Quality Standards for Paediatric Audiology Services

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Membership of Steering Group

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Comments and feedback are welcome on the document.

Quality Standards for Paediatric Audiology Services

1. Introduction

1.1 It is widely accepted that permanent childhood hearing impairment can have a significant negative impact on a child's communication skills, social integration and educational progress. It is important that children with permanent childhood hearing impairment and children with persisting or recurring conductive hearing losses are identified early in order to provide those children and their families with appropriate intervention, support and advice.

1.2 The increasing prevalence of permanent hearing impairment throughout childhood, and the fluctuating nature of many conductive hearing losses, means that paediatric audiology services should have the capacity and appropriate skills, not only to identify and manage children referred from newborn hearing screening, but also to be able to offer timely assessments and appropriate management of confirmed permanent or temporary hearing deficits whenever there are concerns raised about a child's hearing.

1.3 It is important that individual paediatric audiology teams, irrespective of their service model, aspire and strive to deliver the best possible audiology care for children and their families. Those teams need to understand fully the minimum acceptable standards of care that children and their families can expect to receive on their journey through paediatric audiology services.

1.4 Quality Standards enable the quality of service to be evaluated and benchmarked across different services to identify target areas for service improvement focus.

2. Scope

2.1 These standards cover all aspects of the paediatric audiology services delivered by audiology services in Health and Social Care Trusts in Northern Ireland. They are based on the child and family's journey as they move

through the paediatric audiology service and are applicable to children and young people, from birth right through to 18 years old.

2.2 It is intended that these standards apply to all children, young people and families who access paediatric audiology services. This document aims to establish quality assurance throughout all aspects of the audiology process for children, young people and their families, regardless of where the service is delivered.

2.3 The standards acknowledge the important role of other healthcare services such as ENT and Auditory Implants, education, social services and the voluntary sector working with the audiology services to deliver the best possible audiology care for children and their families.

2.4 The standards concern those children who have been referred to audiology services and not children covered by other services such as newborn hearing screening or cochlear implants.
The Standards do however include specific criteria and evidence required to provide quality assurance of services providing diagnostic audiology assessment and follow-up following referral from the newborn hearing screening programme (identified in bold **NBSP**).

2.5 The standards are designed to improve service quality issues in clinical areas unique to audiology. Awareness of and compliance with statutory requirement is assumed, as is awareness and understanding of consent requirements. Standards for training in Safeguarding Children have not been included as these are covered by Health and Social Care Board Policies. Elements of service quality such as workforce planning or cleanliness of facilities are outside the scope of this work as they are expected to be addressed by local healthcare governance mechanisms.

2.6 For the purposes of this document “parent” is defined as any person who has parental responsibility.

3. Format

3.1 The following format was agreed;

3.1.(a) Each standard has a title, which summarises the area on which that standard focuses.

3.1.(b) This is followed by the **standard statement**, which explains what level of performance needs to be achieved.

3.1.(c) The **rationale** section provides the reasons why the standard is considered important.

3.1.(d) The standard statement is expanded in the section headed **criteria**, which states exactly what must be achieved for the standard to be reached and how the service will achieve this. Each criterion is expected to be met wherever a service is provided.

3.1.(e) The criteria are **numbered** to make the document easier to work with, particularly for the assessment process. Please note the number of the criteria is not a reflection of priority.

4. Quality Standards for Paediatric Audiology Services

The Quality Standards are arranged in the form of 8 standards:

Standard 1. Accessing the Service

Standard 2. Information Provision and Communication with Children, Young People and Families

Standard 3. Assessment

Standard 4. Audiology Individual Management Plan (IMP)

