

# Survey of Paediatric Audiology Provision in England 2018



October 2018

## Executive summary

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This report sets out the findings from a national survey of paediatric audiology services in England. We plan to repeat this survey annually; the findings in this report provide a benchmark in order to review how audiology services change in future years.

This is the first time that such detailed information on paediatric audiology services has been available – without it commissioners and providers have been unable to make the most effective decisions. Now that this data is available commissioners should commit to monitoring services more closely. Services must also get better at collecting and sharing data about the children they see, what they do and how they do it.

There is lots to celebrate in this report with many services meeting or exceeding good practice guidelines and standards, but the national picture shows a minority of services are not being effectively supported to meet reasonable standards. We hope that monitoring services rigorously each year, will help us, and service commissioners and providers, to identify areas where improvement is needed and where good practice is happening.

We will use the findings from this research to challenge decision-makers, in local trusts as well as national bodies like NHS England, to provide high quality, well-resourced audiology services for every deaf child wherever they live.

## Key findings

### 1. Data

The data that services returned about the number of deaf children they see was patchy and not of high quality. We'd expect services to have reliable data on the numbers of deaf children they support. This raises questions about how they can be sure they're planning effectively and meeting the needs of deaf children.

### 2. Waiting times

- a. For older children referred to first assessment, most services met the target. There was, however, wide variation in waiting times; children at the worst performing service were waiting more than six months for an initial appointment.
- b. Almost three-quarters of children's audiology services were meeting waiting time targets for earmoulds. The longest wait was nine days over the target – a total of 14 days.
- c. For hearing aid repairs, just over half of services are missing the target of a same day repair. The longest wait for hearing aid repairs was seven days over target.
- d. Nine out of ten were meeting the waiting time target for grommet surgery. However, of the small number that missed the target, it was missed by a long way. The service with the longest waiting time had children waiting for surgery for a full year – 364 days in total.
- e. More than half of deaf children with permanent or temporary deafness will have to wait longer than is clinically appropriate for a follow up appointment.

### 3. Improving Quality in Physiological Services (IQIPS) accreditation

- a. More services are now registered to start the IQIPS accreditation process. This year 27% said they had not started compared with 37% in 2016.
- b. Eight percent of services told us that they had been registered for IQIPS in the past but had dropped out of the scheme.
- c. Of those that hadn't made progress with their accreditation in the last year, for three-quarters of services this was due to a lack of staffing capacity.
- d. Of those services that hadn't started the accreditation process, lack of staffing capacity was cited by 45% of services and was the most frequently given reason.

### 4. Accountability and good practice

- a. The average 'Friends and Family' score (an NHS wide measure that asks patients if they would recommend that service to their friends and family) that audiology services reported was 97% – only two reported a score below 90%.
- b. Children's Hearing Services Working Groups (CHSWGs) bring together the key professionals that support deaf children and should include at least one parent representative – 87% of services are part of a CHSWG that does.
- c. High 'Did Not Attend' (DNA) rates can indicate that a service is struggling to reach out effectively to all families, including those from more disadvantaged backgrounds, or that there is a lack of joined up working between professionals. For children and young people not brought to appointments by parents and carers DNA rates are particularly important because they may indicate safeguarding concerns. Sixty-nine percent of services had DNA rates above the NHS outpatient average – of these services 88% also had issues with waiting times.

### 5. Staffing

- a. In 2018 there was a slight move away from permanent to temporary staff, with permanent Full Time Equivalent (FTE) roles reduced by 6.62 posts in total.
- b. Temporary posts had increased by 26.33 FTE posts, although this increase was not spread evenly across services.
- c. Taking into account vacant posts, there was a net increase of 3.6 FTE posts across all services in England, yet 33% of services saw a net decrease. There was considerable regional variation in staffing levels – London, the West Midlands, the North West, the South West and the North East saw a net decrease in posts.
- d. Experienced staff were most likely to be lost. Permanent and temporary staff in the three highest bands saw reductions of between 8% and 17% on the previous year.
- e. The reasons given for staff reductions were staff hours being reduced (voluntarily or otherwise) and problems recruiting staff at both lower and higher bands.

### 6. Training

Eighty percent of services said that all staff were able to access the Continued Professional Development (CPD) necessary for their roles. For those reporting difficulties, the most common reasons were financial constraints (62%), no cover for clinical duties (48%) and because training expenses were not covered (38%).

## 7. Funding and commissioning

- a. Most services were funded through an individual tariff per child (44%) or a block contract for both children's and adults' audiology services (30%).
- b. Three-quarters of services had joint budgets for adults' and children's services.
- c. There is a wide variation in the tariff for children's audiology services, with the highest funded hearing aid provider being paid over 17 times the amount that the lowest provider was paid. A number of services reported a tariff for hearing aids that was lower than the national average unit cost of a hearing aid. This raises questions as to how this intervention is being funded.

## Introduction

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Our aim is to remove the barriers that deaf children face. We challenge cuts to local and national services and advocate for improvements to the services that deaf children rely on.

But, without information about how well services are doing, we can't know which improvements are needed and whether changes are having an impact. This is why we monitor audiology services – these services test the ear, hearing and balance system, fit and maintain hearing aids and provide other support for deaf children. They are vital to ensuring that deaf children are able to develop, communicate and achieve.

Although we have gathered evidence on the quality of audiology services in England in the past, this report should be seen as the benchmark for a more in-depth, annual study of audiology services.

