

Paediatric audiology provision in England (2019)



A report by the National Deaf Children's Society

1. Executive summary

This report sets out the findings from our second national annual survey of paediatric audiology services in England.

There is lots to celebrate in this report with many services meeting or exceeding good practice guidelines and standards. However, the national picture shows that a minority of services are not being effectively supported to meet expected standards.

We hope that monitoring paediatric audiology provision each year will allow us to identify trends over time whilst supporting service commissioners and providers to identify areas where improvement is needed and where good practice is happening.

2. Key findings

Waiting times

- Despite a slight increase in the number of services missing their waiting time targets, most services met the target for referrals to first assessment (whether via the newborn or post-newborn screening pathway).
- The percentage of services not meeting their targets for replacement earmoulds decreased by seven percentage points (from 29% in 2018 to 22% in 2019).
- There was an increase in the percentage of services missing their 24 hour target for hearing aid repairs (from 56% in 2018 to 64% in 2019).
- Nearly a quarter of services continue to miss their waiting time target for grommet surgery. Some services told us that waiting times for this provision could be up to a year (the target is 126 days).
- More than half of our services told us that deaf children with permanent or temporary were waiting longer than is clinically appropriate for a follow-up appointment.

Policies

- A small number of services reported that they do not provide some children (e.g. children with mild or moderate loss) with hearing instruments.
- A wide range of support continues to be offered to children with temporary hearing loss. There was a slight increase in those offering otovent and bone conduction hearing aids.
- Hearing aid batteries are always provided at no cost. Coloured moulds are nearly always provided.
- There was an increase in the number of services offering extended opening times in 2019. A quarter of services also allow phone and video appointments.

Caseload

- A total of 42,246 children with permanent childhood hearing impairments were on our services caseload. This number is slightly lower than the 46,345 deaf children identified by the Consortium for Research into Deaf Education (CRIDE) report.
- Caseload data also reports an increase in the number of children with temporary deafness and Auditory Neuropathy Spectrum Disorder.

Quality Improvement

- 44% of services have not registered for Improving Quality in Physiological Services (IQIPS).
- Lack of capacity and the fact that it is not mandatory are the most cited reasons for not pursuing accreditation.

Staffing and training

- 48% of services in 2019 reported a decline in the number of permanent staff. Overall figures, however, indicate that the number of permanent staff is higher than in 2018.
- There was a decline in the number of temporary staff in 2019 (from 48.46 to 36.74).
- The decline in the number of staff seem to be at band 8 (e.g. heads of services)

Children's Hearing Service Working Groups

- There was a slight decrease in the number of services which had a CHSWG with a parent representative (from 86% to 82%).
- Only a quarter of services produced a publicly available annual report.

Technology

- Assistive listening devices are most likely to be provided by local authorities.
- Services are most likely to provide streamers and remote microphones. Few services provide radio aids.
- Services stated that there were no plans to stop the provision of hearing equipment.

Patient engagement

- There is an increase in the range of support provided by services to help prepare deaf young people for their transition.
- Services continue to report high approval ratings on the Friends and Family score in 2019.
- 75% of services reported a Did Not Attend rate that was higher than the NHS average of 9%.

3. Background

As with our first survey in 2018, we developed questions with input from audiologists through our Audiology Advisory Group (AAG). We would like to thank all those who gave up their time to help improve and refine the questions to create a comprehensive survey that would take up as little clinical time as possible and, where practical, use data that services already collect. For our 2019 survey, some questions were changed or added following further feedback from the AAG.

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. We acknowledge that audiology services can be structured in different ways that standardised surveys may not be able to fully capture. Results should therefore be interpreted with caution.

We would also like to thank the services that responded to the survey and provided further feedback.

4. Methodology

In 2019, 130 children's audiology services and providers in England were sent Freedom of Information (FOI) requests with questions about the paediatric audiology services they provide. Thirteen services in 2019 told us that they don't provide paediatric audiology or don't fit our criteria for inclusion¹ in the survey.

Two 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 for these services giving us our final total of 120 services in 2019.

Services that provided a response by September 2019 were included in the survey. One hundred and twenty children's audiology services responded to our request but not every service answered every question. A list of services who responded to our requests in 2018 and 2019 is provided in Appendix 1.

Figures have been rounded to the nearest whole number. Percentages may not always add up to exactly 100%. Unless otherwise indicated, the total number of services for each year (119 in 2018 and 120 in 2019) have been used to calculate percentages.

The methodology outlined in this section refers to the 2018-2019 survey cycle. For information on how the 2017-2018 survey data was collected, please view our published report: www.ndcs.org.uk/media/3941/survey_of_paediatric_audiology_provision_2018_final.pdf

5. Waiting Times

We asked services how long children were waiting for a range of treatment and appointment types. Reported waiting times were then compared to targets set by the Government. These targets help ensure that deaf children are identified early and receive treatment promptly. They also ensure that deaf children have access to well-fitted hearing aids which are regularly checked and reprogrammed to take account of the child's growth and development.

Referral to first assessment (newborn hearing screening pathway)

The NHS target for waiting time from screening outcomes to attendance at an audiological assessment appointment is 28 days.² This is recorded nationally as a key performance indicator (KPI NH2).

In 2018, almost all children's audiology services met the newborn hearing screening target. Only one hospital did not meet this target.

In 2019, three hospitals did not meet the target set by the NHS. Although the median waiting time has not changed significantly, longer waiting times were reported in 2019. One service reported that patients waited 84 days for their first assessment.

¹ The criteria was: *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.*

² 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.

Year	Maximum waiting time	Median waiting time	Number not meeting target	Response rate	Percentage missing target
2018	34	18	1	108	1%
2019	84	16	3	109	3%

Table 1: Referral to first assessment

In Figure 1, data from 2018 and 2019 are displayed. The y axis represents the number of days waited and the x axis represents the year. The horizontal black line shows the target set by the NHS (in this case, 28 days). Data points above this line indicate waiting times that are longer than the target, data points below this line indicate waiting times that are shorter. Each coloured line represents a service and its slope indicates whether waiting times were longer or shorter in 2019. Each box represents a different region. The black lines and dots provide the median waiting times for each region by year.

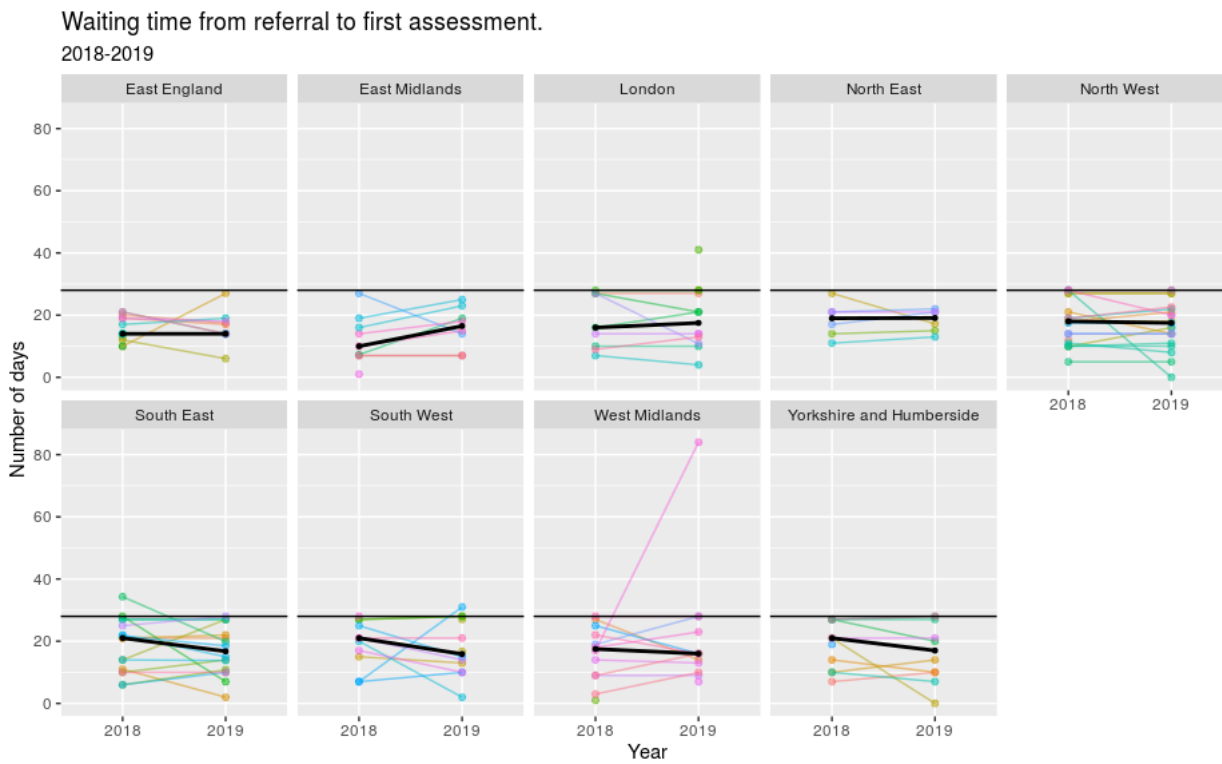


Figure 1: Waiting time from referral to first assessment

Figure 1 shows that most services reported waiting times that were below the NHS target. Services that missed the targets were located in the London and West Midlands areas. One hospital in the South East who missed the NHS target in 2018 reported a shorter waiting time in 2019.

Referral to first assessment (post newborn screening)

The NHS waiting time target for referrals to first assessment for older children (post newborn screening) is 42 days.³

Year	Maximum waiting time	Median waiting time	Number not meeting target	Response rate	Percentage missing target
2018	190	32	10	108	9%
2019	554	35	15	115	13%

Table 2: Referral to first assessment for older children

In 2018, 10 services did not meet their target of 42 days. Within these 10 services, there was considerable variation in waiting times. The longest waiting time was 190 days. Children at the worst performing service were waiting more than six months for an initial appointment.

In 2019, more services are not meeting their target when compared to the previous year. 15 services did not meet their target of 42 days. The variation in waiting times in services who did not meet their target was much worse than 2018. The longest waiting time was 554 days. Children at the worst performing service were waiting more than 18 months for an initial appointment. The median waiting time in 2019 increased by 3 days when compared to 2018.

Waiting times for each service are illustrated in Figure 2. Viewed by region, services in the London and North West regions report the longest waiting times. Services in London also show the most increase in waiting times in 2019. With the exception of London, all other regions have median waiting times that meet the target of 42 days in 2019.

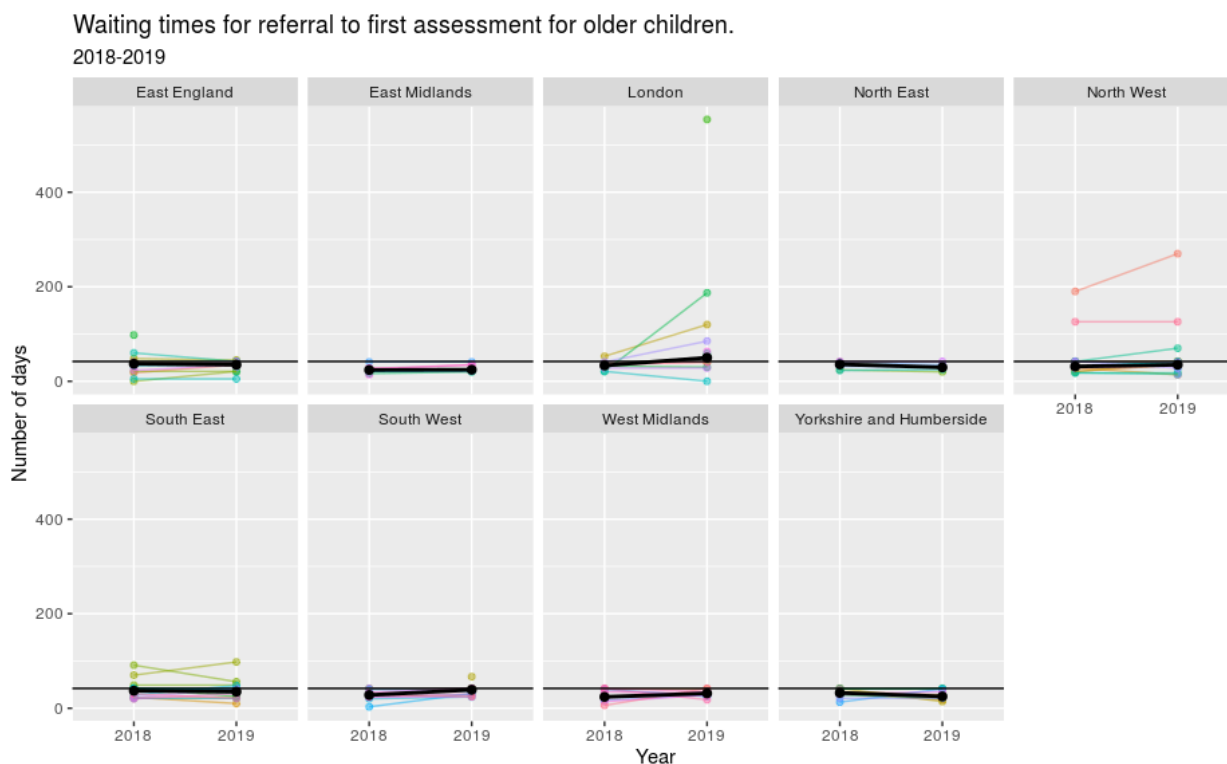


Figure 2: Waiting times for referral to first assessment for older children

³ For more detail on diagnostic waiting times, please see: <http://www.qualitywatch.org.uk/indicator/diagnostic-test-waiting-times>

Decision to fit hearing aids to time fitted for PCHI

In our 2019 survey, we asked how long children were waiting for their hearing aids to be fitted after a decision had been made. These figures include children referred via the newborn hearing screening pathway and older children referred from other routes. The NHS target for a hearing aid fitting following a decision is 28 days.

