Guideline group to include relevant articles. A second review of these articles by one to three members of the Guideline group evaluates their abstracts and identifies the list of references where a full text of the paper is required. Full texts are obtained from institutional or electronic library subscriptions or memberships or Journals/books held as personal copies by guideline group members. The librarians can help in requesting full text articles. One of the Guideline group members then compiles a database of references relevant to the guideline

- All the articles used in preparing the guideline will be tabled and graded for level of evidence [Appendix 4,5] in the interests of transparency.

- The level of evidence supporting each recommendation will be mentioned in the guideline. This will provide an informative and transparent summary for clinicians and policy makers. This approach permits the development of guidelines in the absence of a high level of evidence such as a randomized clinical trial.

- Where evidence is poor, there will be a discussion between members of the guideline group with input from Chairman of the CSS. Recommendations maybe put forth to the BAAP executive for further discussion if there is no consensus within the Guideline group.
  - If consensus cannot be achieved, a voting system will be employed

- Lack of evidence should be noted in the recommendations for future research at the end of each guideline.

3.3 Layout of the guidelines

- A template for BAAP guidelines is given in Appendix 6. All sections of the guideline are clearly numbered for clarity.

- A summary of the guideline provides a list of all recommendations for ease of use and serves as a quick reference guide.

- The search strategy, search key words, dates of search and methods should be described.

- The grading of evidence and recommendations will be detailed.

- The background details the rationale for the development of the guideline. Links to previous versions of the guideline will be described when appropriate

- The guideline itself will be clear and unambiguous about recommendations. The various options for investigation/management will be presented.

- Each guideline will include audit measures to promote an improvement in the quality of care. The audit measures should be specific, measurable and achievable.

- Significant contributions to the guidance should be acknowledged. All co-authors should provide declarations of interest. Where these exist they will be managed by the Chairman of the CSS in accordance with the Conflicts of Interest Policy.

3.4 Other factors for consideration

- Management of Audiovestibular conditions may be limited by resources, organisational factors and availability of suitably trained professionals. They are influenced by patient/parent choice. Although BAAP guidelines are based mainly on clinical effectiveness, they will consider resource implications and parent/patient choice. The cost benefit of the guideline will be considered if such data is available. Effort will be made to acquire such data by future audit and research if none is available.

- The BAAP guidelines will consider the risks and health benefits of implementing the guideline. These will be detailed in the guideline document

- The BAAP guidelines will not make any recommendation which may prejudice clinical care based on gender, age, ethnicity or socio-economic status.

3.5 Lay/patient input

Each guideline should have input from a lay person/ parent of affected child/affected patient. This is to ensure that

- The guideline is sensitively worded,
- Issues that matter to patients are considered in the guideline
- Parent/patient choices are acknowledged in the guideline
- There is advice on sources of further information [e.g. parent/ patient information leaflets] in the guideline

[4] Availability and Dissemination of BAAP guidelines

BAAP guidelines are made available on the BAAP website for free access. Education and Training for the BAAP guidelines may be covered in BAAP conferences, audit meetings and specific courses which are advertised on the BAAP website. BAAP supports national audit to assess the implementation of these guidelines. Areas for audit will be identified in each guideline. The Audit subcommittee of BAAP will take the lead in organising and supporting these national audits. Results of any national audits will be considered when updating the guidelines.

BAAP guidelines will be submitted for publication in NICE Evidence services. They may also be submitted for publication by an appropriate Journal for dissemination to other interested healthcare professionals. The guidelines will be peer-reviewed by the journal before publication. Reviewers are frequently from an international panel, selected by the journal editor and stay anonymous. This adds a further layer of scrutiny by experts in the field.

[5] Support tools for BAAP guidelines

There will be an attempt to produce patient/parent information on the BAAP guidelines. This information may be produced by BAAP, or may be available from other sources e.g. NDCS. This information will be written in simple, clear language free of medical jargon.