For this survey we developed questions with input from audiologists – our Audiology Advisory Group (AAG). They helped us to design a comprehensive survey that would take up as little clinical time as possible, and where practical, used data that services already collect.

However, it is clear that some services have difficulties in extracting data about the deaf children they support and there may be inconsistencies in how some questions were answered. The response rates to individual questions sometimes vary.

There is lots to celebrate in this report with many services meeting or exceeding good practice guidelines and standards, but the national picture is very varied. We hope that monitoring services rigorously each year, will help us, and service commissioners and providers, to identify areas where improvement is needed and where good practice is happening. We will use the findings from this research to challenge decision-makers, in local trusts as well as national bodies like NHS England, to provide high quality, well-resourced audiology services for every deaf child wherever they live.

## Acknowledgements

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Many thanks to those in the Audiology Advisory Group (AAG) who gave up their time to improve and refine the questions. We very much appreciate your input.

Many thanks also to the services that responded for spending time finding data and answering the questions. Our aim is to safeguard and improve paediatric audiology services for deaf children – your help with this is vital.

## What services can deaf children access?

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### Numbers of deaf children supported by audiology services

Although we asked services about the number of deaf children they see each year, the data that was returned was patchy and not of high quality.<sup>1</sup> Many could not give us caseload data for the date we requested and gave data that fitted a different timescale, meaning it would not be comparable.

The most recent Consortium for Research into Deaf Education (CRIDE) figures show that there are 45,631 permanently deaf children in England.<sup>2</sup> Audiology services only identified 22,812 on their caseload with almost half of services (51) leaving this question blank.

One service told us that they had in excess of 8,000 deaf children on their caseload which would mean that around a sixth of the population of deaf children in England were seen by one semi-rural service, with only two hospitals. For this reason we decided not to publish this data or use it in our analysis.

Some services used exemptions under the Freedom of Information Act (FOIA) to avoid responding to this question. Reasons for not responding included:

- › collecting the data would take longer than the 18 hour limit specified by the FOIA
- › the service does not collect or hold this information
- › the service is not required to make calculations under the FOIA
- › the service would have to check every patient record to find the information.

It is possible that the way the data was requested made it more difficult for children's audiology services to respond easily. But, as services all record data in different ways and use different systems, it is difficult to find a way to ask this question in a way that suits all services.

## Which children aren't provided with hearing instruments?

We asked services if there are any children that they don't provide hearing instruments for in order to identify any gaps in provision. Of the services responding, 96% said that they provide hearing instruments for all deaf children.

**Table 1: Gaps in hearing aid provision**

	Don't provide hearing instruments for temporary conductive loss	Don't provide hearing instruments for unilateral loss	Don't provide hearing instruments for mild loss	Don't provide hearing instruments for moderate loss	Don't provide hearing instruments for Auditory Neuropathy Spectrum Disorder (ANSD)	We provide hearing instruments for all children	Other
Number of services	0	1	1	0	3	101	4
Percentage of services	0	1%	1%	0	3%	96%	4%

Response rate: 105. Services could select multiple responses.

Two of the services that selected 'other' gave more information about the clinical basis on which a decision would be made to provide hearing instruments. Two responses related to Auditory Processing Disorder which is not generally classified as a type of deafness.

## What is available for children with temporary hearing loss?

Audiology services support deaf children to use the hearing they have to best effect. This applies to children with temporary deafness who may also lose out at school and struggle with language development if they do not have the right support. We wanted to know more about the range of interventions that children with temporary losses are able to access.

**Table 2: Interventions offered for children with temporary deafness**

	Provide air conduction hearing aids for temporary losses	Provide bone conduction hearing aids for temporary losses	'Watch and wait' approach for temporary losses	Provide grommets for temporary losses	Provide Otovent for temporary losses
Number of services	106	92	107	102	72
Percentage of services	99%	86%	100%	95%	67%

Response rate: 107.

Not all services are funded for bone conduction hearing aids so we expected that not all children's audiology services would provide this option and that children would be referred elsewhere. Three services said that although they don't provide the Otovent (a treatment for glue ear) to parents directly, they do provide information about it.

## Are batteries always provided for children’s hearing aids?

We asked services if they always provide batteries for children’s hearing aids, provide them with limitations or never provide them.

All services said that they always provide them, with no limitations.<sup>3</sup>

The possibility of charging for hearing aid batteries is a concern in the current financial climate, where NHS budgets are under pressure. We did not ask whether batteries were rationed or restricted in other ways. However, this is an area that has been highlighted by families in previous surveys suggesting that the number of batteries given out at appointments can be restricted and that in order to get free batteries, they may have to return to the hospital to collect more. This may be inconvenient or costly if the hospital is far away, especially considering how often batteries in hearing aids need changing.

## Are coloured moulds always provided at no extra charge?

Children often prefer to wear hearing aids and earmoulds in colours other than the standard NHS beige, brown and grey that adults often wear. Offering a range of colours helps children take ownership of their deafness and hearing aids, develop self-esteem, and remove the stigma attached to wearing them.

The Modernising Children’s Hearing Aid Services guidelines recommend that:

“Services should offer earmoulds in a variety of different colours and decorations.”<sup>4</sup>

This is an area that has been highlighted by families in previous surveys suggesting that options were becoming limited due to financial restrictions.

**Table 3: Services providing coloured earmoulds**

	Never provide coloured moulds for free	Always provide coloured moulds for free	Provide coloured moulds for free, but with limitations
Number of services	0	104	3
Percentage of services	0	97%	3%

Response rate: 107.