Standard 5. Hearing Aid Management, Selection, Verification and Evaluation

Standard 6. Skills and Expertise

Standard 7. Service Effectiveness and Improvement

Standard 8. Collaborative Working

Standard 1. Accessing the Service

Standard Statement	Rationale	Criteria
1a. All newborns, infants, children and young people are able to: 1. have clearly defined referral pathways to audiological services that are widely disseminated and reviewed regularly, 2. access the audiological services they require in a timely fashion, as quickly as any other specialist medical service, 3. conveniently access the services they require, 4. be seen if facilities that are fit for purpose,	Correct referral information results in more efficient use of available resources. Prompt identification of permanent hearing problems and subsequent intervention leads to improved outcomes for the child at a later date. Parents support the principle of early identification and intervention. Fluctuating hearing loss can have a disadvantageous effect on the child's development. Public Health principles promote delivery of services in appropriate facilities close to patients for their ultimate health benefit. To provide an equality based service audiology centres must allow for all different types of patients and their families to gain physical access to the	**Referral Pathways** **1a.1.** Clearly defined written referral pathways from all referral sources are in place, reviewed at least every **3** years, and disseminated to all potential referrers on a regular basis.
		Speed of Access **1a.2.** Routine new referrals for diagnostic hearing assessment are offered an appointment within **9** weeks of receipt of referral.
		1a.3. Urgent new referrals for diagnostic hearing assessment are offered an appointment within **4** weeks of receipt of referral.
		1a.4. Waiting times for referrals to Audiology are the same as waiting times for patients who are referred to other specialist medical services such as ENT.
		1a.5. The maximum waiting time from referral to fitting of hearing aid(s) should meet the targets (9 week diagnostic, 13 week fitting), regardless of the referral route and regardless of whether a patient is re-accessing the service or accessing it for the first time.

	service. Young people need a clear transition route from child to adult services.	**1a.6.** Children requiring follow-up hearing assessment/hearing aid reviews are offered appointments within an identified timescale.
		1a.7. Newborn Hearing Screening Programme (NHSP). Referrals from NHSP for diagnostic assessment are offered an appointment within the nationally agreed timescales.
		Flexibility of Appointments **1a.8.** Flexibility is available in appointment times, and where possible locations, to suit the individual needs and preferences of the parents and child or young person.
		1a.9. NHSP. Flexibility is available in appointment times, and where possible locations, to suit the individual needs and preferences of the family.
		1a.10. The audiology centres provide ease of physical access to all areas where audiology is delivered and are well signposted.
		1a.11. All accommodation and facilities must be in good decorative order and condition. All waiting, fitting and repair areas must be family and child friendly.

		Transition from Child to Adult Audiology Service **1a.12.** Robust systems are in place, used and regularly reviewed, to manage the transition from child to adult audiology services.
1b. Service demand and referral data are accurately monitored, reviewed and reported to guide service planning.	Effective allocation of health resources is reliant upon accurate information on the balance between demand for services and available resources. It is important that waiting times for all stages of the patient pathway are collected and monitored in an effective manner. The number of incorrect referrals to the specialist medical route informs the effectiveness/clarity of referral criteria and compliance of referrers to those criteria. Improvements can then be made to ensure that children are correctly referred to appropriate services.	**Service Planning** **1b.1.** Key data are identified, collected, reviewed and used in annual service review.
		1b.2. Waiting times are monitored based on robust data collection
		Monitoring of Service Referrals **1b.3.** The number of incorrect referrals to audiology is monitored annually, and action continuously taken to address any non-compliance with referral criteria.

Standard 2. Information Provision and Communication with Children, Young People and Families

Standard Statement	Rationale	Criteria
2a. Each service has in place processes and structures to facilitate communication with children, young people and families. Use of interpreters, and other interpreting services, should be in line with Health and Social Care Board policy.	Newborns, infants, children, young people and families need clear and timely information to facilitate attendance, reduce anxiety/concerns and encourage appropriate uptake of further concerns... Families need to be aware of ways to contact departments and professionals working with the child or young person. It is important that information is provided in an accessible and understandable format. Effective communication enables newborns, infants, children, young people and families to participate in the development of the Individual Management Plan (IMP) to understand information and make informed decisions.	**Written Information to Families Prior to Appointment** **2a.1.** Written information regarding the audiology appointment (directions or maps, parking facilities, appointment duration, procedures, and facilities) is provided as part of the appointment process. This will include a request to contact the department in advance if an interpreter is required.
		2a.2. NHSP. Newborn hearing screening specific letter is provided as part of the appointment process.
		2a.3. Families are provided with appropriate methods to contact departments including phone numbers and either text or email.
		Information Given After Assessment **2a.4.** Children, young people and families receive verbal explanation of the audiological assessment results, and supporting literature if required, on the same day that the assessment is carried out.