[6] Revising the guidelines

All BAAP guidelines will be revised every 3-5 years or sooner if the evidence base to the guidelines has changed. The revision may be triggered by new developments or new guidelines from other organisations. Two years after publication of the guideline, the Chairman of the CSS will consult with the guideline authors and guideline group about the need for an early update of the guidelines. Each member of the guideline group will be asked if they have come across any new advances or developments that may trigger an early update. No literature review is undertaken, but this opinion will rest on the general awareness of the guideline group members about the advances in the specialty. A vote will be taken by the Chairman of the CSS within the guideline group and a simple majority would decide if the guideline needs an early upgrade. If no significant additional evidence is available, the CSS may decide to postpone the revision of the guidelines for a further 1-2 years. This decision has to be approved by the BAAP executive committee. The process of revising the guidelines will be the same as the process for making new ones.

Date of review of guideline manual: February 2024

[7] References

1. National Institute for Health and Clinical Excellence –‘ Accreditation process manual – renewals , 2021

2. AGREE II (Appraisal of guidelines for research and evaluation), 2009www .agreetrust.org

3. British Society for Allergy and Clinical Immunology Guideline Production ManualAugust 2012

4. Renal Association Clinical Practice Guidelines Guideline Development Policy Manual June 2010

5. National Institute for Health and Clinical Excellence – ‘The guidelines manual’ DraftMarch 2012

[8] Appendix list:

Appendix 1: BAAP constitution
Appendix 2: Declaration of interest form
Appendix 3: Confidentiality agreement
Appendix 4: Grading the Evidence
Appendix 5: Grading the Recommendation
Appendix 6: Template of BAAP guidelines
Appendix 7: Summary of process

Appendix 1

The Constitution of the British Association of Audiovestibular Physicians

1. DESIGNATION
Thebody should betermed the British Association of Audiovestibular Physicians, hereinafter termed the Association.

2. AIMS
2.1 The aims of the Association are:
2.1.1 To provide a forum for doctors in Audiovestibular Medicine to discuss issues relevant to their profession;
2.1.2 To provide information and/or opinions relevant to Audiovestibular Medicine to other bodies or agencies asappropriate;
2.1.3 To concern itself with training in the specialty at all levels by supporting the Specialist Advisory Committee in Audiovestibular Medicine at the Royal College of Physicians (RCP) and the Audiovestibular Medicine Post-Graduate Medical Training Committees;
2.1.4 To set the professional and clinical standards for doctors working in the specialty through regular communication with RCP and Royal College of Paediatrics and Child Health (RCPCH) and take the lead in auditing practice against those standards;
2.1.5 To support the continuing professional development of members by organising regular academic meetings;
2.1.6 To disseminate information about the specialty;
2.1.7 To promote multidisciplinary working by maintaining links with other professional bodies and agreeing pathways of clinical care;
2.1.8 To develop and promote evidence-based high quality patient care.

3. MEMBERSHIP
3.1 All consultants from any discipline whose practice is predominantly in Audiovestibular Medicine in the British Isles shall be eligible for full membership of the Association.
3.1.1 Any Audiovestibular Physician who has completed UK Training in Audiovestibular Medicine, having obtained their CCT, CST, CESR orequivalent, shall be eligible to apply for full membership of the Association, even if they are not in a

substantive Consultant post. Having once been admitted to full membership, any such member would be obliged to retain that status and would not have the option of reverting to associatemembership.

3.2 Associate membership shall be open to Staff and Associate Specialists and junior doctors whose practice is predominantly in Audiovestibular Medicine. Doctors working overseas in the specialty may be admitted as associate members. Associate members may attend business meetings but have no voting rights.

3.4 The Executive Committee may award Honorary Life membership to those considered to have made a significant contribution to the specialty.

3.5 Membership of the Association, other than Honorary Life membership, will automatically include membership of the International Association of Physicians in Audiology (IAPA).

3.6 Retired membership ofprevious full orassociatemembers is available on request.

4. SUBSCRIPTION

4.1 All members shall pay an annual subscription fee as determined from time to time at the annual general meeting. The full subscription includes the subscription for IAPA.