We asked those that said there were limitations to specify the limits of the policy:

“Limited range of colours.”

“The conductive temporaries cannot choose coloured moulds whereas the PCHIs [Permanent Childhood Hearing Impairment] can.”

“On request.”

## How long are children waiting?

The Government set waiting time targets for different types of treatments and appointments. These targets help ensure that deaf children are identified early, offered early intervention (including hearing aids or grommets), and ensure they are able to make maximum and consistent use of well-fitted hearing aids which are regularly checked and reprogrammed to take account of the child’s growth and development. The targets are:

- › time from screening outcome to attendance at an audiological assessment appointment: 28 days<sup>5</sup>
- › time from referral to first assessment (children not identified at newborn hearing screening): 42 days<sup>6</sup>
- › time taken to replace earmoulds (from the time the service was notified of need): five days
- › time taken to repair hearing aids (from the time the service was notified of need): 24 hours or less
- › time from referral to surgery to fit grommets for glue ear: 126 days.<sup>7</sup>

Almost all children’s audiology services met the newborn hearing screening target (time from screening outcome to attendance at an audiological assessment appointment) which is recorded nationally as a key performance indicator (KPI).

**Table 4: Number of services not meeting waiting time targets**

	Referral to first assessment (newborn hearing screening pathway)	Referral to first assessment (older children post-newborn hearing screening)	New earmoulds	Hearing aid repairs	Grommet surgery for glue ear
Number of services not meeting waiting time target	1	7	29	58	13
Percentage of services not meeting waiting time target	1%	7%	27%	57%	12%
Response rate	99	101	99	101	55

For older children referred for first assessment the number not meeting the waiting time target is slightly higher. However, within the children’s audiology services reporting that they had missed the target, there was a large variation in waiting times. Half of the services that had missed the target had waits of between 28 days and 148 days, on top of the 42 day target. So, children at the worst performing service were waiting more than six months for an initial appointment.

Almost three out of four children’s audiology services were meeting targets for replacement earmoulds. When we asked parents how long it took them to get replacement earmoulds in 2014, only 5% were getting them within the target time of five days. A proportion of services do still miss the target – the longest wait was nine days over the target – a total of 14 days.

Just over half the services were missing the target of a 24 hour repair for hearing aids. Although this sounds like a testing target, in practice services are often able to implement strategies to help meet it, such as programming a replacement hearing aid on the day for collection from reception or posting a replacement out to families. The longest wait for hearing aid repairs was seven days over target.

Almost half the children’s audiology services responding to the survey were unable to provide a response to the question about grommet surgery. Unfortunately many services told us this information was held by the Ear Nose and Throat (ENT) service and they couldn’t provide the information. One in ten were missing the waiting time target, but those that were missing the target were missing it by a long way. Two services had waiting times of up to 14 days on top of



the 126 day target. Waiting times for the other 11 services ranged from 42 days over target to 238 days over. Children at the service with the longest waiting time were waiting for surgery for a full year – 364 days in total.

Routine follow-up hearing tests for children with permanent and temporary deafness do not have government targets associated with them. However, our quality standards for audiology say that children needing follow-up appointments should be “offered appointments as deemed clinically appropriate”.

We asked services to tell us the number of days a child would wait to be seen beyond what was expected. So for example, if an appointment was set for six months’ time and a child was not seen for six months and 12 days, the wait would be 12 days.

**Table 5: Waiting times for routine follow-up hearing tests**

	Routine follow-up hearing tests for children with permanent deafness	Routine follow-up hearing tests for children with temporary deafness
Number of services with waits beyond expected	51	55
Percentage of services with waits beyond expected	55%	63%
Mean waiting time	44 days	52 days
Longest waiting time	135 days	260 days

Response rate: 92 (permanent), 88 (temporary).

Most children with permanent and temporary deafness will have to wait longer than is clinically appropriate for a follow-up appointment.

## Are the services good quality? Improving Quality in Physiological Services (IQIPS) accreditation

Although all healthcare providers are officially inspected by the Care Quality Commission (CQC), outpatient services like audiology receive less focus than inpatient and more risky specialisms. The CQC’s inspection regime focuses on “core services (for example critical care and surgery), particularly those that require improvement or are inadequate”.<sup>8</sup> This means that paediatric audiology services are unlikely to be inspected in detail if they haven’t been accredited by the IQIPS scheme. Because of the comprehensive nature of these inspections, an IQIPS accreditation is the primary indicator we use to determine whether services are of high quality.

### Where are services on the accreditation journey?

In the journey towards accreditation, registering with the accreditation provider the United Kingdom Accreditation Service (UKAS), is the first step.

In 2016, 37% of audiology services said they weren’t registered with UKAS.<sup>9</sup> This year 27% said they had never registered with UKAS.

**Table 6: Number of services registered with UKAS**

	Have not (to date) registered with UKAS	Have registered with UKAS
Number of services	29	77
Percentage of services	27%	73%

Response rate: 106.

Of those that had registered, the majority (57%) were still participating and had not yet had an on-site assessment.

**Table 7: Progress with IQIPs accreditation**

	Registered for the IQIPs process but dropped out	Registered for the IQIPs process, had an onsite assessment but did not reach the required standard	Registered for the IQIPs process but have not had an onsite assessment	Gained accreditation with IQIPs <sup>10</sup>
Total number of services (2018 survey)	6	1	44	26
Percentage of services (2018 survey)	8%	1%	57%	34%

Response rate: 77 (2018). This response rate excludes services that have never registered with IQIPs.