Year	Maximum waiting time	Median waiting time	Number not meeting target	Response rate	Percentage missing target
2019	126	21	19	112	17%

Table 3: Waiting times for hearing aid fitting

Responses indicate that 17% did not meet their target of 28 days. Children at the worst performing service were waiting 126 days before being fitted with their hearing aid. This service, however, reported a much longer waiting time than other services who missed their target. The next longest waiting time was 42 days. The median waiting time was 21 days.

In Figure 3, we can see that most services report waiting times that meet their target with some missing this target by a few days. The service with a waiting time of 126 days is located in the South West.

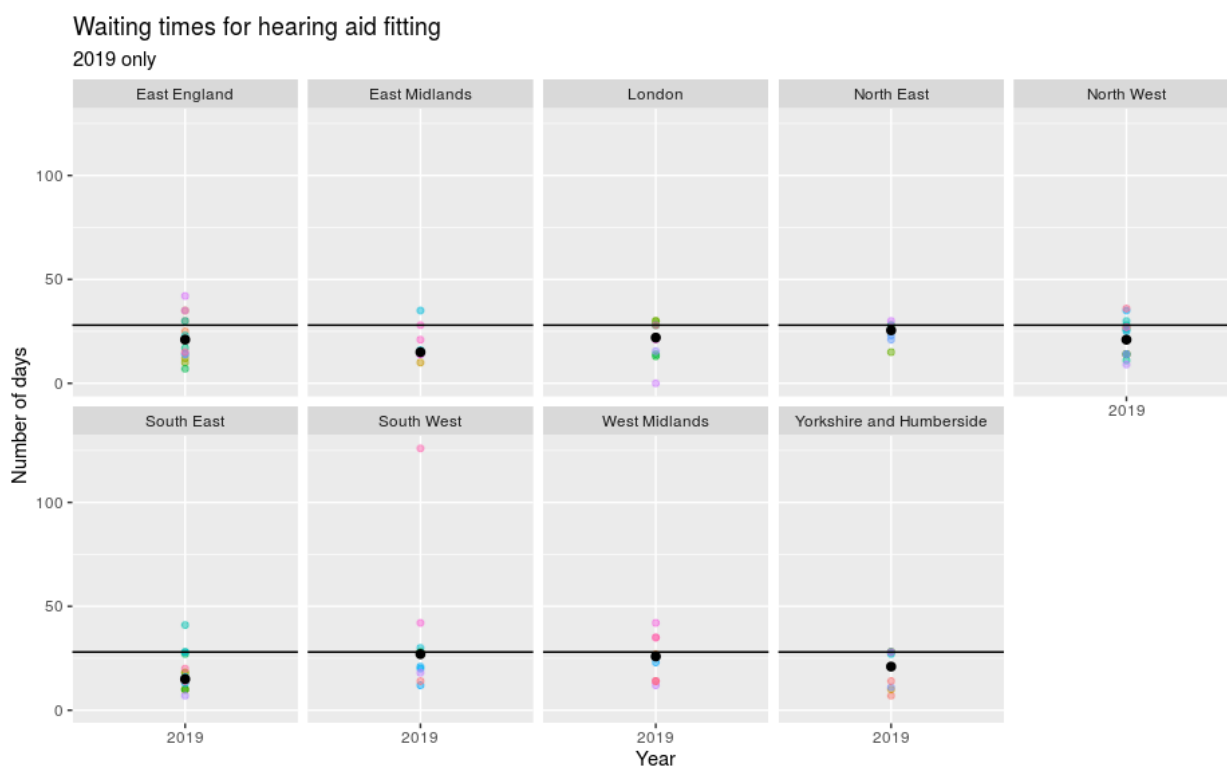


Figure 3: Waiting times for hearing aid fitting

Earmoulds

The NHS target for replacing earmoulds from the time the service was notified of need is five days. Table 4 summarises the results from our survey.

Year	Maximum waiting time	Median waiting time	Number not meeting target	Response rate	Percentage missing target
2018	14	3	32	109	29%
2019	14	2	25	115	22%

Table 4: Waiting times for earmoulds.

In 2018, the median waiting time was three days which is below the NHS target. However, 29% of services were not meeting their targets. For children at these services, the wait for replacement earmoulds could be as long as 14 days.

In 2019, the median waiting time was two days. The number of services not meeting their targets also decreased by seven percentage points. Only 22% took more than five days to replace a child's earmoulds. However, some children in England are still waiting as long as 14 days for replacement earmoulds.

In Figure 1, waiting times for earmoulds show considerable variation by region. Many services in the South West and the West Midlands are exceeding their targets. Services in East England are also exceeding the target set although there is a decrease in the median waiting time in 2019.

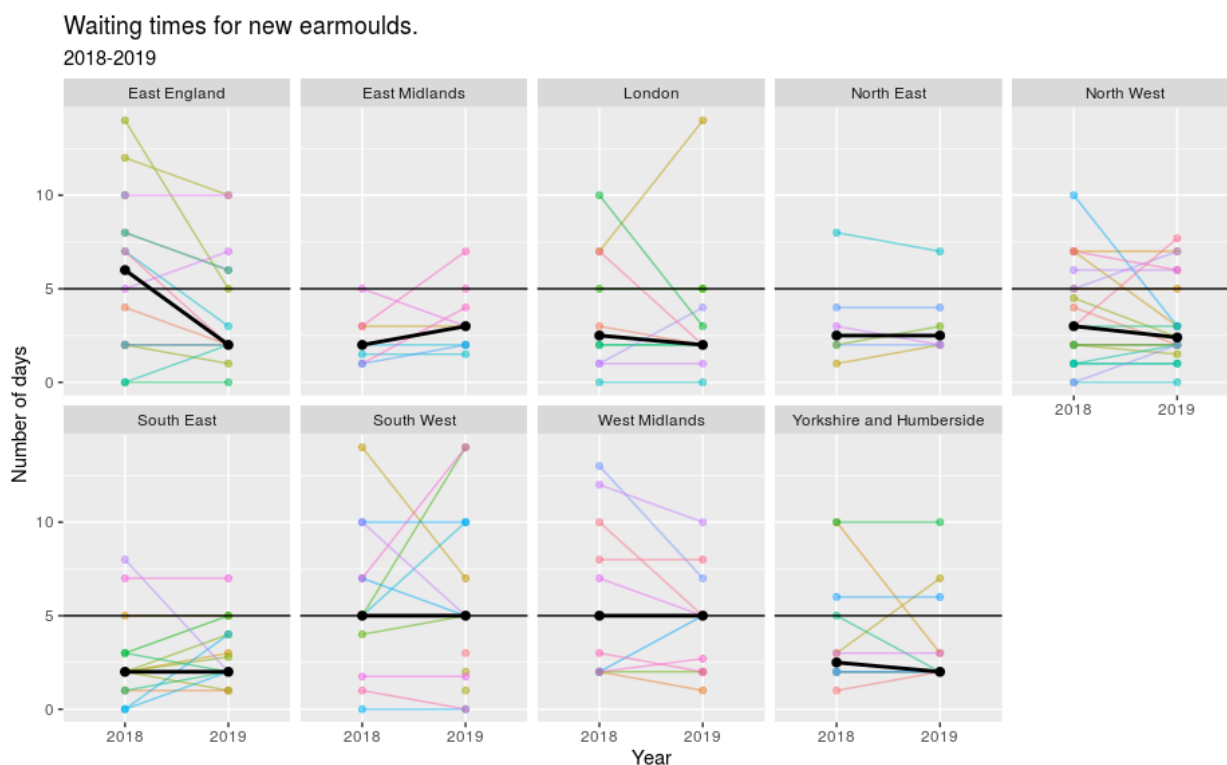


Figure 4: Waiting times for new earmoulds

Hearing aid repairs

The NHS target for hearing aids repairs is within one day. Table 5 provides the overall waiting times and the number of services meeting this target.

Year	Maximum waiting time	Median waiting time	Number not meeting target	Response rate	Percentage missing target
2018	8	2	62	111	56%
2019	7	2	75	117	64%

Table 5: Waiting times for hearing aid repairs

In 2018, we reported that 56% of services were missing their 24-hour target. In 2019, the number of services not meeting this target has increased to 64%.

Children typically wait two days before their hearing aids are repaired. For some services, children are waiting as long as a week before their hearing aid is repaired.

Although this sounds like a testing target, in practice services should be able to implement strategies to help meet it. This might involve programming a replacement hearing aid on the day for collection from reception or posting a replacement out to families.

In Figure 5, waiting times for hearing aid repairs show considerable variation by region. Most services in the East Midlands do not appear to be meeting their target. There is also variation in waiting times in East England, London, North West and Yorkshire and the Humber.

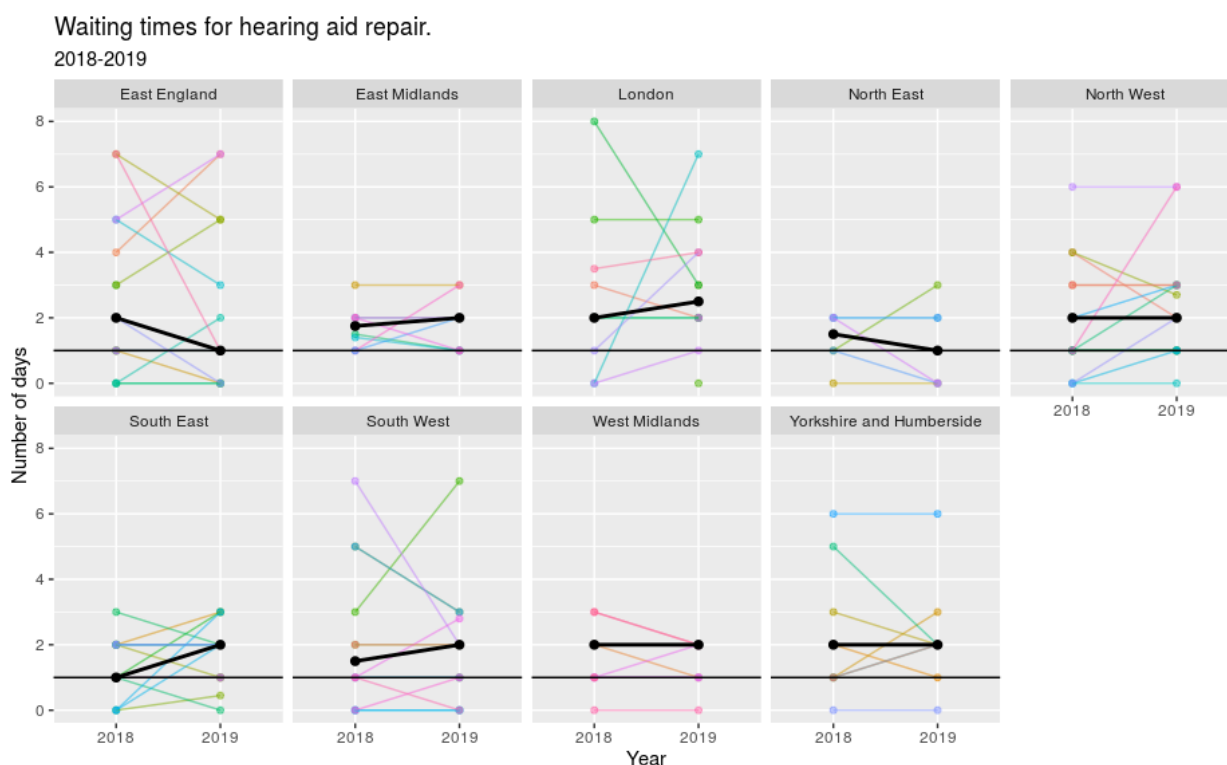


Figure 5: Waiting times for hearing aid repair.

Grommet surgery for glue ear

The NHS target for grommet surgery is 126 days.⁴

Year	Maximum waiting time	Median waiting time	Number not meeting target	Response rate	Percentage missing target
2018	364	101	15	61	25%
2019	336	100	16	70	23%

Table 6: Waiting time for grommet surgery

Response rates for this category are much lower than other categories. We have waiting times from only 61 services in 2018 and 70 services in 2019.