4.2 There will bedifferential subscription rates for Associateand Retired membership.

4.3 The subscription shall fall due on 1st January annually.

4.4 A reminder shall be sent by the honorary treasurer to those who have not paid by the follo wing 1st March and if the subscription has not been paid by the follo wing 31st December i.e. they are one year overdue, their membership will be terminated.

5. OFFICERS

5.1 The Officers of the Association shall be the President, Vice President, Honorary Secretary, Honorary Treasurer and the immediate Past President.

5.2 The President, the Vice President, the Honorary Secretary and the Honorary Treasurer shall serve for a period of three years commencing at the end of the AGM at which appointed.

5.3 The Vice President shall normally become President on the expiry of the latter's term of office, the President then becoming Past President and normally serving for three further years in that capacity.

5.4 The Vice President, Honorary Secretary and Honorary Treasurer will beelected by a simple majority vote at the AGM.

5.5 The Honorary Treasurer and Honorary Secretary may stand for re-election for one further three year term.

5.6 In order to provide for continuity, in the event of the terms of office of Officers ending simultaneously, those of the Honorary Secretary or Honorary Treasurer may be extended by one year.

6. ELECTION OF OFFICERS

6.1 The Honorary Secretary shall inform all members of the Association of the expiry of terms of office of the Officers of the Association not less than one year before the expiry date.

6.2 Nominations for Officers should be sent by any full member of the Association to the Honorary Secretary not less than four months before the expiry of the terms of office. In the event of no nominations being received, the Executive Committee will propose a candidate.

6.3 Each nomination should be seconded and accompanied by an agreement from the nominee to stand for that office.
6.4 If there is more than one nomination for an office there will be a secret ballot of the full members of the Association at the AGM. The candidate with the majority of votes will be elected.
6.5 In the event of a tie, the President shall have the casting vote.
6.6 Only full members are eligible to be elected as Officers of the Association.

7. EXECUTIVE COMMITTEE

7.1 An Executive Committee shall be established comprising the Officers of the Association, the Chairmen of the Audit & Governance, Education, Clinical Standards and Promotion & Recruitment sub-committees, the Chairman of the Specialist Advisory Committee. A specialty registrar (elected by the registrars) shall serve on theCommittee but will not have voting rights and may be asked to leave any meeting ofthe Committee when requested to do so by that meeting's chairman, for the discussion of any reserve business.
7.2 The powers and functions of the Executive Committee shall include the following:
7.2.1 To make decisions on behalf of the membership;
7.2.2 To incorporate any decisions made into Officers reports which are presented at the next full meeting of the membership;
7.2.3 To consider applications for membership and accept or reject as appropriate;
7.2.4 To prepare the agenda for meetings of the Association;
7.2.5 To respond to queries from outside agencies;
7.2.6 To award prizes of the Association;
7.2.7 To invite members of the Association to represent the Association on other professional committees as and when required;
7.2.8 To promote and nominate members of the Association for appropriate positions and awards.
7.3 The Executive Committee shall meet at least three times per year.
7.4 The meetings shall be called by the President at his or her discretion or when requested to do so by another member of the executive committee.
7.5 The members of the Executive Committee and those invited to attend the meeting shall have at least 6 weeks' notice of meetings.
7.6 Other members of the Association may be invited to attend the meetings in order to provide appropriate advice or information, but will not have voting rights.
7.7 A quorum shall be five members with at least two Officers present.
7.8 Where ever possible decisions of the Executive Committee should be by consensus. In exceptional circumstances, a vote by a show of hands may be used to resolve a difference of opinion.
7.9 The Honorary Secretary shall keep minutes of the proceedings and decisionsmade at all Executive Committee meetings and copies of these minutes will be circulated to all Executive members and anyone who attended the meeting by invitation. Once agreed by the Executive Committee, the minutes will be available to members on request and will be posted in the Members' Area of the website.
7.10 The Honorary Secretary shall prepare a list of all members representing the Association on outside professional committees and present it to the Annual General Meeting.

8. SUB-COMMITTEES

8.1 The sub-committees of the Association will be:

- Audit & Clinical Governance
- Education
- Clinical Standards
- Promotion & Recruitment

Additional sub-committees may be set up as required by the Executive Committee. The Hallpike committee shall be a subgroup of the Education sub-committee; its Chairman shall liaise with and report to the Chairman of the Education sub-committee.