In order to decide whether they are ready for accreditation, services are asked to assess themselves against a traffic light system, where green suggests they are close to accreditation standard and it is time to book an assessment.

**Table 8: Progress against traffic light system for IQIPs accreditation**

	Red	Amber	Green	Not using it
Number of services	6	10	8	31
Percentage of services	11%	18%	15%	56%

Response rate: 55.

Most of the services are not taking part in the traffic light system to assess how close they are to being ready for UKAS to assess their service. As we didn't ask services why they weren't using it, we don't know the reasons for this.

## Why have services not progressed with accreditation?

We asked those that had registered with UKAS when they registered. Those that had registered with IQIPS but haven't become accredited are shown below with the date of their registration.

**Table 9: Services registered for IQIPS that haven't been accredited**

	2012	2013	2014	2015	2016	2017	2018
Number of services	8	6	6	14	3	6	3
Total (cumulative) number of services	8	14	20	34	37	43	46
Percentage of services	17%	13%	13%	30%	7%	13%	7%

Response rate: 46 (unaccredited services only).

Of those services that had registered with IQIPS, 28% (13) said they had made progress in the last year.

We gave services nine options for why they had not made progress, including a free text 'other' box. Of those that hadn't made progress, this was due to a lack of staffing capacity for 74% (25). A quarter of services gave us an 'other' reason (see below), whilst 9% (3) said there was "no budget" for progressing with IQIPS accreditation and 3% (1) said that "Trust management haven't prioritised it".

Many of the 'other' responses gave further detail on the service's situation or reformulated one of the options provided. However, there were some additional reasons that services had not progressed:

- › "In the process of a merger and intend to apply for IQIPS as one Trust once this is complete."
- › "Awaiting relocation of the department as current shared paediatric-adult accommodation would not satisfy IQIPs assessors."
- › "Will extend the scope of the adult accreditation to include paediatrics once the four-yearly visit has been scheduled. There are significant cost savings in aligning with existing visit schedules."
- › "Applying for accreditation is very time consuming."
- › "Maintaining clinical standards has taken priority over gaining accreditation. The IQIPS accreditation could be more focused on clinical quality."

## Why haven't services begun accreditation?

As the IQIPS accreditation scheme has been running since 2012, the number of paediatric audiology services that have never registered is reducing – and is now at 27%. But, have the reasons for not beginning accreditation changed? In the last survey of audiology services in 2016, the most often cited reasons for not registering were a lack of staff (29%) and a lack of budget (24%).<sup>11</sup>

**Table 10: Reasons for not registering for IQIPS accreditation**

	Lack of capacity (staffing)	No budget for it	Management haven't prioritised it	It is not mandatory	Other
Number of services	13	2	2	5	7
Percentage of services	45%	7%	7%	17%	24%

Response rate: 29.

This year, 45% said that lack of staff capacity was the main reason that they hadn't registered for IQIPS. However this question is not directly comparable because this year we only asked for one reason – the main reason – rather than accepting multiple reasons for not registering.

Many of the 'other' responses gave further detail on a service's specific situation:

- › "Preparing to register for IQIPS."
- › "Accrediting the adult service first."
- › "Other priorities are taking precedence."

Most commissioners don't require services to be accredited despite guidance from NHS England<sup>12</sup> and Public Health England<sup>13</sup>, which some services may feel is unfair to those that invested in IQIPS early on, and may put some off from registering:

"We are accredited for adult services... This has been hugely time consuming, in terms of resource required to complete the accreditation process, to reach the required standard and to maintain the required standard year on year. What we have seen is the vast majority of services – both private providers and other NHS providers – have not embraced the IQIPS process and commissioners have not made this a mandatory process. In the case of our adult services it was removed from the second round contract for Any Qualified Provider (AQP), thus devaluing the accreditation process. When it is cost prohibitive... to maintain accreditation, when it is too onerous and is so intensive that it distracts from clinical priorities then it makes it less appealing to add yet more work, more stress, more resource, hence part reason for our delay in adding paediatrics to our scope of practice."

## Are services good quality? Accountability and good practice

Although the Improving Quality in Physiological Services (IQIPS) scheme is the most comprehensive indicator of quality available for audiology services, there are other indicators of how effective a service is. In this survey, we also asked questions about:

- › the department's 'Friends and Family' score (an NHS-wide measure that asks patients if they would recommend that service to their friends and family)
- › parent representation on Children's Hearing Services Working Group (CHSWGs)
- › the proportion of patients that do not attend booked appointments – also widely used across the NHS and often known as a Did Not Attend (DNA) rate
- › the range of appointment times available so that children and young people can avoid missing school time to visit the audiologist
- › the processes in place to support deaf young people to make a good transition to adult services.

A quality service should be monitoring these indicators and scoring highly on them.

## Would users recommend services to friends and family?

The 'Friends and Family' test is used widely in the NHS to gather feedback from service users. The test asks people if they would either recommend or not recommend the services they have used. The score is the percentage that say they would recommend a service after using it.

Many services do not record this data specifically for the audiology department but 56 services were able to give us a score (52% of the services responding). Overall the results were very promising – the average score was 97% – with 24 services recording a score of 100%. The lowest score was 75% but there were only two services that recorded a score below 90%.

## Are services accountable?

Like all public services, audiology services should be accountable to those they serve. This is why we asked about whether services are part of a Children's Hearing Services Working Group (CHSWG).