In 2018, 25% of services were not meeting their target of 126 days. These services were often missing their targets by a long way. Children at the worst performing service were waiting nearly a year before receiving surgery.

In 2019, 23% of services are not meeting their target of 126 days. This decrease in percentage may be attributed to a higher response rate in 2019. The actual number of services not meeting their target has increased by one service. As in 2018, services continue to miss their targets by a long way. Children at the worst performing service are still waiting nearly a year before receiving surgery.

In Figure 6, data from 2018 and 2019 are displayed by region and show considerable variation. The West Midlands and the North East appear to be meeting their targets while services in the South East and East Midlands have more services exceeding the target waiting time of 126 days.

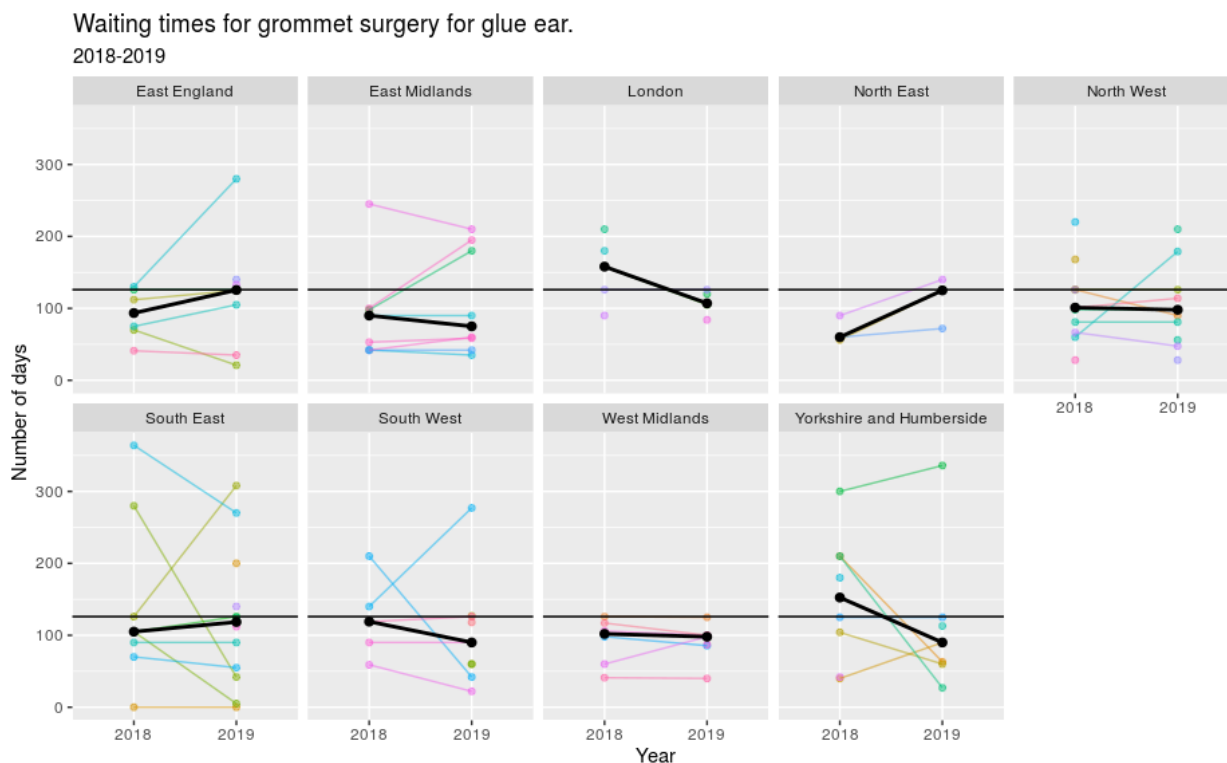


Figure 6: Waiting times for grommet surgery for glue ear.

⁴ For more detail on treatment waiting times please see: <http://www.qualitywatch.org.uk/indicator/treatment-waiting-times>.

Routine follow-up hearing tests

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. If an appointment was set for six months’ time and a child was not seen for six months and 12 days, the reported wait time would be 12 days.

Table 7 reports the waiting times beyond what would be expected for routine follow-up hearing tests for children with permanent deafness.

Year	Maximum waiting time	Median waiting time	Number not meeting target	Response rate	Percentage missing target
2018	135	7	57	101	56%
2019	210	17	71	115	62%

Table 7: Waiting times for routine follow-up hearing tests

In 2018 and 2019, 56% and 62% of services reported that children with permanent deafness were waiting longer than necessary for a follow-up appointment. Compared to 2018, the median waiting time in 2019 increased by 10 days from 7 to 17 days.

The number of services not meeting their own targets increased in 2019 and the duration of waiting times have also increased. Children at the worst performing service could be waiting an additional 210 days in 2019 compared to 135 days in 2018 before their follow-up appointment.

In Figure 7, data from 2018 and 2019 are displayed by region. Services in London and the North West show the largest increase in median waiting times.

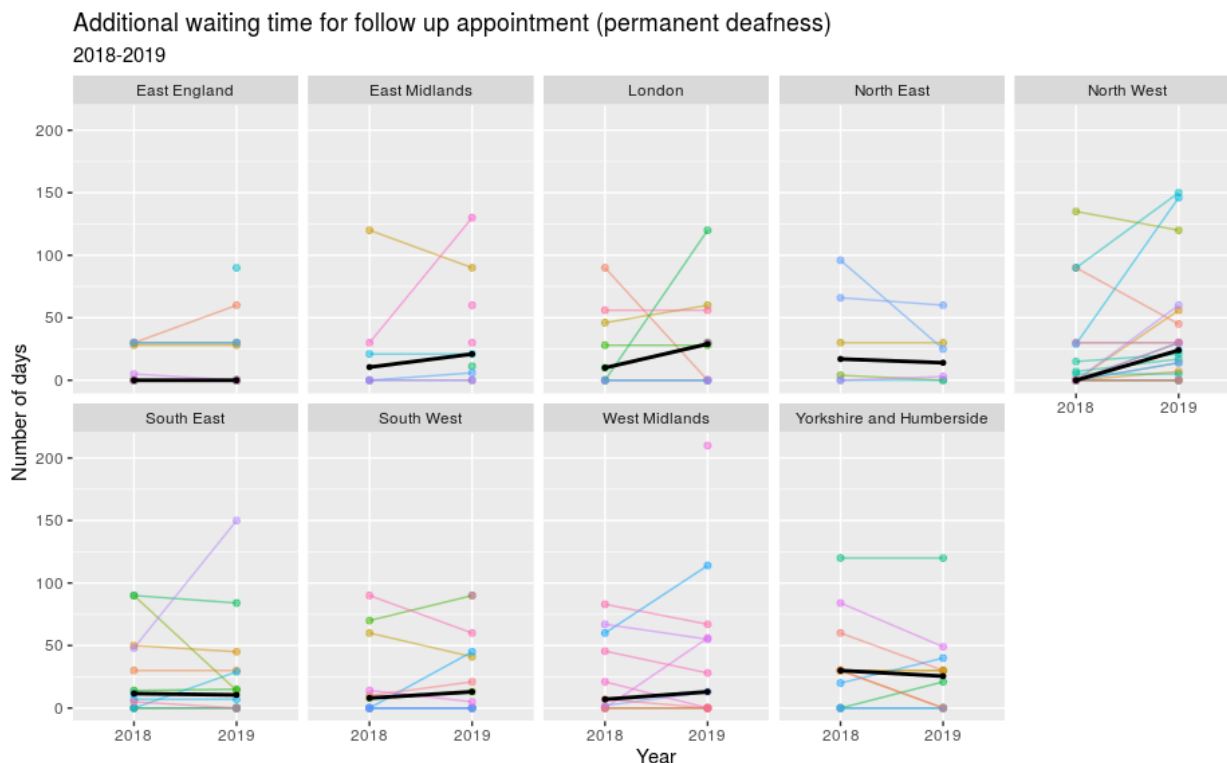


Figure 7: Additional waiting time for follow up appointment (permanent deafness).

Table 8 reports the additional waiting times for routine follow-up hearing tests for children with glue ear.

Year	Maximum waiting time	Median waiting time	Number not meeting target	Response rate	Percentage missing target
2018	260	20	62	97	64%
2019	175	22	71	106	67%

Table 8: Waiting times for routine follow-up hearing tests (for children with temporary deafness)

In 2018 and 2019, 64% and 67% of services reported that children with temporary deafness were waiting longer than necessary for a follow-up appointment.

The number of services not meeting their targets increased from 62 to 71 services. Despite this increase, waiting times are shorter in 2019. The worst performing service in 2018 reported an additional waiting time of 260 days for a follow-up appointment. In 2019, the worst performing service reported an additional 175 days. Although this is a positive change, most children in England with temporary deafness continue to wait longer than necessary for follow-up appointments.

In Figure 8, waiting times show considerable variation by region. Long waiting times reported by services in the North West and Yorkshire and Humber regions are much shorter in 2019 while services in the West Midlands show a sharp increase in waiting times in 2019.

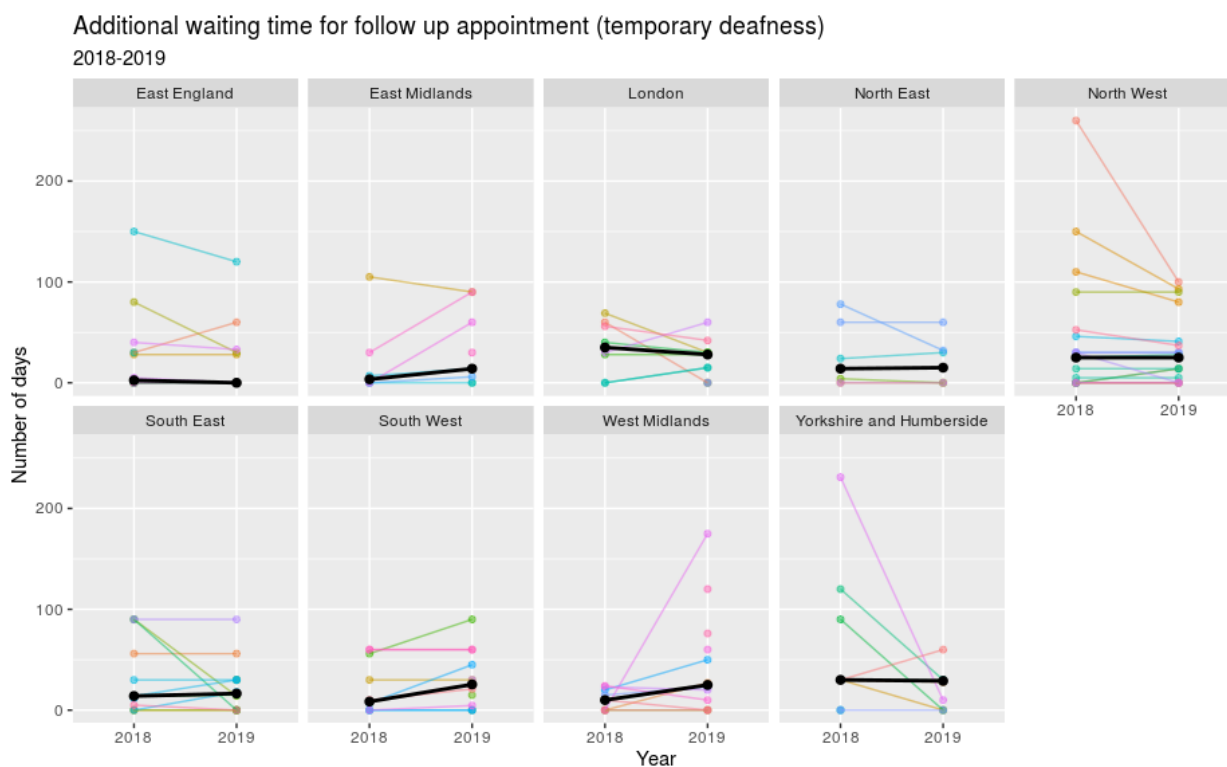


Figure 8: Additional waiting time for follow up appointment (temporary deafness).

6. Your policies

Which children aren't provided with hearing instruments?

Services were asked if there were children that they did not provide with hearing instruments to identify any gaps in provision.

	Number of services (2018)	%	Number of services (2019)	%
We provide instruments for all	112	94%	112	93%
ANSD	3	3%	3	2%
Mild loss	2	2%	0	0%
Moderate loss	1	1%	0	0%
Temporary Conductive Loss	1	1%	2	2%
Unilateral Loss	2	2%	1	1%
Other	4	3%	8	7%

Table 9: Groups not provided with hearing instruments

94% of services in 2018 and 93% of services in 2019 said that they provided hearing instruments for all deaf children. Raw figures, however, indicate that the number of hospitals providing hearing instruments for all deaf children went down by one service.

All other options listed in the table received three or fewer responses. In 2019, no services indicated that they did not provide hearing instruments for children with mild and moderate hearing loss.

Four services in 2018 and eight services in 2019 selected 'other'. In 2018, 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 were related to Auditory Processing Disorder which is not generally classified as a type of deafness.