8.2 Election to the Chair of a sub-committee is by nomination by any full member of the Association, seconded by a full member and with the agreement of the nominee, follo wed by a secret ballot of the full members at the AGM. The Chairman will hold office for three years and may be elected for a second term.

8.3 The Chairman will assemble a sub-committee of at least four members of whom one will be selected to be secretary. Each sub-committee should include a specialist registrar. The Honorary Secretary shall be informed of the composition of the sub-committee.

8.4 The Chairman of each sub-committee shall call as many meetings of their sub-committee as is required for the completion of their designated tasks.

8.5 The Chairman of each sub-committee will provide a report of the activities of their group for the AGM.

8.6 Any member of the Association may be invited by the Executive Committee to represent the Association on other professional committees or representative bodies as and when required (see 7.2.7 above).

8.7 Any member who is absent from work due to permanent or temporary suspension (for whatever reason), lack of success in revalidation, or long term (more than three months) sickness, may not:

- be eligible to be nominated for election as an officer of the Association or as chairman of one of the sub-committees of the Association;
- be invited to serve on any sub-committee of the Association;
- be invited to represent the Association at any level.

8.7.1 Any such member who is already serving in any of the capacities mentioned above should cease to do so within a maximum period of one month (or three months in the case of sickness) and should inform the Executive Committee of their situation. The Executive Committee should decide upon the need for their temporary or permanent replacement according to the immediate and longer-term needs of the Association.

8.7.2 Any such member may continue to be a full member of the Association and would continue to be welcome to attend and participate in all meetings of the Association, including the AGM, and to vote in elections.

9. ANNUAL GENERAL MEETING

9.1 There shall be one annual general meeting of the Association each year.

9.2 Meetings shall be open to all grades of membership. The exception to this will be those items of the agenda which may be designated as “Reserve Business”. Such a

designation will be by the agreement of the Officers and will only be discussed by full members.
9.3 Members must be notified of meetings at least three months beforehand.
9.4 An agenda for each meeting shall be agreed by the Executive Committee and distributed to the members at least two months before the meeting.
9.5 The decisions taken at the AGM shall be written down as minutes and circulated to members as soon as possible after the meeting but not less than two months before the subsequent meeting.
9.6 In the absence of the President, the meeting shall be chaired by the Vice President: failing that, by the Honorary Secretary.
9.7 At least twenty full members including at least one of the Officers, must be present to constitute a quorum for a meeting.
9.8 Voting for Officers and Chairmen of sub-committees shall be by secret ballot.
9.9 All full members present will have the right to vote.
9.10 Decisions, other than election of Officers and chairmen of sub-committees, shall be determined by a simple majority of votes on a show of hands.
9.11 The President of the meeting shall have no voting power unless the votes are equal, in which case he/she will have the casting vote.
9.12 The business to be transacted at the AGM shall include:
9.12.1 Consideration of the annual report from the President;
9.12.2 Consideration of the annual report from the Honorary Secretary;
9.12.3 Consideration of the income and expenditure account and balance sheet presented by the Honorary Treasurer;
9.12.4 Election of Officers and Chairmen of sub-committeesasrequired;
9.12.5 Presentation of reportsby Chairmen of sub-committeesandrepresentatives of the Association on committees of other professional organisations.

10. EDUCATIONAL MEETINGS

10.1 Hallpike symposia shall beheld regularly.
10.2 Audit meetings will be held at least once a year.
10.3 There will be regular opportunities for Specialist Registrar presentations.
10.4 A conference shall be held each year.

11. FINANCE

11.1 The Honorary Treasurer shall keep proper accounts of all income and expenditure of the Association.
11.2 The financial year shall run from April to March.
11.3 The accounts shall be presented to the members at the AGM.
11.4 The Honorary Treasurer shall make recommendations on the subscription rates to be levied for each year to cover the running costs of the Association and these will be discussed and voted on at the AGM.