An effective CHSWG will bring together the full range of professionals working with deaf children: audiologists, Teachers of the Deaf, social care workers, speech and language therapists, newborn hearing screeners, educational psychologists and others with an interest. CHSWGs should also include parents and gain meaningful feedback from deaf young people to ensure that service users' views are broadly represented. We asked services whether they had a CHSWG and if it included at least one parent representative.

**Table 11: CHSWGs with parent representatives**

	CHSWG includes at least one parent rep	CHSWG doesn't have a parent rep	Not sure if CHSWG has a parent rep	We don't have a CHSWG
Number of services	93	8	3	3
Percentage of services	87%	7%	3%	3%

Response rate: 107.

## How many appointments are missed?

The Did Not Attend (DNA) rate is used across the NHS to track the number of appointments that were not attended by patients. Appointments that are not used waste resources and increase waiting times. DNA rates are regularly used as key performance indicators when reporting to commissioners or senior management on progress. They can often be reduced by simple actions, for example, sending a text reminder of an appointment the day before.

For outpatient services across the NHS, DNA rates were 9% between 1 January and 31 March 2018.<sup>14</sup>

High DNA rates can indicate that a service is struggling to reach out effectively to all families in the area, including those from more disadvantaged backgrounds, or that there is a lack of joined up working between professionals. For children and young people not brought to appointments by parents and carers DNA rates are particularly important because they may indicate safeguarding concerns. For this reason in paediatric health settings there is a move to record DNAs as 'Was Not Brought' to recognise that non-attendance at appointments is

rarely the child’s choice.<sup>15</sup> The Care Quality Commission (CQC) say that all NHS services should have a safeguarding policy that includes a process for following up children who miss outpatient appointments.<sup>16</sup>

DNA rates varied dramatically across services; the lowest was 2% and the highest was 33%.

Sixty-nine percent of services had DNA rates above the NHS outpatient average of 9%. Of the services with a higher than average DNA rate 88% had issues with waiting times.<sup>17</sup>

**Table 12: Did Not Attend (DNA) rates in comparison to NHS outpatient average**

	Services with DNA rates above 9%	Services with a DNA rate above 9% and issues with waiting times
Number of services	64	56
Percentage of services	69%	88%

Response rate: 93.

## Are appointments flexible?

Overall 99% of services offered at least one type of flexible appointment. Being seen in school would minimise time out of the classroom as no time would be needed to travel to appointments at a hospital or clinic that may be some distance away.

**Table 13: Types of flexible appointment offered**

	Offer extra appointments in school holidays	Offer extended opening times (before 9am and/ or after 5pm)	Offer Saturday appointments	Deliver some services in schools
Number of services	51	84	34	54
Percentage of services	48%	79%	32%	51%

Response rate: 106. Services could select multiple responses.

## Are services following good practice on supporting deaf children to transition to adult services?

Transition planning should ensure continuity of care for the young person, and make them aware of all the options open to them. We asked services about four key ways that they might prepare a deaf young person for their transition.

**Table 14: Transition planning offered to young people**

	Provide information on the adult service for young people	Offer an appointment with the adult service before being discharged from the children's service	Hold joint appointments with both paediatric and adult audiologist present	Visit local schools to offer sessions to share information with young people about deafness, independence and transition etc.	None of the above	Other
Number of services	99	61	49	6	1	45
Percentage of services	94%	58%	47%	6%	1%	43%

Response rate: 105. Services could select multiple responses.

Many of the 'other' responses were giving additional detail on what they had selected in the response options provided or rephrasing the options provided. However, there were some additional ways that services prepare young people for transition:

- › Eleven services said that as they were a joint service the transition process was “smooth” or “not a major issue” as the young people were seen by the same staff.
- › Nine services said that they ran a transition clinic or had a specific transition appointment.
- › Five said they discussed the young person and their needs with other professionals, for example, the education support service.
- › Four said they had a dedicated transition audiologist.
- › Four said they held a transition event.
- › Four said they were currently reviewing their transition offer or information.
- › Two said they offered a tour of the department.

## How many staff are there and are their numbers changing?

In our previous survey of audiology services in 2016, staffing was a concern for services, with almost a third saying they had lost staff in the previous year. Of those that had seen a reduction in staff, this was due to recruitment problems and financial constraints on staffing, with the reductions concentrated amongst the most experienced staff.

In this survey we asked how many staff were working in the different bands, as well as whether staff were permanent or temporary and how many vacancies the service was carrying, so we could compare where these losses had happened.

We asked for staffing numbers expressed as a fraction of a full working week. So, one full-time role and a part-time role of three days a week would be 1.6 Full Time Equivalent (FTE).

The data showed that overall around a third of children’s audiology services were reducing permanent staff (31%) and a third (30%) were increasing permanent staff. However the overall number of permanent staff being lost was higher than that being recruited. In 2018 the 99 services that responded reported a combined total of 731 FTE permanent staff, whilst in 2017 the same services had a combined total of 737.62 FTE. This is a reduction of 6.62 permanent audiology staff across all bands.

Across all services, in 2018 temporary posts had increased by 26.33 from 19.84 FTE in 2017, to 46.17 FTE. However, this increase was not spread evenly as only 15% of services increased their use of temporary staff. In 2018 vacancies had increased by 15.38 from 35.35 in 2017 to a total of 50.73.