		2a.5. NHSP. Families receive verbal explanation of the neonatal and paediatric diagnostic hearing assessment results, and supporting literature, if required, on the same day that the assessment is carried out.
		2a.6. Children, young people and families are offered written information following appointments within **10** working days of the appointment.
		2a.7. NHSP. Following completion of newborn diagnostic hearing assessment, families are offered written information within **10** working days of the appointment.
		2a.8. Children, young people and families are routinely given information on support services (when appropriate) to include educational sensory service as well as local and national voluntary support groups for deaf children and young people.
		2a.9. NHSP. Families of babies referred by NHSP for further diagnostic tests and then subsequently identified with a hearing loss are routinely given information on support services (when appropriate) to include educational sensory service as well as local and national voluntary support groups for deaf children and young people.

		2a.10. Children, young people and families have access to information in their preferred language via the provision of translated material where possible.
		2a.11. NHSP. Families of babies referred by NHSP have access to information in their preferred language via the provision of translated material where possible.
		2a.12. Information is provided to young people on the transition process and future service provision.

Standard 3. Assessment

Standard Statement	Rationale	Criteria
3a. All referred newborns, infants, children and young people receive audiological assessment appropriate to their age and stage of development. There is a spectrum of audiology appointments from routine to more complex assessments. In some cases this may involve a multidisciplinary approach. The range of audiological assessments available enables definition of degree and nature of hearing loss.	Accurate and complete assessment is required to inform decisions and discussions regarding support and management options. It is important to be able to assess hearing status in children who may have other social, educational and medical difficulties; a multidisciplinary approach will assist with this. Parental involvement and that of the child or young person where possible, in the assessment and habilitation process improves outcomes. The quality of assessment is more likely to be assured if undertaken in accordance with nationally recommended procedures. Measures are compromised if not gathered using equipment calibrated to national and international standards and in a quiet test	**Comprehensive Assessment (Care Pathways)** **3a.1.** Local care pathways, with a comprehensive range of audiological assessments, are available.
		3a.2.NHSP. Local care pathways, with a comprehensive range of audiological assessments, are available.
		3a.3. All audiological procedures follow national standard/guidelines (e.g. British Society of Audiology (BSA) where these exist.
		3a.4. NHSP. All audiological procedures follow national standard/guidelines (e.g. BSA) where these exist.
		Assessment Equipment and Conditions **3a.5.** All equipment is calibrated at least annually and documented to international (ISO) standards.
		3a.6. Daily checks are carried out and documented, across all sites.

	environment.	**3a.7.** Hearing tests via headphones/insert earphones/bone conduction are always carried out in acoustical conditions conforming to national and international (ISO) standards.
		3a.8. Hearing tests performed in the sound field are always carried out in acoustical conditions conforming to national and international (ISO) standards.
3b. The assessment process should inform a clearly defined management plan.	Prompt, accurate and complete audiological information informs appropriate management, and amplification, as required.	**Assessment Process** **3b.1.** All assessments are interpreted taking into account the developmental status of the child and any co-existing medical conditions.
		3b.2. NHSP. All assessments are interpreted taking into account the developmental status of the child and any co-existing medical conditions following NHSP guidelines.
		3b.3. Written local protocols exist which define appropriate management options arising from the assessment (such as decisions to refer, review or discharge).