12. RELATIONSHIP WITH THE AUDIOVESTIBULAR MEDICAL FEDERATION

12.1 The Audiovestibular Medical Federation is a union between the Association and the British Association of Paediatricians in Audiology (BAPA). The Federation was formed in order to:
12.1.1 Present a shared political voice with regard to matters of national importance in paediatric Audiovestibular Medicine;

12.1.2 Provide information for commissioners and service providers about paediatric Audiovestibular Medicine in order to promote the specialty, maintain existing posts and create new posts where required;
12.1.3 Enable shared professional education and audit;
12.1.4 Enable peer support and review between the two associations.
12.2 The Association shall provide secretarial and financial support to the Federation to a level agreed by the Executive Committee.
12.3 Regular communication between the Officers of BAAP and BAPA shall occur. This will be either by attendance at executive meetings and at the AGMs of either association or bye-communication coincident with these meetings and as appropriate.
12.4 In order to encourage shared education and peer review between members of BAAP and BAPA, the following activities shall be supported and encouraged:
12.4.1 Joint national (paediatric) audit;
12.4.2 Mutual attendance at conferences and meetings of each Association;
12.4.3 Development of Guidelines and Clinical Standards.

13. AMENDMENTS TO THE CONSTITUTION

13.1 A resolution for the alteration of the constitution must be circulated to the membership at least 3 months before the AGM.
13.2 The proposed resolution shall be discussed at the AGM and the members shall then have the opportunity to vote by postal or e-mail ballot.
13.3 The resolution shall be carried if supported by two thirds of members of the Association voting in the ballot.
13.4 Were the specialty or the Association to change their name, the constitution would be amended appropriately to reflect these changes without needing the vote of the membership.

14. DISSOLUTION OF THE ASSOCIATION

14.1 Dissolution can only be considered at an AGM. The resolution may be proposed by the Executive Committee or on receipt by the Honorary Secretary of a written request signed by five full members of the Association.
14.2 A resolution for dissolution of the Association must be circulated to the membership at least 3 months before the AGM.
14.3 The proposed resolution shall be discussed at the AGM and the members shall then have the opportunity to vote by postal ballot.
14.4 The resolution shall be carried if supported by two thirds of the full members of the Association.
14.5 The Executive Committee will decide on the distribution of any assets of the Association.

15. INTERPRETATION OF CONSTITUTION

15.1 Any possible ambiguity that might arise in the constitution, or its application, shall be interpreted by Officers present at the particular meeting where such possible ambiguity arises.

Appendix 2

Declaration of Interests

Date
To all members of BAAP Guideline groups

It is important to ensure any potential conflicts of interest of those members involved in the BAAP Guideline groups are detailed and if necessary, addressed. BAAP will maintain a register of interests.

These interests fall into two categories detailed below:
- Personal – any fees (over £250) paid directly for: presenting at conferences, travel, expenses, various grants, writing literature, attending meeting/conferences.
- Non Personal – funds/fees that are made to the department for salaries, research, equipment, education.

With your signature on this form you affirm that the information you give is a true indication of interests. Please complete the attached form and return it to the Chairman of the BAAP CSS electronically no later than Date (usually at the beginning of a calendar year)

Yours sincerely

Chairman of CSS

Declaration of Interest Form for the period of 1st January – 31st December (previous year)

Please complete all sections on this form and return it to Chairman of the CSS even if you have nothing to declare.

Full name:_____

Please tell us all the BAAP Subcommittees/ Guideline groups you are a member of:

_____

I have no conflict of interest

Personal Benefits
This section includes payment/fees (over £250) eg: for lectures, advisory committees or consultancy services, either on a regular or irregular basis from which you will personally benefit. Benefits in kind should also beregistered.
Company
Reason for payment
Completed at the end of Dec(previous year) or to be continued.

Personal Travel Grants/Expenses for Conferences
etc. Company
Reason for the benefit

Personal Shares
Company Shares
Shares still held at 31st December previous year

Non-Personal Interests
For funds/fees that are made to your department for salaries, research, equipment, education etc. Also includes benefits in kind and fees for your own work if you do not benefit personally.
Company
Reason for support
Completed at the end of December 31st previous year or continuing?