In order to get a true picture of how many staff are working in paediatric audiology services in 2018, compared with 2017, vacancies and frozen posts were factored in to give a net increase/decrease in staff across the different staffing categories. There was a slight increase in staffing of 3.6 FTE across the 99 children’s audiology services. Thirty-three percent of services saw a net decrease of staff, whilst 28% saw an increase. There were also significant regional variations.

**Table 15: Increase/decrease in posts across regions**

Region	Net increase/ decrease in posts	Number of children’s audiology services	Average post increase/ decrease per service
East	3.42	13	0.26
East Midlands	11.21	8	1.40
London	-7.93	6	-1.32
North East	-0.6	4	-0.15
North West	-2.19	20	-0.11
South East	3.64	14	0.26
South West	-1.485	13	-0.11
West Midlands	-7.075	12	-0.59
Yorkshire and the Humber	4.61	9	0.51
England	3.6	99	0.04

Response rate: 99.



**Table 16: Increase/decrease in Full Time Equivalent posts across bands**

Full Time Equivalents (FTE) staff	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7
Permanent and temporary staff 2017	32.3	75.2	39.9	82.0	231.8	177.3
Permanent and temporary staff 2018	37.2	71.9	44.2	91.0	239.3	177.0
Percentage difference	15%	-4%	11%	11%	3%	0%

Full Time Equivalents (FTE) staff	Band 8a	Band 8b	Band 8c	Band 8d	Doctor specialising in audiology	Other
Permanent and temporary staff 2017	42.1	14.8	5.9	1.2	39.2	15.7
Permanent and temporary staff 2018	42.4	16.5	4.9	1.1	36.0	16.0
Percentage difference	1%	12%	-17%	-8%	-8%	2%

Response rate: 99. Bands 1 and 9 were offered as responses but there were no staff recorded in these categories.

We asked those that had seen a reduction in the number or skill level of staff to explain the reasons for this change.

**Table 17: Reasons for reduction in staff**

	We have been unable to recruit staff at higher bands – Band 6 and above	We have been unable to recruit staff at lower bands – Band 5 and below	Posts have been frozen	Posts have been deleted	Staff hours have been reduced – voluntarily or otherwise
Number of services	10	13	5	5	17
Percentage of services	26%	33%	13%	13%	44%

Response rate: 39. Services could select multiple responses.

18 services selected ‘other’ and gave additional detail on their responses, or highlighted other reasons for staffing reductions:

“Very challenging to recruit competent experienced paediatric audiologists.”

“At present difficulties attracting higher grade applicants.”

“Department expanding but two Band 7 on maternity leave from 2017–2018.”

“We were granted an extra FTE to cover the increase in ENT demand. In reality this is never fully met due to sharing between the adults and paed services.”

“We have a combined workforce that see both the adult service and the paediatric service. We have had significant staffing issues in the last year but have prioritised paediatrics and complex adults over our routine adults and rerouted staff to ensure paediatric services are not compromised. Our failure to recruit Band 5 audiologists to

see our routine adults has resulted in a great strain over all disciplines. We are working to develop a number of our lower band staff to assist with paediatrics to ensure our wait times remain acceptable.”

“We have employed a paediatric assistant (Band 2) to assist in hearing assessment clinics and free up some Band 5/6 time for adult work.”

“Maternity leave – no applicants for fixed term maternity cover.”

“Couldn’t recruit an associate specialist so changed the post to consultant paediatrician and 8a audiologist.”

“Locum in post as some difficulty with recruiting a Band 6.”

“Retirement, maternity and other childcare issues.”

“Retirement. Staff not trained in paediatrics.”

These are similar issues to those highlighted by services in the previous survey.

We also asked services if they were planning any staffing changes in the next year. Forty-five services said they were. Over half of them were planning increases in staff, although it’s not clear how many of these staff increases were confirmed. Eight services mentioned staffing reviews and a number referenced training up current staff due to difficulties in recruiting appropriately trained staff:

“The audiology department as a whole is undergoing a restructure including internal training and promotion for existing staff. This includes one member of staff undertaking the Higher Training Scheme in Paediatric Assessment. The emphasis is on multi-skilling the existing workforce and future-proofing the service including apprentice training for some roles (not for paediatric service).”

“Due to a shortage of audiologists in the UK, we are growing our own workforce, recruiting more clinical assistance to fill roles within the department. These staff will allow higher band staff to be released to cover complex and paediatric clinics.”

## Are staff able to access training?

Eighty percent of services said that all staff were able to access any Continued Professional Development (CPD) necessary for their roles. Of those that reported difficulties accessing CPD, the most common reasons were: financial constraints (62%), no cover for clinical duties (48%) and because training expenses are not covered (38%).<sup>18</sup>

“Funding for external staff training is limited to £300 for the whole service so staff take turns in going to external courses and this training is needs based.”

“There is increasing pressure to cover clinical duties which can impact on protected CPDtime.”

“Service commitments may occasionally make it difficult to release staff.”

“I have selected no but it should be noted our requests for external training funding have largely been approved. However we have had one instance where it was rejected so I don’t feel I can say ‘yes’. We are reapplying for this particular course.”

“Training opportunities may be limited at times [where we] are at risk of breaching [waiting time targets].”

“We do attend courses run by hearing aid companies etc. However this is dependent on finance being available.”

“Struggling to meet targets so only mandatory CPD completed, although some CPD possible for all staff.”

## What technology is available?

We asked services who provides assistive listening devices for deaf children and what kinds of technology was available to them.