In 2019, three responses again indicated that children with Auditory Processing Disorder were not provided with hearing instruments. One response mentioned mixed loss and the remaining four responses indicated that hearing aids were often provided based on clinical need; one response indicated that this was only the case for children with unilateral losses.

What is available for children with temporary hearing loss?

Audiology services also provide support to children with temporary deafness who may lose out at school and struggle with language development without the right support. We asked services to indicate which options they provided for this group.

	Number of services (2018)	%	Number of services (2019)	%
Air Conduction Hearing Aids	118	99%	118	98%
Bone Conduction Hearing Aids	102	86%	108	90%
Grommets	113	95%	118	98%
Otovent	81	68%	91	76%
Watch and wait	119	100%	120	100%
Other	13	11%	8	7%

Table 10: Support available to children with temporary hearing loss.

Table 10 indicates similar responses in 2018 and 2019. In general, there is a slight upwards trend. The largest increase is in the number of hospitals offering Otovent treatment: 76% of services in 2019 reported offering Otovent treatment compared to 68% in 2018. However, this treatment is also the least likely to be available in services across England. This is followed by bone conduction hearing aids which were offered by 86% of services in 2018 and 90% of services in 2019.

An increase in the number of services offering Otovent treatment is a positive finding. NICE's current guidelines indicates that the use of this treatment led to improvement in middle ear function when compared to standard care. In some cases, it has led to a significant reduction in the need for grommets.⁵

11% and 7% of services in 2018 and 2019 respectively told us that they provided other types of support.

Some hospitals provided more information as other sources of support:

“Involvement of Hearing and Vision Support Service when hearing aids are fitted. Information provided on Glue Ear where appropriate.” (2018)

“If seen by Consultant and child has Allergic Rhinitis, nasal spray are prescribed.” (2018)

“Referral for softband BAHA (for babies/children with glue but not suitable for grommets e.g. Downs Syndrome).” (2018)

“We may offer BAHA for conductive HLs if AC hearing aids are not successful e.g. for Down Syndrome cohort.” (2018/2019)

“Advice and information leaflets to parents and nursery/schools. We may involve sensory support to assess in classroom environment.” (2019)

⁵ <https://www.nice.org.uk/advice/mib59>

Some hospitals indicated that, although they had told us they offered the service, they only provided information on the service itself.

“We do not offer a BAHA or softband service but would refer on for this.” (2018)

“We do not provide the Otovent itself but information is available.” (2018 and 2019)

Are batteries always provided for children’s hearing aids?

We asked services if they provided batteries for children’s hearing aids. All services in both 2018 and 2019 said they always provide them with no limitations.

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. For example, if the number of batteries given out at appointments is restricted, families may have to return to the hospital to collect more free batteries. 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.⁴ In previous surveys, families have expressed concern that options were now limited due to financial restrictions.

	Number of services (2018)	%	Number of services (2019)	%
No, never	0	0	0	0
Yes, always	116	97%	118	98%
Yes, with limitations	3	3%	2	2%

Table 11: Number of hospitals providing coloured moulds.

97% and 99% services in 2018 and 2019 respectively said they always provide coloured earmoulds to children. Few services indicated that there were limitations to this. Those that did provided further information:

“Limited range of colours.” (2018)

“The conductive temporaries cannot choose their coloured moulds whereas the PCHIs [Permanent Childhood Hearing Impairment] can.” (2018/2019)

“On request.” (2018)

“Children who require ear-mould type 3145, this does not come with a coloured option.” (2019)

What type of appointments do you offer?

	Number of services (2018)	%	Number of services (2019)	%
Deliver in schools	60	50%	59	49%
Extended opening times	91	76%	102	85%
Extra appointments during school holidays	56	47%	57	48%
Phone and video appointments	0	0%	29	24%
Saturday appointments	37	31%	38	32%

Table 12: Extra appointment types offered by hospitals.

There was an increase from 76% to 85% in the number of services offering extended opening times in 2019. For all other flexible appointments, the number of services offering this type did not change by more than one percentage point.

Telephone or video appointments was not available as an option in the 2018 survey. In 2019, only 24% of services offered this option. This was the option that is the least likely to be offered by services.

49% of services offered extra appointments during school holidays in our 2019 survey. 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.

7. Your caseload

In our 2018 report, the number of deaf children seen each year was not reported as the data returned did not appear to be reliable. Many services could not provide their caseload data for the dates requested and gave data that fitted a different timescale. This made it difficult to compare figures across hospitals.

Number of births per annum

In our 2019 survey, the question on service population was replaced with a different question. Instead, services were asked to indicate the number of births per annum that their service covered. The response rate for this question was an improvement on last year's figures: 105 hospitals responded. The median number of births reported in 2019 was 5000.

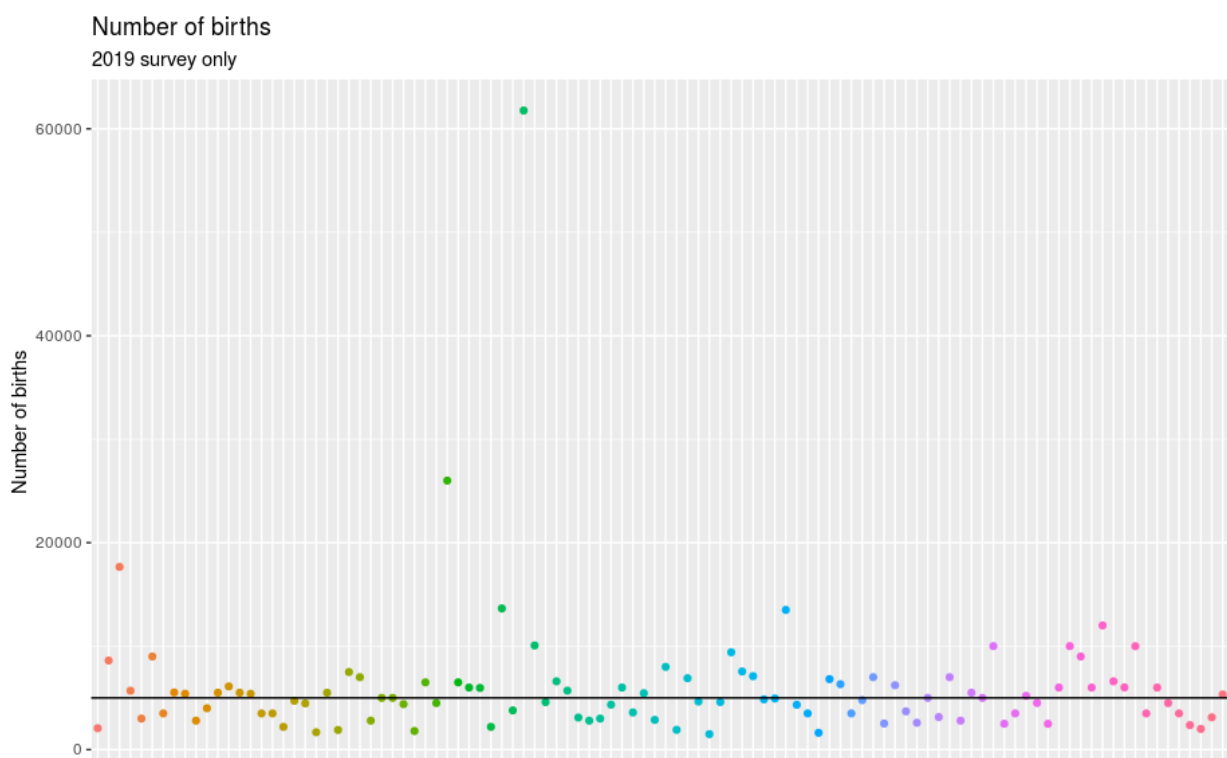


Figure 9: Number of births by 105 services.

As can be seen in the graph, most services report a number close to the median (the median is indicated by a horizontal black line). One service reported a figure of 61,764 births per annum. The second largest figure reported was 26,000.

In the following table, the total sum of births and the median is provided by region. More births were recorded in the North West and South East region in 2019.

Region	Response rate	Total	Median
North West	20	133315	3132
South East	15	100251	6109
London	8	82217	6982
East England	14	61456	4673
Yorkshire and Humberside	11	60266	5522
West Midlands	10	58481	5666
South West	13	58082	4500
East Midlands	8	46856	5324
North East	6	30219	4752
Overall number	105	631143	5000

Table 13: Number of births per region.

Age range

In 2019, we asked services to indicate what age ranges they covered.

Age range	Count	%
0-16	120	100
16-18	72	60
18-25	47	39

Table 14: Age range covered by services

100% of services told us that they covered the 0-16 age range. 60% covered the 16-18 age range. 39% of services a range with an older age limit.

Total number of children with PCHI

Services were asked to indicate the total number of children with permanent childhood hearing impairments (PCHI). This information is provided in Table 15. Table 15 indicates that the number of children with PCHI reported by services has increased. Compared to a median figure of 187 children in 2017, our 2019 survey reports a median of 250. This increase may be associated with a higher response rate in 2019.

Year	Total Responses	Total	Median
2017	63	24309	187
2018	91	33496	207
2019	107	42246	250

Table 15: Overall number of children with PCHI as reported by services

The total number of children with PCHI for each region are provided in Table 16 and Figure 10. Two services reported much higher caseloads than other services leading to higher numbers for their regions: one trust in the South East region has a caseload of more than 8000 children each year and another trust in the South West region has a caseload of more than 2400 each year.

Generally, each region reports an upwards trend in the number of children with PCHI that their service sees. By way of comparison, the Consortium for Research into Deaf Education (CRIDE) identified that there were 46,345 deaf children (aged 0-19) in England in 2019. This is based on data provided to CRIDE by local authority specialist education services for deaf children.⁶

⁶ www.ndcs.org.uk/CRIDE

Number of children with PCHI by region
2017-2018-2019

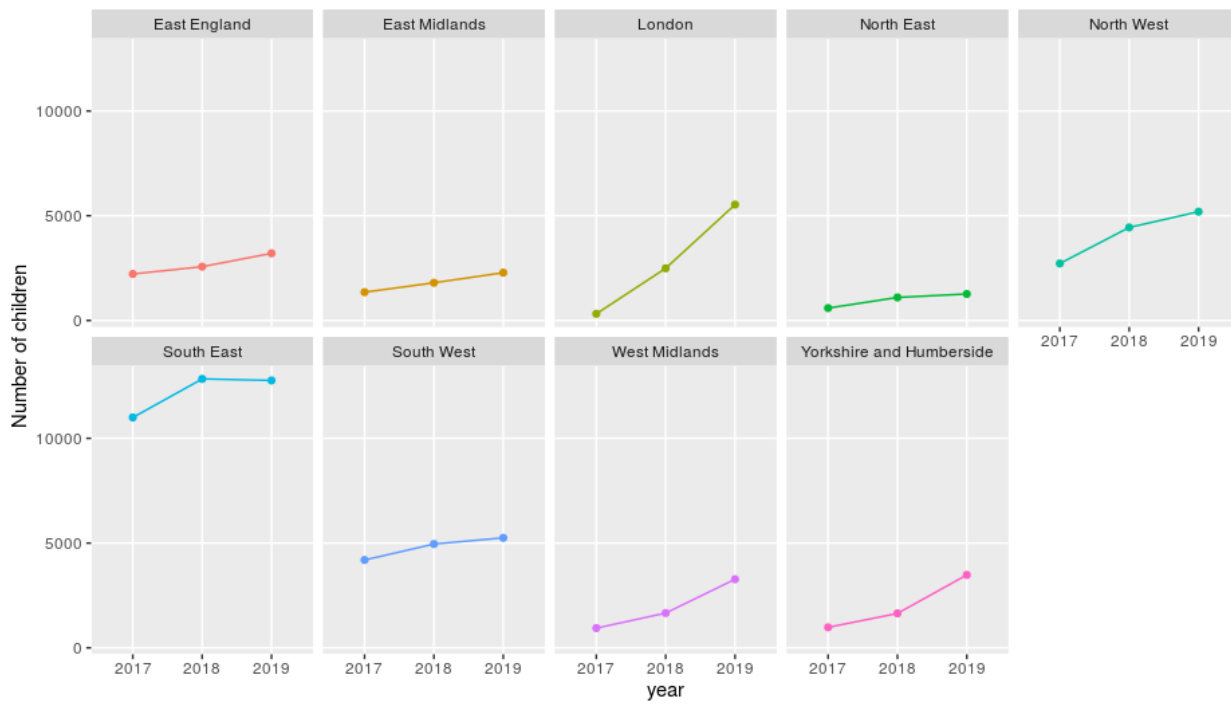


Figure 10: Total number of children with PCHI by region.

Region	2017	2018	2019
East England	2220	2568	3206
East Midlands	1351	1799	2282
London	318	2491	5531
North East	591	1099	1264
North West	2721	4442	5193
South East	10997	12837	12764
South West	4193	4956	5250
West Midlands	941	1660	3275
Yorkshire and Humberside	977	1644	3481

Table 16: Total number of children with PCHI by region and year.