Other potential conflicts of interest
Commercial interests of spouse/partner and membership of relevant outside agencies, organizations, including pressure groups etc.
Company
Reason for support
Completed at the end of December 31st previous year or continuing?

Additional interests for present year
Please list activities which you are sure will take place.
Company
Reason for support

I declare that the information I have given is a true indication of interests.

SIGNATURE: ……

PRINT NAME: ……

DATE: ……

Please return this by date (beginning of the year) to:
Chairman of BAAP CSS

Appendix 3

BAAP Confidentiality Agreement

This agreement covers all those who have sight of documents, or are party to discussions, relating to the development of guidelines before public consultation. This includes Guideline group members.

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1. I undertake to BAAP that I shall:

a. Keep all confidential information strictly confidential

b. Not use confidential information for any purpose other than participating in the deliberations of any BAAP Subcommittee

c. Not disclose any confidential information to any commercial industrial party without the prior written consent of BAAP and in the event that such disclosure is permitted I shall ensure that such party is fully aware of and agrees to be bound by these undertakings

d. Not disclose the deliberations of any BAAP guideline Subcommittee to any other person without the explicit consent of the Chairman of the Subcommittee.

2. The undertakings set out in paragraph 1 above ('the undertakings') shall not apply to the use or disclosure of information that:

a. At or after the time of disclosure or acquisition is in the public domain in the form supplied otherwise than through a breach of any of the undertakings, or

b. Was lawfully within my possession before its disclosure to me by BAAP provided that the source of such information was not bound by, or subject to, a confidentiality agreement with BAAP;

or

c. I am required to disclosure by any court of competent jurisdiction or any government agency lawfully requesting the same, provided that BAAP is notified in advance of such disclosure; or

d. Is approved for release by prior written authorisation from BAAP.

Signed ……..Date……

Print name…….

Appendix 4

Grading the Evidence [SIGN]

Level of evidence	Definition
1++	High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias
1-	Meta-analyses, systematic reviews, or RCTs with ahigh riskof Bias
2++	High quality systematic reviews of case control or cohort or studies High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
2+	Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
2-	Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
3	Non-analytic studies, e.g. case reports, case series
4	Expert opinion

Appendix 5

Grading the recommendation [SIGN]

Grade of recommendation	Type of evidence
A	At least onemeta-analysis, systematic review, or RCT ratedas 1++, and directly applicable to the target population; *or* A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population,
B	A body of evidence including studies rated as 2++ directly applicable to the target population, and demonstrating overall consistency of results; *or* Extrapolated evidence from studies rated as 1++ or 1+
C	A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; *or* Extrapolated evidence from studies rated as 2++
D	Evidence level 3 or 4; *or* Extrapolated evidence from studies rated as 2+
E [not contained in SIGN]	Recommended best practice based on the clinical experience of the guideline development group

Appendix 6

Template of BAAP guidelines

Title: ‘BAAP guidelines for ……’

Authors

Summary

Search Methodology

Keywords

Grade of evidence and recommendation

Background

Aim and Scope

Subjects

Guidelines with supporting rationale

Economic considerations for implementation of guidelines

Audit Measures

Future Research

References

Acknowledgements and Declarations of interest

Date of next review

Appendix 7

Process Summary

Process Step	Key responsible party
Selection and approval of Guideline topic	BAAP membership /BAAP Executive
Appointment of Guideline lead	Chairman of CSS + BAAP Executive
Formation of Guideline group	Guideline lead + Chairman of CSS
Declaration of interests and confidentiality	Guideline lead + Guideline group
Scope & Timeline of Guideline is mapped	Guideline lead + Guideline group
Literature search	Guideline lead + Guideline group
First draft	Guideline lead + Guideline group
Consultation	Stakeholders, BAAP membership, Lay representatives
Second draft	Guideline lead + Guideline group
Scrutiny by BAAP executive and Expert review	BAAP Executive and for Expert External reviewer
Final draft	Guideline Lead and group
Approval of final draft	BAAP Executive
Publication and dissemination	BAAP Executive