**Table 18: Services providing assistive listening devices**

	Radio aids	Streamers	Remote microphones
Local authority	102 (95%)	46 (43%)	73 (68%)
Your service	0	17 (16%)	13 (12%)
Provided jointly by audiology and the local authority	5 (5%)	3 (3%)	2 (2%)

Response rate: 107.

In all areas audiology services expect that children are able to access radio aids through the local authority or through joint provision – although eligibility criteria may be in place. Streamers are only provided in 62% of areas and remote microphones in 82%.<sup>19</sup> Although professionals working with deaf children should have a good understanding of the offer for deaf children in education services, if they don't provide the technology themselves they may not be clear on exactly which options are available.

We asked audiology services about whether they will balance or pair equipment that has been purchased by the local authority or the parents of a deaf child.

**Table 19: Services offering balancing or pairing of equipment**

	FM systems	Streamers
Local authority	64 (61%)	53 (50%)
Parents of a deaf child	29 (28%)	53 (50%)
We don't balance or pair devices unless we've provided them	19 (18%)	21 (20%)

Response rate: 105. Services could select multiple responses.

The responses to this question show quite a variation in what different services offer to support deaf children with the technology they have.

We also asked if services knew of any plans to stop the provision of hearing equipment in 2018/19. Although three responded with further details, all the cuts mentioned were to education budgets.

## How is the service funded and commissioned?

Budgets and funding in the NHS vary and many services found it difficult to unpick exactly how much money they got and from which source. A number also refused to answer questions on their specific budget. This was because they felt that this was commercially sensitive and may leave them vulnerable to competition from private providers who would have the upper hand in future bids for the service.

We had hoped to compare the caseload of each service with their total budget for deaf children to get an accurate idea of the cost of audiology services but the data was not complete enough to make this comparison. Only 36 out of a total of 107 services would or could provide us with their total budget for the paediatric service, but most told us the type of payment or contract they were on:

**Table 20: How services are funded**

	Block contract within ENT services	Block contract within wider children's services	Block contract for all children's audiology services	Block contract for both children's and adults' audiology services	Individual tariff per child
Number of services	4	13	18	31	46
Percentage of services	4%	12%	17%	30%	44%

Response rate: 105. Services could select multiple responses.

Other options mentioned were:

- › guaranteed income contract
- › actual cost charges to the Clinical Commissioning Group (CCG)
- › an overall block/risk share agreement contract with the CCG for all services provided, not just audiology
- › a combination of tariffs for hearing aid services and block contract arrangements.

We also asked services where their funding came from: the CCG, NHS England or other. According to the Manual for Prescribed Specialised Services 2016/17, NHS England fund some hearing aid services for deaf children, so we expected every service to be funded in part by them. However, only three services told us that they received funding from NHS England. This may be because funding lines aren't clear, or the money goes via the local CCG.

In previous surveys we had heard from services that serve both adults and children, that financial and staffing pressures in the adult service could have an impact on the service for deaf children. The Any Qualified Provider (AQP) policy had, in some services, caused staffing problems as staff were moved from paediatrics to adult services to ensure they could compete with private providers.<sup>20</sup> We asked services if they were joint and if they shared budgets across the adult and paediatric services.

**Table 21: How budgets are shared**

	Our service is joint and budgets are shared	Our service is joint and budgets are not shared	Our service is paediatric only
Number of services	78	7	17
Percentage of services	76%	7%	17%

Response rate: 102.

Over three-quarters of services share budgets between their adult and paediatric services. Some services were unable to separate their paediatric and adult budgets – we only recorded figures for services where they could give us a figure that just covered deaf children.

Of the services that told us they get funding on a tariff per child basis, 32 gave us specific figures. We asked about how much each service was paid for each appointment type.<sup>21</sup>

**Table 22: Tariffs per appointment type**

	Initial hearing assessment/diagnosis	Follow-up assessment	Hearing aid fitting	After care
Average	£81	£68	£151	£45
Minimum	£19	£29	£33	£16
Maximum	£294	£201	£586	£106
Variation	£275	£172	£553	£90
Response rate	32	31	29	29

Whilst there is no national tariff for children’s services, in a recent NHS Improvement consultation a tariff was suggested for adult hearing services:

- › initial hearing assessment only – £53
- › hearing assessment, fitting of one hearing aid, plus first follow-up appointment – £268
- › hearing assessment, fitting of two hearing aids, plus first follow-up appointment – £370
- › hearing aid after care (repairs) – £25.<sup>22</sup>

Although this non-mandatory tariff for adult hearing services is not currently being used, it gives an indication of the figures that have been used widely to commission adult services under Any Qualified Provider (AQP).

Children’s hearing assessment takes 2–3 times as long as an adult assessment and frequently needs two members of staff to carry out tests. A child with very complex needs may take longer than this. Children are also more likely to have tests done that require a greater use of consumables, for example, ear pieces that are thrown away after each visit. After care for children includes new earmoulds which are made far more frequently than for adults, as children grow out of them.

Although the amount of funding that each service receives for the different elements varies widely there doesn’t appear to be a regional correlation.

**Table 23: Highest average appointment tariffs by region**

	Average cost of initial hearing assessment/ diagnosis	Average costs of follow up assessment	Average cost of hearing aid fitting	Average cost of after care
Highest	East Midlands (£126)	North West (£96)	South West (£212)	South West (£75)
Second highest	South East (£98)	London (£84)	West Midlands (£201)	East Midlands (£57)

The services that had the highest and lowest tariff for hearing aid fitting were both in the same region, and the areas where the tariffs were highest varied across regions and didn't cluster around the regions where the cost of living is highest.<sup>23</sup> However, it should be noted that only two London services provided data for this question.