Standard 4. Audiology Individual Management Plan (IMP)

Standard Statement	Rationale	Criteria
4a. An audiology Individual Management Plan (IMP) is: 1. developed for each newborn, infant, child or young person, 2. agreed with parents and/or the child or young person, 3. updated on an ongoing basis, 4. accessible to the team members involved with the child's care.	An audiology Individual Management Plan (IMP) is required as each child needs to be treated as an individual case as circumstances, medical condition, audiological status and family needs will vary. There is evidence that families value joint working as it avoids duplication and there is less conflict of information. Parental involvement and that of the child or young person where possible improves outcomes. Regular revision allows the management plan to be responsive to the child's changing needs. It also gives the plan the flexibility to incorporate additional information for the benefit of the child's management.	**Developing an IMP** **4a.1.** The IMP includes an initial programme of audiological management (including provision of hearing aids where appropriate) and details of ongoing assessment as required.
		4a.2. NHSP. The IMP includes an initial programme of audiological management (including provision of hearing aids where appropriate) and details of ongoing assessment as required.
		4a.3. The IMP is agreed with the parents and/or the child or young person at each appointment and reviewed and updated at subsequent appointments.
		4a.4. NHSP. The IMP is agreed with the parents and/or the child or young person at each appointment and updated at subsequent appointments.
		Record of Service Provision **4a.5.** The IMP includes, where appropriate, service provision from those currently involved with the child and family.

		Further IMP Documentation **4a.6.** The IMP details any requirements families have for information, family support and practical advice.
		4a.7. The IMP is circulated to parents and relevant professionals, where appropriate, with the consent of the family.
		4a.8. The IMP follows the young person through transition and is available to the adult service.

Standard 5. Hearing Aid Management, Selection, Verification and Evaluation

Standard Statement	Rationale	Criteria
5a. All newborns, infants, children and young people using hearing aids should have access to all aspects of services they require in a timely fashion.	Appropriate fitting of hearing aids, coupled with good multidisciplinary and family support lead to better outcomes for the child or young person. Well fitting ear moulds are essential if hearing aids are to work to specification. Regular reviews allow monitoring of the newborn, infant, child or young person's progress, underlying hearing loss and use of hearing aid(s). Information obtained can be used to fine tune the aiding as required.	**Speed of Access** **5a.1.** All referrals for hearing aids are offered an appointment for fitting within **4** weeks of decision to aid, with the exception of mild, unilateral and temporary conductive hearing losses, where appointments can be offered within **6** weeks of decision to aid.
		5a.2. NHSP. All referrals for hearing aids for babies identified via NHSP are offered an appointment for fitting within **4** weeks of decision to aid.
		5a.3. Appointments for replacement ear moulds are within **2** working days of request, in at least one site in the area, unless delayed at young person/family request.
		5a.4. Appointments for hearing aid repair are within **2** working days of request, in at least one site in the area, unless delayed at young person/family request.
		5a.5. Services offer the option of drop-off/postal repairs.

		5a.6. Children and families are offered regular reviews, appropriate to their age and hearing loss.
5b. The service is able to provide a variety of amplification devices, and features, suitable for the needs of the individual child.	Children need appropriate amplification to safely access sound.	**Selection of Hearing Aids** **5b.1.** The type of amplification, and features employed, are selected based on the individual child's needs.
		5b.2. The service signposts children and families to environmental/assistive listening devices.
5c. Where provision of hearing aid(s) is required, the service ensures: 1. nationally agreed procedures and protocols are followed at a local level, 2. performance of hearing aid(s) is carefully matched to individual requirements and settings are recorded.	Professional bodies' and national guidelines are followed to ensure provision meets the needs of the child. Evidence suggests that hearing aids are most effective when their performance is carefully matched to the requirements of the child.	**Verification of Hearing Aids** **5c.1.** Local protocols which comply with the latest professional bodies' and national guidance (e.g. BSA) are in operation concerning selection, fitting and verification of hearing aids.
		5c.2. Verification of hearing aid performance is carried out using Real Ear Measurement (REM) or coupler measurement (measured/predicted Real Ear to Coupler Difference) unless clinically contraindicated for individual children.
		5c.3. Where REM/RECD is performed, measurements are made according to BSA recommended procedure.