Total number of children with temporary deafness (and fitted with hearing aids)

Services were asked to indicate the total number of children with temporary deafness (and fitted with hearing aids) they cover. Figures are reported in Table 17. There is a slight decrease in the median number of children with temporary deafness reported by services in 2019.

Year	Total Responses	Total	Median
2017	48	4776	52
2018	72	8038	66
2019	88	8409	63

Table 17: Overall number of children with temporary deafness as reported by services

In 2019, the number of children with temporary deafness has increased. This may be associated with a higher response rate.

The total number of children with temporary deafness by region and year are provided in Figure 11 and Table 18. Each region generally reports an upward trend in the number of children with temporary hearing loss except for the South West. This is due to missing 2019 data from a South West service which previously reported a high caseload in 2018.

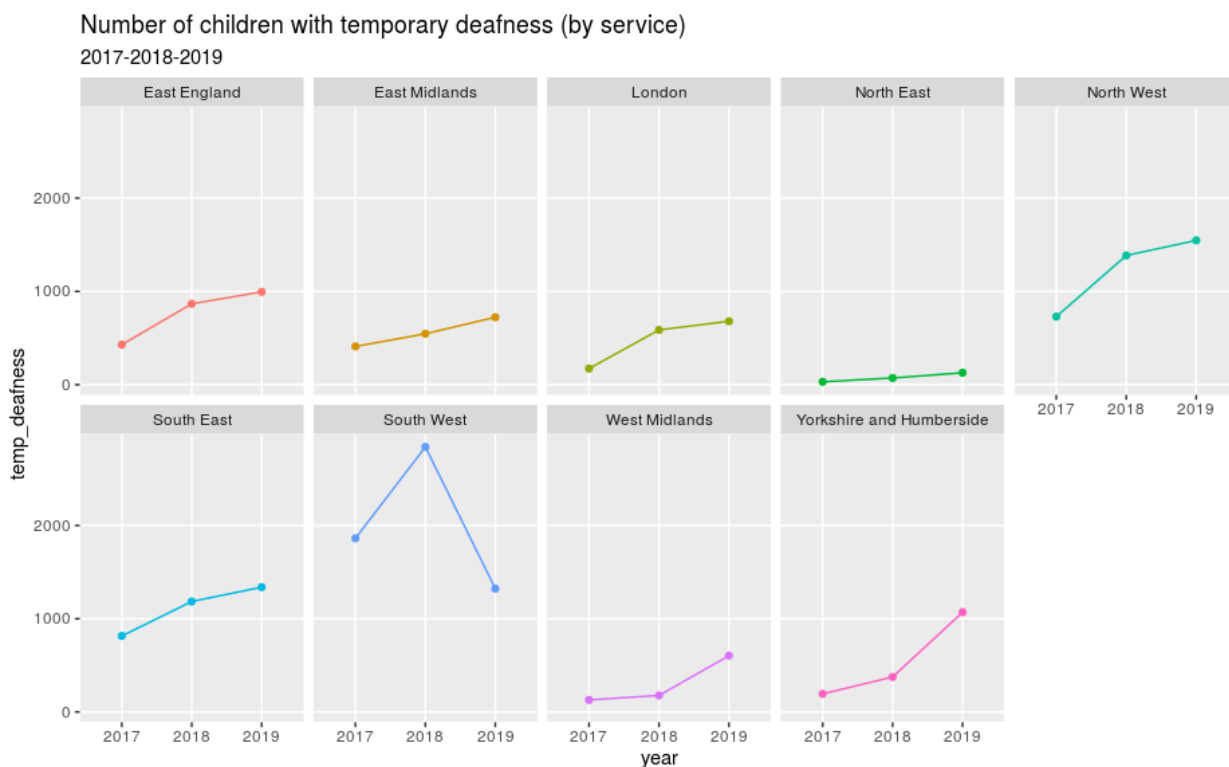


Figure 11: Number of children with temporary deafness (by service).

Region	2017	2018	2019
East England	429	867	995
East Midlands	410	546	723
London	173	587	680
North East	31	72	128
North West	730	1385	1547
South East	816	1185	1339
South West	1862	2842	1323
West Midlands	130	178	604
Yorkshire and Humberside	195	376	1070

Table 18: Number of children with temporary deafness by year and region

Total number of children with Auditory Neuropathy Spectrum Disorder (ANSD)

Services were asked to report the number of children with ANSD. Figures are provided in Table 19.

Year	Response rate	Total	Median
2017	63	488	5
2018	83	766	5
2019	99	993	6

Table 19: Overall number of children with ANSD as reported by services.

The number of children with ANSD being reported is increasing but is probably still very low. Due to newborn hearing screening protocols, ANSD is only reliably diagnosed in babies following test procedures undertaken in those who have spent time in Neonatal Intensive Care Units (NICU) and is not diagnosed following the screen used in the 'well baby' population. Universal newborn hearing screening has been in place in England since 2006. Figures provided through the newborn hearing screening programme indicate that around 1 in 10 congenitally deaf children have ANSD. This suggests therefore some under-reporting by services. This is probably due to under-identification of ANSD in deaf young people – those who did not receive newborn screening because they were born before the roll-out of universal screening in 2006, those 'well babies' who passed screening and were identified later, and those with acquired/progressive deafness who have not been tested for ANSD.

The total number of children with ANSD is provided by region and year in Figure 12 and Table 20. When compared by region, there is generally an upwards trend in the number of children reported over three years. The biggest increase in numbers for 2019 are reported in London and Yorkshire and Humberside.

Number of children with ANSD (by region)
2017-2018-2019

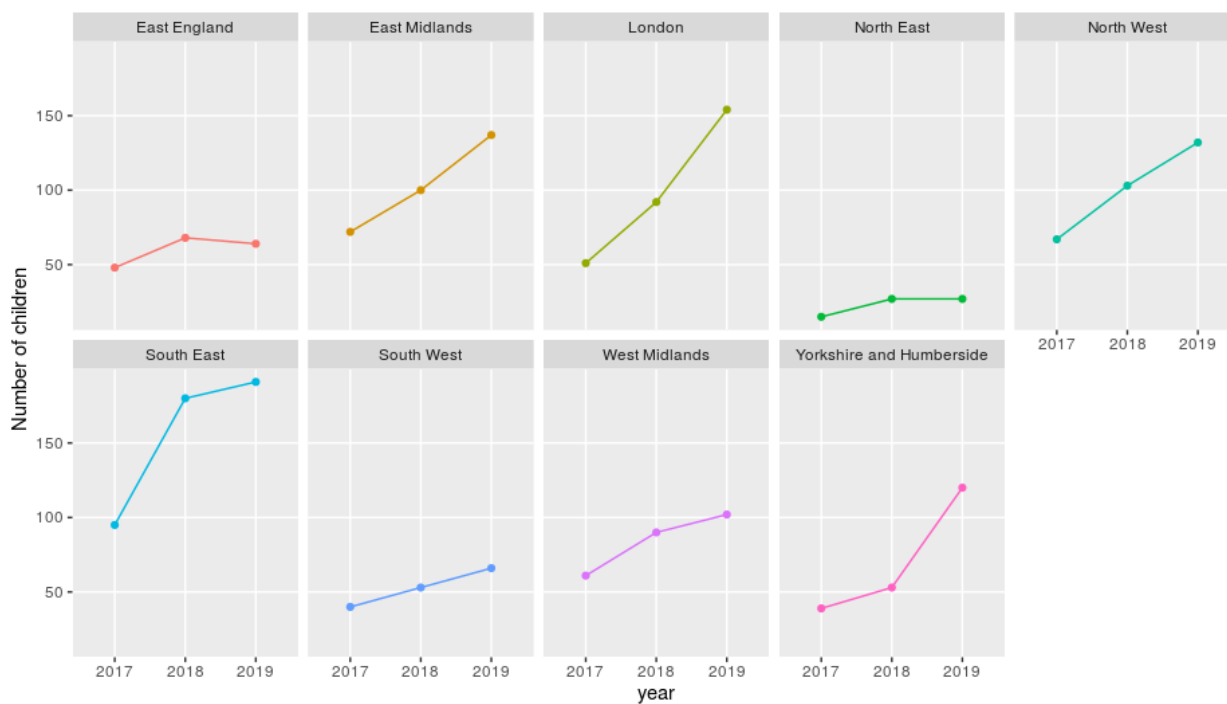


Figure 12: Total number of children with ANSD by region.

Region	2017	2018	2019
East England	48	68	64
East Midlands	72	100	137
London	51	92	154
North East	15	27	27
North West	67	103	132
South East	95	180	191
South West	40	53	66
West Midlands	61	90	102
Yorkshire and Humberside	39	53	120
Total	488	766	993

Table 20: Number of children with ANSD by region and year

Number of children referred to service from newborn hearing screen

Services were asked how many children on their caseload were referred to their service from the newborn hearing screen. Figures are reported in Table 21. Note that, compared to previous sections, we do not have numbers for 2017.

Year	Response rate	Total	Median
2018	83	19077	92
2019	85	15763	122

Table 21: Overall number of children on caseload referred to services from newborn hearing screen

Overall, the median number of children on caseload who had been referred from the newborn hearing screen has increased from 92 to 122 in 2019. The total number of children on caseload referred to services in 2019 has decreased.

Figure 13 and Table 22 provide the number of referrals by region and year. The number of referrals has decreased in all regions except for East Midlands and Yorkshire and Humber. The London region shows a sharp fall in the number of referrals reported in 2019.

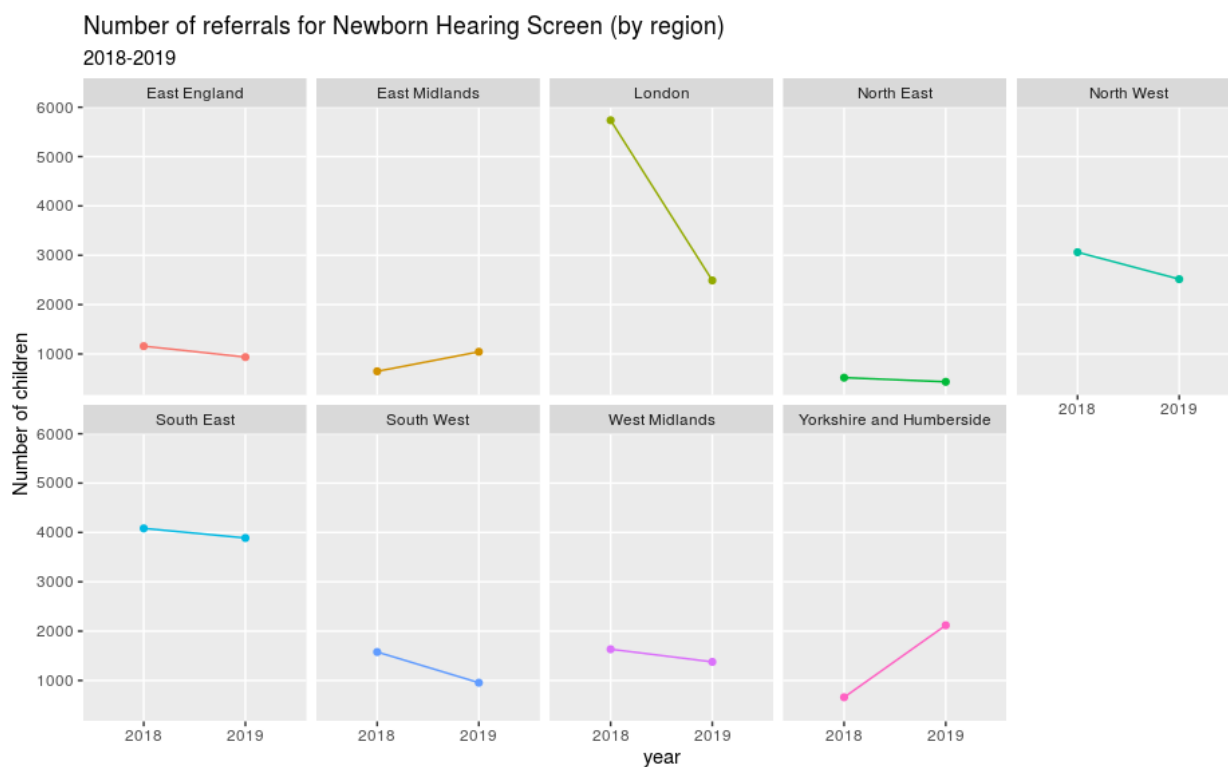


Figure 13: Total number of referrals from newborn hearing screen on caseload (by region).

Region	2018	2019
East England	1158	937
East Midlands	649	1045
London	5736	2490
North East	520	436
North West	3062	2516
South East	4082	3888
South West	1577	955
West Midlands	1633	1377
Yorkshire and Humberside	660	2119

Table 22: Number of referrals from newborn hearing screen on caseload by region and year.

8. Quality Improvement

Although all healthcare providers are officially inspected by the Care Quality Commission (CQC), outpatient services like audiology receive less focus than inpatient services 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".⁷ 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 the services on the accreditation journey?