## Methodology

In May 2018, 135 NHS Trusts and providers in England were sent Freedom of Information (FOI) requests with 35 questions about the paediatric audiology services they provide. Eleven of these services told us that they don't provide paediatric audiology or don't fit our criteria for inclusion in the survey:

Please complete this survey if your audiology service provides diagnostic hearing assessments and hearing aid provision for children. This may be hospital or community based. It is not necessary to complete this survey if your audiology service only provides hearing screening or assessments (such as primary tier, second tier or community services) and refers children on to other services for hearing aid provision when necessary.

Those that had not provided a response by 12 July 2018 were not included in the analysis. One hundred and seven children's audiology services were included in the analysis but not every service answered every question.

Where services returned an FOI with varying results for different parts of their service, or where they are commissioned to provide services for another children's audiology service, we recorded separate entries.

The questions were developed with the input of an Audiology Advisory Group (AAG): six paediatric audiologists or clinical scientists (audiology), working in a range of services across England. The AAG helped us to refine the questions to make sure they were clear, that we were requesting data that is already collected where possible, and would take up minimal time of busy audiology professionals.

Figures have been rounded to the nearest whole number. Percentages may not always add up to exactly 100%.

We worked out the net increase/decrease in staff by excluding any services where we didn't have comparable data for both 2017 and 2018. We then calculated the difference between the total number of permanent and temporary posts between 2017 and 2018, and the difference between the total number of frozen and vacant posts between 2017 and 2018, and combined these into a net increase/decrease.

## Endnotes

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1. We asked for data on caseload on 31 March 2017 and 31 March 2018. Specifically:
  - › total service population
  - › total number of children with permanent childhood hearing impairment
  - › total number of children with temporary deafness (and fitted with hearing aids)
  - › total number of children with Auditory Neuropathy Spectrum Disorder.
2. Consortium for Research into Deaf Education (CRIDE). CRIDE 2017 England Report p3. [http://www.ndcs.org.uk/professional\\_support/national\\_data/cride.html](http://www.ndcs.org.uk/professional_support/national_data/cride.html)
3. Response rate: 107.
4. Guidelines for the Taking of Impressions and Provision of Ear Moulds within a Children's Hearing Aid Service, Modernising Children's Hearing Aid Services, University of Manchester, 2005.
5. It is mandatory for services to collect this data which is published by Public Health England: <https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2017-to-2018>. The acceptable threshold for this key performance indicator (NH2) is 90% of children attending a follow up appointment within 28 days.
6. For more detail on diagnostic waiting times please see: <http://www.qualitywatch.org.uk/indicator/diagnostic-test-waiting-times>
7. For more detail on treatment waiting times please see: <http://www.qualitywatch.org.uk/indicator/treatment-waiting-times>
8. Care Quality Commission. Shaping the Future: CQC's strategy for 2016 to 2021, p.6.
9. National Deaf Children's Society. The Health of Children's Hearing Services in England. 2017, p.12.
10. We know that 28 services have achieved accreditation to date (July 2018) but not all responded to the survey in time – for further information please visit: <https://www.ukas.com/search-accredited-organisations/>
11. National Deaf Children's Society. The Health of Children's Hearing Services in England. 2017, p.12.
12. Public health functions to be exercised by NHS England Service specification No. 20 <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/04/serv-spec-20-chld-hearing-screening-prog.pdf>
13. NHSP Operational Guidance (updated October 2018) <https://www.gov.uk/government/publications/newborn-hearing-screening-programme-nhsp-operational-guidance/9-audiology>
14. NHS England. NHS Inpatient Admission and Outpatient Referrals and Attendances, 25 May 2018, p.4.
15. We used 'Did Not Attend' (DNA) in our survey as we felt it is the most commonly used term by health professionals.
16. Care Quality Commission. Safeguarding Children: A review of arrangements in the NHS for safeguarding children. July 2009, p.18.

17. We regarded services as having a problem with waiting times if any of their responses to the waiting times question were above the waiting time target or our quality standards.
18. Services could select multiple responses so percentages add up to more than 100%.
19. Children's audiology services selected which of the options were provided in their authority, by who. As this was a Freedom of Information (FOI) request, if none of the boxes were selected, the assumption was made that the type of technology was not provided at all.
20. "Any Qualified Provider (AQP) was a government policy intended to encourage all NHS, private, third sector or social enterprise health service providers to compete for contracts on an equal footing. It required Clinical Commissioning Groups (CCGs) to put in place arrangements for certain services where patients could choose treatment from a range of providers who must all be licensed by the Care Quality Commission." <https://www.kingsfund.org.uk/projects/verdict/nhs-being-privatised>
21. Not all services provide all elements so response rates vary slightly.
22. [www.england.nhs.uk/resources/pay-syst/national-tariff/tariff-engagement/](http://www.england.nhs.uk/resources/pay-syst/national-tariff/tariff-engagement/)
23. The Office for National Statistics' relative regional consumer price levels suggest that three regions in England are above the UK average: London, South West and the South East. ONS. Relative Regional Consumer Price Levels of Goods and Services, UK: 2016, 1 March 2018, p.13.



## For more information

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See: [www.ndcs.org.uk/listenupsurvey](http://www.ndcs.org.uk/listenupsurvey).

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