		5c.4. Where REM/RECD measurements are performed, responses fall within recommended target tolerances, unless clinically contraindicated for individual children.
		5c.5. When REM/RECD is not attempted, completed or is contraindicated, an explanation is recorded in the IMP.
5d. The effectiveness of amplification is assessed, and is recorded in the IMP.	The effectiveness of hearing aid fitting is best assessed using functional measures, and supplemented by the use of age-appropriate questionnaires and feedback from the family and wider team.	**Evaluation of Hearing Aid Fitting** **5d.1.** A range of outcome measures are available to, and used by, the service.
		5d.2. Outcome measures are appropriately used to evaluate hearing aid fitting, and to guide further management.

Standard 6. Skills and Expertise

Standard Statement	Rationale	Criteria
6a. Each audiology service demonstrates that they have the clinical competencies necessary to support the assessments and interventions they undertake.	Newborns, infants, children and young people who require ongoing health interventions must have access to high quality evidence based care, delivered by staff that have the right skills for diagnosis, assessment, treatment and ongoing care and support. Audiology departments have a duty of care to newborns, infants, children, young people and families and must ensure that assessments and interventions are delivered by appropriately trained, qualified and registered clinicians. Through the clinical governance framework, organisations can manage their accountability for maintaining high standards. Paediatric audiology is a rapidly changing field and clinical competency must, therefore, be	**Experienced, Trained and Qualified Staff** **6a.1.** All eligible, clinical staff working in Audiology are registered with a registration body e.g. The Registration Council for Clinical Physiologists (RCCP).
		6a.2. Staff in senior positions (Bands 7/8) are trained to post-graduate level, or have significant practical experience in paediatric audiology.
		6a.3. NHSP. Audiology staff carrying out neonatal and paediatric assessments should have appropriate qualifications and training/experience for newborn/early years work.
		Staff Competency **6a.4.** Competency of staff performing all clinical procedures is verified by peer review or competency checks at least every **3** years. These are formally documented.

	maintained through continuing professional development. Peer review provides a useful approach to help ensure clinical competencies are maintained.	**6.a.5. NHSP.** Competency of staff performing neonatal and paediatric assessment activity is verified by competency checks at least every **3** years. These are formally documented.
		6a.6. There is a departmental process for dealing with the outcome of peer review observations, and concerns regarding clinical practice at any other time.
		6a.7. NHSP. There is a departmental process for acting on the outcomes of peer review of assessment.
		6a.8. All staff **assisting** audiologists demonstrate competence in the roles performed.
		Continuing Professional Development **6a.9.** All clinical staff participate in relevant CPD activity in line with professional guidance.
		6a.10. All Audiologists have regular training and annual updates on, advances in paediatric audiology, hearing aid technology and assistive listening devices.

		6a.11. NHSP. All Audiologists performing neonatal and paediatric assessments participate in relevant CPD activity, including regular training and annual updates specific to NHSP.
		Deaf Awareness **6a.12.** All staff employed within Audiology are deaf aware.

Standard 7. Service Effectiveness and Improvement

Standard Statement	Rationale	Criteria
7a. Each service has processes in place to measure service quality. Quality measures are used to plan and implement service improvements. Quality measures include regularly consulting with users and stakeholders.	Measurement of qualitative and quantitative data helps to inform ongoing service improvement.	**Service Satisfaction and Monitoring** **7a.1.** The Audiology service, surveys service user views, including the views of children/young people where possible, at least every **2** years, or sooner if significant changes are made in service provision.
		7a.2. NHSP. The Audiology service surveys the views of parents of children with a hearing loss at least every **3** years.
		7a.3. The Audiology service seeks the views of stakeholders at least every **5** years.
		7a.4. Results of surveys and Quality Rating Tool scores, and outcomes, are made widely available.
		7a.5. Using all of the information gathered above, and the outputs of the Quality Standards visit, an ongoing programme of service improvement, is in place.