Registering with the accreditation provider the United Kingdom Accreditation Service (UKAS) is the first step towards accreditation. In 2016, 37% of audiology services said they weren't registered with UKAS.⁸

	Number of services (2018)	%	Number of services (2019)	%
Registered	85	71%	0	0%
Registered (adult services)	0	0%	6	5%
Registered (adults/children)	0	0	54	45%
Registered (children's services)	0	0%	13	11%
Not registered	33	28%	47	39%

Table 23: Services registered with IQIPS (response rate: 118 services (2018), 120 services (2019)).

⁷ Care Quality Commission. [Shaping the Future: CQC's strategy for 2016 to 2021](#), p.6.

⁸ National Deaf Children's Society. *The Health of Children's Hearing Services in England*. 2017

In 2018, 28% of services were not registered with UKAS. In 2019, this figure increased to 39%. In the 2019 survey, those that had registered were asked to clarify if they were registered for adults' audiology services, children's audiology services, or both adults' and children's audiology. Of the 61% registered, 45% were registered for both adults' and children's services, 11% for children's services, and 5% for adult services.

Current status of IQIPS accreditation

Services were asked to clarify the current status of their IQIPS accreditation with regards to children's services only.

	Number of services (2018)	%	Number of services (2019)	%
Assessed: below standards	1	1%	1	1%
Gained accreditation	28	33%	27	37%
Never registered	0	0%	4	5%
Registered: dropped out after March	3	4%	4	5%
Registered: dropped out before March	5	6%	0	0%
Registered: no assessment	47	55%	37	51%

Table 24: Current status of IQIPS accreditation (response rate: 85 services (2018), 73 services (2019)).

In 2018 and 2019, 55% and 51% of services stated that they had registered but had not received an assessment. In 2018, 8 services indicated that they had dropped out of the process after registering. This figure increased to 17 services in 2019. One service in 2019 was found to be below standard.

However, 33% and 37% services in 2018 and 2019 respectively had gained accreditation.

Why have services not registered with IQIPS?

Services that were not registered for children's services were asked to provide the main reason why they had yet to register with IQIPS.

	Number of services (2018)	%	Number of services (2019)	%
No budget	3	9%	4	8%
No capacity	8	24%	16	30%
Not a priority	2	6%	4	8%
Not mandatory	5	15%	7	13%
Too complicated	0	0%	1	2%
Won't reach standard	1	3%	2	4%
Other	7	21%	11	21%

Table 25: Reasons why services were not registered with IQIPS (response rate: 33 services (2018), 53 services (2019)).

In 2018 and 2019, most services indicated that they did not have the capacity to manage the accreditation process. The next frequent reason provided was that this was not mandatory followed by not having a budget for the process. More services in 2019 do not consider IQIPS accreditation a priority.

Services also provided other reasons for not having registered. For example, some stated that they were focused on, or had recently achieved accreditation, for adult services and that this was a time-consuming process.

Services that were registered but had not received the onsite assessment were also asked to clarify why they had not progressed beyond this stage.

	Number of services (2018)	%	Number of services (2019)	%
No budget	3	6%	1	3%
No capacity	25	53%	11	30%
Not a priority	0	0%	1	3%
Not mandatory	1	2%	1	3%
Won't reach standard	0	0%	1	3%
Other	6	13%	7	19%

Table 26: Reasons why services were not making progress with IQIPS accreditation (response rate: 47 services (2018), 37 services (2019)).

Most services in 2018 and 2019 indicated that they did not have the capacity to progress with achieving accreditation. Few services indicated other reasons such as not having a budget or IQIPS accreditation not being a priority.

Services also provided other reasons for not having progressed. They told us that they were making progress towards registration, but services were not yet at the standard required for accreditation. Other services informed us that they were applying for IQIPS accreditation as a trust and were waiting for other services to catch up with preparations before proceeding.

Onsite assessment

More services in 2019 who had yet to have their onsite assessment told us that they had yet to book this appointment with UKAS.

	Number of services (2018)	%	Number of services (2019)	%
Booked	1	2%	3	8%
Not booked	30	64%	33	89%

Table 27: Number of services that have booked their onsite assessment (response rate: 47 services (2018), 37 services (2019)).

Progress against traffic light system for IQIPS accreditation

To decide whether they are ready for accreditation, services can assess themselves against a traffic light system. Green indicates that an assessment should be booked soon as they are close to accreditation standard.

	Number of services (2018)	%	Number of services (2019)	%
Red	2	7%	4	12%
Amber	6	20%	11	33%
Green	3	10%	4	12%
Not Using	18	60%	12	36%

Table 28: Where services are on the traffic light system (response rate: 30 services (2018), 33 services (2019))

Most services are not taking part in the traffic light system to assess whether they are ready for their UKAS assessment. For the 33 taking part in 2019, only 12% are ready for an assessment.

9. Staffing and Training

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.

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).

Number of permanent staff

In our 2019 survey, 40% (n = 43) services reported an increase in the number of permanent staff while 48% (n = 51) reported a decrease. 12% of services reported that the number of permanent staff had stayed the same. The degree of change is not even across services and regions, one service in London shows a marked decrease in comparison to other services.

Permanent staff
2017-2018-2019

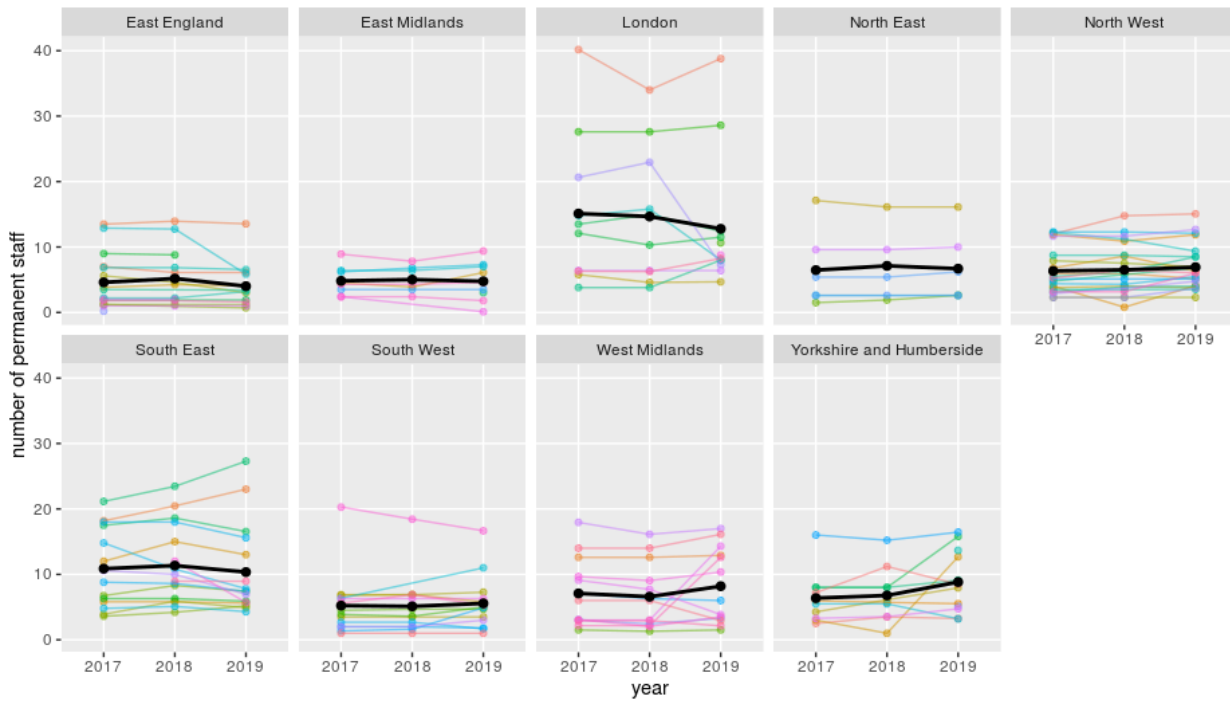


Figure 14: Number of permanent staff

When data are viewed by region, the total number of staff reported for services in the East and South East are lower in 2019 than in 2018. All other regions show an increase in the number of staff reported. Yorkshire and Humber show a marked increase (see Figure 15 and Table 29).

Total number of permanent staff (by region)
2017-2018-2019

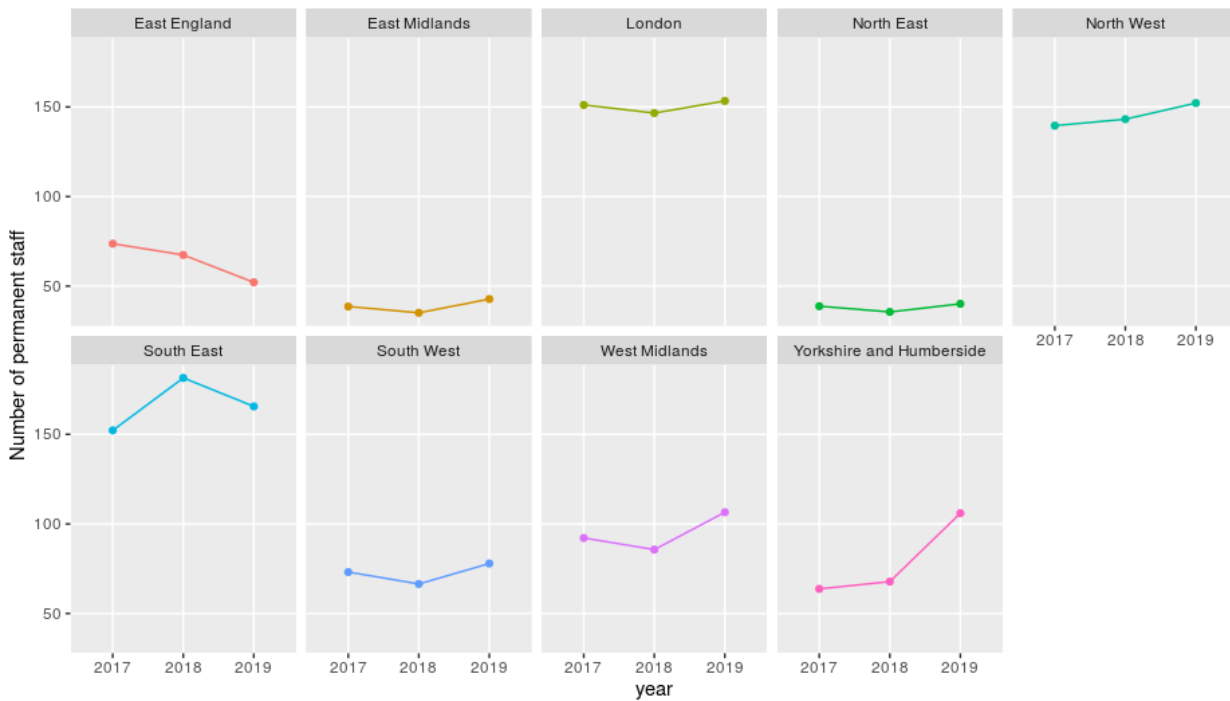


Figure 15: Total number of permanent staff by region

Region	2017	2018	2019
East England	73.7	67.4	52.1
East Midlands	38.6	35.1	42.8
London	151.1	146.6	153.4
North East	38.8	35.6	40.1
North West	139.6	143.2	152.2
South East	152.2	181.5	165.6
South West	73.1	66.5	77.9
West Midlands	92.1	85.7	106.5
Yorkshire and Humberside	63.8	67.8	106.0
Total	823.0	829.4	896.6

Table 29: Number of permanent staff by region and year.

Temporary staff

Fewer services gave us data on temporary staff. Half reported a reduction in the number of temporary staff while a quarter had increased. The remaining number told us that the number of temporary staff had stayed the same. An overview of the number of temporary staff is provided in Figure 16 and Table 30.