7b. Each Audiology service actively participates with local users.	Close working with parents and young people as well as across organisations will lead to improved services for deaf newborns, infants, children, young people and their families. Effective recruitment to user groups will ensure appropriate representation for the child and family, and demonstrates a truly inclusive approach. User groups can ensure that all paediatric and young people's hearing services remain high on the agenda of those responsible for planning and delivering services at a strategic level. They can offer advice and guidance to ensure high quality services are available.	**7b.1.** A local user group exists.
		7b.2. The local group meets regularly, at least **6** monthly.
		7b.3. Audiology services promote and participate in the local user group.
		7b.4. Audiology ensures that the outcomes of Quality Standards and satisfaction surveys are reported to user group.
		7b.5. NHSP. NHSP is a standing agenda item at user group.

Standard 8. Collaborative Working

Standard Statement	Rationale	Criteria
8a. Each Paediatric Audiology service has in place processes and structures to ensure effective collaborative working and communication within the team and with outside agencies and services and each newborn, infant, child or young person, and his/her family.	Effective joint working avoids the need for families to repeat the same information with each new set of professionals. Information sharing within the team ensures that management and care plans reflect the current needs of the child or young person and their family. Collaborative working increases the family's confidence in the support offered and reduces anxiety.	**8a.1.** Each paediatric audiology service works with professionals with expertise in: • paediatric audiology • development of language and speech skills • medical aspects of audiology • child development and family support • educational support
		Access to Other Specialist Services **8a.2.** Each paediatric audiology service has access to: • education services (in particular teacher of the deaf) • specialist speech and language therapy • paediatric medicine • Cochlear Implant services • social work services • voluntary agencies • educational psychology services • Child and Adolescent Mental Health Services (CAMHS).

.		**Information Updates for Referrer and Other Relevant Professionals** **8a.3.** Results of audiological assessments are reported to the referrer and any other relevant professionals.
		8a.4. NHSP. Results of neonatal and paediatric hearing assessments are reported to the referrer and other relevant professionals
		8a.5. Reports are distributed to relevant professionals within **10** working days of the assessment.
		8a.6. NHSP. Reports are distributed to relevant professionals within **10** working days of completion of the neonatal and paediatric hearing assessment.
		8a.7. Non attendance for hearing assessment is reported to the referrer, parent, and appropriate professionals e.g. GP, HV, Child Health, in accordance with local guidelines/protocols.
		8a.8. NHSP. Non attendance for newborn hearing assessment is reported in accordance with NHSP guidelines

		Liaison With Other Services **8a.9.** When Audiology refers families to other agencies and services, there is ongoing sharing of information by audiology.
		8a.10. Feedback from other agencies is used to inform the Audiology IMP.
		8a.11. Audit of multi professional and multiagency working should be carried out annually and should include the take up of referral to these agencies. **8a.12.** The Audiology Lead should be aware of any concerns that arise from the audit and should discuss these with all agencies involved before developing plans to mitigate areas of concern raised in the audit.

Paediatric Audiology Quality Standards Baseline Exercise

2018/19

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Paediatric Audiology Quality Standards

Executive Summary

Adult Audiology services introduced Quality Standards as a framework for measurable, continuous improvement of services in 2012/13.

Currently, Northern Ireland (NI) is the only part of the UK that has yet to introduce quality standards for Paediatric Audiology. Following the review of Adult Quality standards completed in April 2018, the Regional Audiology forum agreed that, during 2018/19, it would develop an agreed set of standards for paediatric audiology services, to be applicable to children from birth to 18 years old, to be presented to the Department of Health (DOH) for approval.

The Department of Health, Health and Social Care Board, Trusts and the National Deaf Children's Society (NDCS) worked together to develop an agreed set of quality standards for paediatric audiology services with the Regional Audiology Forum working with stakeholders and user representatives to draft the Paediatric Audiology Quality Standards paper in November 2018.

The standards include detailed assessment of paediatric audiology services in NI under the following headings;

1. Accessing the service
2. Information provision and communication
3. Assessment
4. Audiology Individual Management Plan (IMP)
5. Hearing Aid Management, Selection, Verification and Evaluation Outcome
6. Skills and Expertise
7. Service Effectiveness and Improvement
8. Collaborative Working

The Regional Audiology Forum also developed a Paediatric Audiology Quality Standards Scoring Tool based on the standards to test that the standards were fit for purpose and to complete a baseline exercise of current paediatric services. The results of this baseline exercise were then used by the Regional Audiology Forum to develop and finalise the draft quality standards.

This paper presents the results of this baseline exercise which was completed between November 2018 and March 2019 and shows an average level of 78% across all the eight standards achieved.

The participation of staff in completing the quality rating tool is greatly appreciated.

Paediatric Audiology Quality Standards

Quality Standard	Performance Indicator
1. Accessing the Service	• All newborns, infants, children and young people have timely, flexible access and via correct pathway. • Demand and waiting times monitored.
2. Information Provision & Communication with Children, Young People and Families	• Processes and structures to facilitate communication with children, young people and families in place. • Timely and relevant information before during and after intervention. • Use of technology to support communication with patients.
3. Assessment	• Individualised assessment to national standards. • Equipment and rooms tested and conform to national standards. • Assessments are interpreted taking into account the developmental status of the child and any co-existing medical conditions.
4. Developing an Individual Management Plan	• Patient focused plan developed for each newborn, infant, child or young person. • Actions and goals agreed with parents and/or the child or young person. • Information recorded and updated.
5. Hearing Aid Management, Selection, Verification and Evaluation	• Access to all aspects of services, including replacement and repair, in a timely fashion. • The type and features of amplification are selected based on the individual child's needs. • Real Ear Measurements performed to validate fitting.

	• Effectiveness of amplification is assessed, and is recorded in the IMP.
6. Skills and Expertise	• All clinical staff registered with appropriate registration body. • Demonstrated clinical competence. • Appropriately maintained Continuing Professional Development (CPD) programme for all staff. • All staff employed are deaf aware.
7. Service Effectiveness and Improvement	• Processes in place to measure service quality, e.g. patent satisfaction surveys. • Quantitative analysis of quality/effectiveness of service. • Process for participating with stakeholders • Participation with local users.
8. Collaborative working	• Processes and structures in place to ensure collaborative working and communication.

Paediatric Audiology Quality Standards – Baseline Exercise

Table1.

Standards	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	NI
1. Accessing the service	67%	82%	58%	95%	63%	73%
2. Information provision and communication	81%	90%	65%	100%	58%	79%
3. Assessment	86%	98%	80%	100%	86%	90%
4. Individual Management Plan	53%	97%	50%	100%	56%	71%
5. Hearing Aid Management, Selection, Verfification and Evaluation	92%	88%	62%	98%	72%	82%
6. Skills and Expertise	96%	96%	75%	92%	81%	88%
7. Service Effectiveness and Improvement	40%	55%	45%	55%	38%	47%
8. Collaborative working	91%	95%	95%	91%	91%	93%
Overall Average for Standards	**77%**	**88%**	**66%**	**92%**	**69%**	**78%**

The draft Paediatric Adult Audiology Quality Standards were scored by Trust staff using the quality standards scoring tool and reviewed by the audiology heads of service in the Regional Audiology Forum. Regionally the overall average score was 78%.

With relation to individual Trusts, all Trusts scored above 66%, the range being 66% in the SEHSCT to 92% in the SHSCT.

With regard to the quality standards, regionally the scores ranged from 47% for service effectiveness and improvement to 93% for collaborative working.

Information provision and communication, assessment, skills and expertise and collaborative working all scored above the overall average score (above 78%).

Accessing the service and individual management plans scored above 70% highlighting the need for Trusts to meet waiting times standards to access the service, difficulties with physical accommodation in some locations and the need to improve communication with patients with regard to individual management plans.

Service effectiveness and improvement scored at 47% highlighting the need for Trusts to improve processes to measure service quality and engage with users.

The Regional Audiology Forum has been asked to review the draft standards based on the regional scoring as part of the process to sign off the draft standards. Trusts have been asked to review their individual scores to identify areas of improvement which will be consolidated in an agreed work programme through the Regional Audiology Forum.