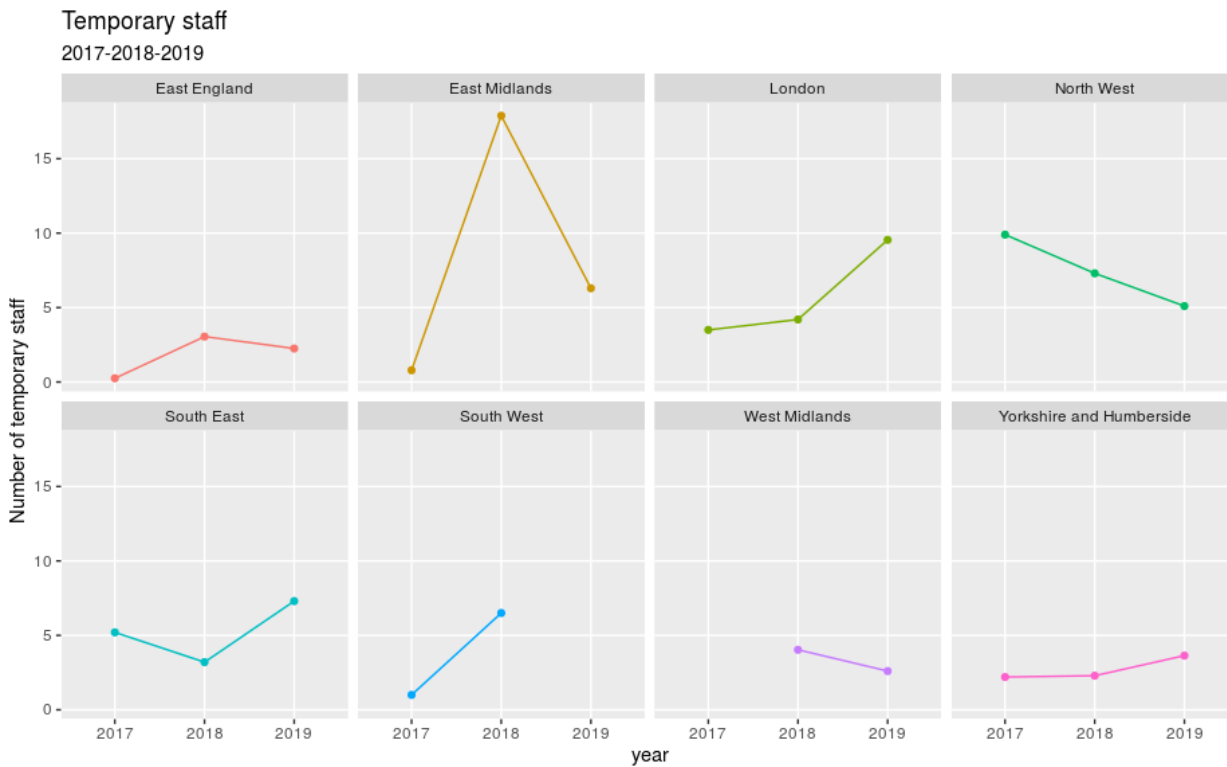


Figure 16: Total number of temporary staff by region

	2017	2018	2019
East England	0.25	3.05	2.25
East Midlands	0.79	17.89	6.30
London	3.50	4.20	9.55
North West	9.90	7.30	5.10
South East	5.20	3.20	7.30
South West	1.00	6.50	NA
West Midlands	NA	4.03	2.60
Yorkshire and Humberside	2.20	2.29	3.64
Total	22.84	48.46	36.74

Table 30: Number of temporary staff by region and year.

Frozen and vacant posts

A small number of services reported that some positions were frozen. The number reported was higher in 2019. When added together, 9 posts have been frozen since the beginning of this survey.

The number of vacant posts is slightly lower in 2019. Across 38 services, 58.3 posts have yet to be filled.

Year	Frozen posts			Vacant posts		
	2017	2018	2019	2017	2018	2019
Number of staff	4.9	3.6	5.4	40.4	62.9	58.3
Response rate	4	4	2	22	32	38

Table 31: Number of frozen and vacant posts

Net decrease and increase

One area of concern in our previous survey was a reduction in skill level across audiology posts. NDCS's position is that key staff must be appropriately trained at postgraduate level (for example MSc or equivalent) as the minimum level for paediatric practice.⁹ Viewed in terms of the staffing bands listed in Table 33, this means that supervising staff working with children should be employed at band 7 and above. In most cases, it is appropriate for an experienced band 6 staff member to work with children. However, the loss of higher band posts is a concern when caseloads consist of children with complex audiological needs and hospitals are recruiting staff at band 5 without the means to provide that individual with appropriate support, supervision and training to upskill.

⁹ <https://www.ndcs.org.uk/media/3837/audiology-services-uk-position-statement-june-2016.pdf>

Clarification regarding each band and what they mean is provided in the following table.

Band	Description
Permanent band 2	Administration staff
Permanent band 3	Assistant audiologist – supports routine hearing aid repairs and logistics / administration of service. May assist in testing children with band 6 and above staff
Permanent band 4	Associate audiologist (Foundation degree), routine adult hearing aid work under non-direct supervision. May assist in testing children with band 6 and above staff
Permanent band 5	Audiologist – newly qualified (BSc), able to work autonomously on routine cases – usually adults and older children – and assist with complex work and younger children
Permanent band 6	Senior audiologist – has gained experience, started to specialise, can work autonomously with the majority of children
Permanent band 7	Specialist audiologist (MSc, higher level qualifications or equivalent experience) – highly skilled and experienced in one or more specialisms within audiology, team leader for one area of expertise
Permanent band 8a	Principle audiologist / head of paediatrics (within a very large department that serves adults and children) / head of service / etc.
Permanent band 8b	As 8a depending on size of service, number of staff, number of specialisms offered in service, etc.
Permanent band 8c	As above
Permanent band 8d	As above
Permanent (doctor)	Consultant grade audiologist (AuD, PhD) or medical doctor (such as paediatrician with special interest in audiology)
Permanent (other staff)	Nursing staff, hearing therapists, specialist health visitors, newborn hearing screening coordinator, etc.

Table 32: Description of the different staffing bands.

The percentage change reported in our 2019 survey often differs from our 2018 survey. In some cases, however, an additional decline in the number of staff was reported. For example, at band 8d, there was an 18% decrease reported in 2019 in addition to the 8% decrease reported in 2018. A similar pattern was observed at band 8c.

	2017	2018	2019	2017-2018 (% change)	2018-2019 (% change)
Permanent band 2	34.1	34.6	31.9	1%	-8%
Permanent band 3	79.4	78.1	79.3	-2%	2%
Permanent band 4	51.2	54.5	49.8	6%	-9%
Permanent band 5	83.5	83.3	91.9	0%	10%
Permanent band 6	247.8	256.6	281.8	4%	10%
Permanent band 7	201.6	196.4	227.8	-3%	16%
Permanent band 8a	49.7	52	53.2	5%	2%
Permanent band 8b	16.7	17.5	20	5%	14%
Permanent band 8c	7.7	6.7	6	-13%	-10%
Permanent band 8d	1.2	1.1	0.9	-8%	-18%
Permanent (doctor)	39.4	36.2	42.2	-8%	17%
Permanent (other staff)	10.8	12.3	11.7	14%	-5%

Table 33: Net increase/decrease across bands

Reasons for reduction

Services were asked why there might have been a reduction in the number or skill level of staff in all posts above.

	Number of services (2018)	%	Number of services (2019)	%
Posts deleted	5	4%	3	2%
Post frozen	6	5%	2	2%
Staff hours reduced	17	14%	12	10%
Unable to recruit level 5 and below	13	11%	14	12%
Unable to recruit level 6 and above	12	10%	21	18%
Other	21	18%	31	26%

Table 34: Reasons for staff reductions.

More services in 2019 stated that they were unable to recruit at level 6 and above (an increase of 8 percentage points) while a similar number stated that they were unable to recruit at level 5 and below. Fewer services said that a reduction in staff hours, posts being frozen or deleted were reasons for a reduction in staff levels.

In 2019, most services indicated other reasons for a decline in staffing levels. These reasons included:

“Staff moving on to other roles, organisations or retiring. Several services stated that posts were in the process of being advertised/filled.”

“Fewer apprentices.”

“Being unable to arrange cover for staff on maternity leave.”

“Staff on long-term sick leave.”

“Flexible working requests from staff resulting in a change in how workloads are allocated.”

Many services mentioned difficulty in attracting high quality candidates when advertising:

“We have recently advertised for a Band 6 and not had any suitable applicants.”

“Our inability to attract any qualified Audiology staff to B5/6 posts over the last 2 years has led to a business plan to train our own Associate Audiologists.”

“The reason for the vacancies on band 4 and on band 7 is because the Trust has not yet sourced the right candidates”.

“Since the BSC removed paediatric modules from the degree course we have seen a decrease in Audiologists expressing an interest in Paediatric Audiology.”

“Increased skill mix (ATOs) within department as result of inability of recruiting audiologists.”

One service described how difficulties in recruiting staff for adult audiology has put a strain on other areas (such as paediatrics).

“Our failure to recruit Band 5 and 6 audiologists to see our routine adults has resulted in a great strain over all disciplines. We have successfully recruited to a number of band 6 posts in the last year and have developed some staff to work in the paediatric services. We currently have a number of locums working in adult services allowing substantive staff to work in paediatrics.”

Other services indicated that a restructure in their organisation has led to a change in staffing levels.

“The organisation made a decision to withdraw from AQP as of End March 2019. As a result we have reduced our establishment by deleting vacant posts.”

“Department restructure ongoing with 2 staff moving into Head of Department role and other staff receiving further training including one audiologist working towards HTS paediatric audiology qualification.”

“We have increased the number of staff and skill level.”

“Senior Team currently changing hence the vacant post, no plans to not recruit to return to full WTE.”

“2 staff relocated and we are developing staff from apprentice thorough to skilled qualified audiologist. Very reduced number of applicants for recent band 5 and 6 posts and not a lot of paediatric experience / expertise around at the level we require – so we are successfully “growing our own”

Training

We asked services if all staff are able to access the CPD necessary for their roles.

	Number of services (2018)	%	Number of services (2019)	%
Yes	96	81%	102	85%
No cover	10	8%	7	6%
Financial constraints prevent this	14	12%	15	12%
CPD training not covered	8	7%	6	5%
No (other reasons)	6	5%	11	9%

Table 35: Training opportunities for staff

81% and 85% of services in 2018 and 2019 stated that staff were able to access CPD training for their roles. A similar percentage of services indicated that CPD was not provided due to financial constraints and that training expenses were not covered.

Some services in our 2019 survey provided further explanation or reasons as to why staff are unable to access training such as:

“Lack of paediatric courses suitable for experienced paediatric audiologists e.g. advanced ABR, advanced paed assessment.”

“Whilst training may be available generally for Audiology it will be held quite a distance from site. This leads to additional expense and time away which will not always be funded by the Trust. Contribution towards time and costs are now expected, many audiologists cannot always afford this to be covered by them personally.”

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

“Accessing training funds is more difficult than in the past – applications are made to hospital funding sources on a case by case basis, there is no specific training budget per clinician.”

“Staff do not undertake any roles without the necessary training but funding for CPD remains limited.”

Planned changes to staffing

	Number of services (2018)	%	Number of services (2019)	%
No	71	60%	73	61%
Yes	47	39%	45	38%

Table 36: Planned changes to staffing

61% of services in 2019 stated that they were not aware of any planned changes to staffing for the following year.

Services who were aware of upcoming changes were asked to provide further information on these changes. Responses indicated that upcoming changes could involve general changes in staffing due to people leaving. This was the most frequent reason cited. Some services indicated that they were struggling to find a replacement (particular for short-term cover).

“1 x Band 6 full-time leaving (Sept 2019), 1 x Band 6 full-time going on maternity leave.”

“We have had Band 7 paediatric staff member resign and they will be leaving end of April 2019. At present there are no plans in place to fill this staffing role. A Band 5 staff member has been successfully recruited and should start July 2019, the other band 5 is being held pending further decisions.”

“0.8 FTE member of staff coming back from long term leave in June 2019 and will do 0.5 FTE of paediatric audiology.”

“1 WTE Band 6 maternity leave June 2019, we are currently struggling to recruit to this temporary post.”

“Yes, we will be recruiting for: Band 7 1 WTE Lead Paediatric Audiologist, Band 5 1 WTE Paediatric Audiologist, Band 3 1 WTE Term Time post, Band 3 1 WTE Fixed Maternity Cover.”

“We will lose 0.6 Band 5 and gain 1.0 Band 6. Interviews complete and awaiting pre-employment checks.”

“We currently do not have a clinical lead for audiology, due to recent stepdown of the clinical role. Currently we have a non-clinical operational manager allocated to the department. It is hoped to appoint a new clinical lead in the forthcoming months.”

“Funding approved for an apprentice post to start Sept 2019.”

“Full time permanent band 6 audiologist is due to start working with us in July 2019.”

Few services mentioned the planned addition of new posts. These were either bids in progress or a desire to increase the number of staff at their service:

“We want to increase our audiological staffing footprint and have plans to recruit and increase staffing levels and the division are happy to support increasing our establishment.”

“Business case to be submitted for additional B7 1.00wte.”

“The aim is to put in a capital bid to add another soundproof booth and to recruit staff.”

“Workforce planning supporting increase of 1 lower band and 1 high band post.”

“We will look to increase our staffing in children’s audiology to meet the demand.”

“We are putting in a bid for an overall head of department who will manage paed, adults and CI (We have been without one for 7 years).”

10. Children’s Hearing Services Working Groups

All services were asked whether they were a 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, and educational psychologists. 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.

	Number of services (2018)	%	Number of services (2019)	%
Yes	102	86%	99	82%
No	9	8%	15	12%
Don’t have one	5	4%	3	2%
Don’t know	3	3%	3	2%

Table 37: Services with CHSWG

Most services confirmed that the CHSWG in their area included at least one parent representative. However, there appears to be a decline in the number of CHSWGs having at least one parent representative.

In 2019, only three services indicated that they did not have a CHSWG in their area.

Working group guidance (2010) and annual reports

In 2018, services were asked if they used the CHSWG Guidance (2010). 66% indicated this was the case while 24% were unsure.

	Number of services	%
Yes	79	66%
No	2	2%
Don’t know	28	24%

Table 38: Services using the CHSWG Guidance (out of 119 services)

In 2019, a different question was asked. Services were asked if the CHSWG in their area produced a publicly available annual report. Only 26% said this was the case while 48% said they did not. 26% were unable to answer this question.

	Number of services	%
Yes	31	26%
No	56	48%
Don’t know	30	26%

Table 39: Number of CHSWGs producing an annual report (out of 117 services)

11. Technology

Organisations providing technology

Services were asked who provides assistive listening devices (radio aids, streamers, and remote microphones) for deaf children. Table 40 indicates that radio aids are most likely to be provided by local authorities. In a few cases, radio aids are provided jointly by the service and local authority. The local authorities are also most likely to provide remote microphones and streamers but not to the same extent as radio aids.

Not all services provide remote microphones and streamers. Streamers are least likely to be provided and their availability appears to be in decline. Fewer local authorities provide streamers in 2019 when compared to 2018.

Year	Jointly		Local authority		Not provided		Your service	
	2018	2019	2018	2019	2018	2019	2018	2019
Radio aids	5	9	114	113	0	0	0	1
%	4%	8%	96%	94%	0%	0%	0%	1%
Streamers	4	5	53	44	0	47	17	20
%	3%	4%	45%	37%	0%	39%	14%	17%
Remote microphones	3	5	80	78	0	19	13	14
%	3%	4%	67%	65%	0%	16%	11%	12%

Table 40: Organisations providing technology

Who balances equipment?

Audiology services were also asked if they would balance or pair equipment that has been purchased by the local authority or the parents of a deaf child.

60% and 54% services in 2018 and 2019 respectively said they would balance equipment provided by local authorities. 28% and 35% of services stated that they would balance equipment purchased by parents.

Fewer services stated that they would pair streamers provided by local authorities in the 2019 survey. In contrast, more services said they would pair streamers purchased by parents in the 2019 survey.

Year	Local authority		Not provided		Parents		We don't balance or pair devices unless we provided them	
	2018	2019	2018	2019	2018	2019	2018	2019
FM systems	71	65	0	14	33	42	21	20
%	60%	54%	0%	12%	28%	35%	18%	17%
Streamers	59	51	0	16	60	70	24	19
%	50%	42%	0%	13%	50%	58%	20%	16%

Table 41: Who balances equipment for the child?

Plans to stop provision of equipment

Services were asked if there were plans to stop the provision of hearing equipment or accessories for hearing equipment.

	Number of services (2018)	%	Number of services (2019)	%
Yes	1	1%	2	2%
No	115	97%	114	95%

Table 42: Number of services planning to stop provision of equipment.

Few services indicated that there were plans to do this. The two services who responded yes provided further clarification:

“Funding for children under 2 years of age has been a challenge but we are supporting our education partners to resolve this.”

“Previously integrated receivers were provided by health, however, as this is not funded, education will be supplying non-integrated receivers as of April 2019.”

12. Patient Engagement

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 ways that they might prepare a deaf young person for their transition. These options are:

- 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.

	Number of services (2018)	%	Number of services (2019)	%
Provide information	109	92%	110	92%
Offer appointment with adult service	67	56%	73	61%
Joint appointments	55	46%	66	55%
Visit local schools	7	6%	9	8%
Other	50	42%	49	41%
None of the above	1	1%	2	2%

Table 43: Services offering advice and support with transition planning to adult services.

Responses from 2018 and 2019 show a slight increase in the number of options offered to a deaf young person to prepare them for their transition into adulthood. In 2019, there was a 5% increase in the number

of appointments offered and a 9% increase in the number of joint appointments offered. There was also 2% increase in visits to local schools. The proportion of services providing information remained the same in 2018 and 2019. Although the figure is low, two services said they did not provide any of the options listed.

Some services used the 'other' option to provide additional detail on what they had selected or rephrased the options provided. There were also some additional ways in which services were preparing young people for transition.

- 11 services in 2018 and 2019 said they were a joint service so the transition service was not a major issue since young people were seen by the same staff.
- 13 services in 2018 and 12 services in 2019 ran a transition clinic or offered a specific transition appointment.
- 5 services in 2018 and 2019 said they held a transition event.
- 5 services in 2018 and 2019 said they had a dedicated transition audiologist.
- 2 services in 2018 and 2019 said they offered a tour of the department.

Recent score on the family and friends test

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. As a result, only 59 services in 2018 and 65 services in 2019 were able to give us a score. This resulted in a median of 98% for 2018 and 99% for 2019. One service in the South East reported a low score (5%) in 2019.

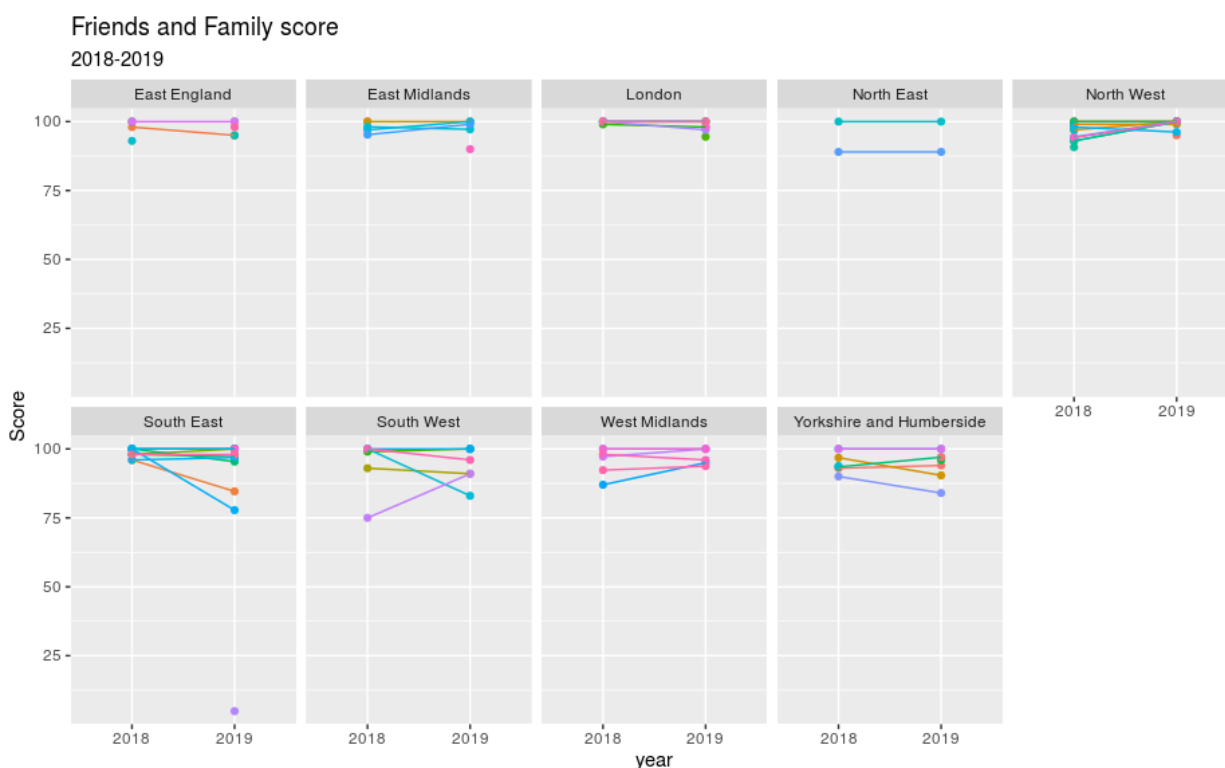


Figure 17: Friends and family score by service and region

	Total responses	Median score
2018	59	98.1
2019	65	99.0

Table 44: Median Friends and Family score by year

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 2018.¹⁰

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 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.¹¹ 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.¹²

DNA rates varied dramatically across services in 2018 and 2019. The black line in the figure below indicates the median DNA rate for each region and whether this rate has increased or decreased between 2018 and 2019. For all regions, the median rate was above the 9% rate reported by the NHS (indicated by the red horizontal line). This is despite some regions seeing a decline in DNA rates in our 2019 survey. In some cases, for London and the South East, DNA rates are increasing.

¹⁰ NHS England. [NHS Inpatient Admission and Outpatient Referrals and Attendances](#), 25 May 2018, p.4.

¹¹ We used 'Did Not Attend' (DNA) in our survey as we felt it is the most commonly used term by health professionals.

¹² Care Quality Commission. *Safeguarding Children: A review of arrangements in the NHS for safeguarding children*. July 2009, p.18.

DNA rates
2018-2019

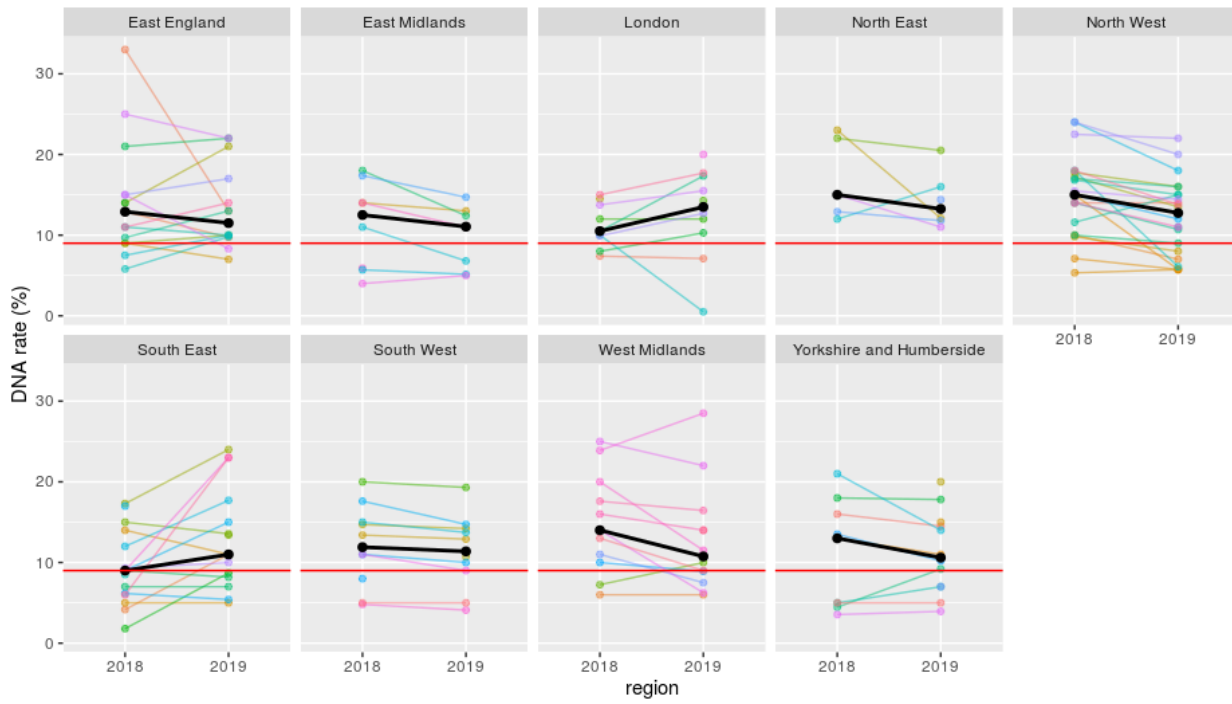


Figure 18: DNA rates by service and trust

	Response rate	Median score	Number over 9% rate	Percentage over 9% rate
2018	105	13%	80	76%
2019	110	12%	82	75%

Table 45: Number and percentages of services over the DNA rate

80 services in 2018 and 82 services in 2019 had DNA rates above the NHS outpatient average of 9%. If we look at DNA rates according to the services in our survey only, the median rate in 2018 was 13% and 12% in 2018 and 2019.

Appendix A:

List of services who participated in our survey in 2018 and 2019.

NHS Trust	2018	2019
Airedale NHS Foundation Trust	1	1
Alder Hey Children's NHS Foundation Trust	1	1
Barts Health NHS Trust	1	1
Basildon and Thurrock University Hospitals NHS Foundation Trust	1	1
Bedford Hospital NHS Trust	1	1
Berkshire Healthcare NHS Foundation Trust	1	1
Birmingham Women's and Children's NHS Foundation Trust	1	1
Bolton NHS Foundation Trust	1	1
Bradford Teaching Hospitals NHS Foundation Trust	1	1
Bridgewater Community Healthcare NHS Foundation Trust - Halton and St Helens	1	1
Bridgewater Community Healthcare NHS Foundation Trust - Warrington	1	1
Bridgewater Community Healthcare NHS Foundation Trust - Wigan	1	1
Brighton and Sussex University Hospitals NHS Trust	1	1
Buckinghamshire Healthcare NHS Trust	1	1
Calderdale and Huddersfield NHS Foundation Trust	1	1
Cambridge University Hospitals NHS Foundation Trust	1	1
Chesterfield Royal Hospital NHS Foundation Trust	1	1
CHIME Social Enterprise Limited	1	1
Countess of Chester NHS Foundation Trust	1	1
County Durham and Darlington NHS Foundation Trust	1	1
Croydon Health Services NHS Trust	1	1
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	1	1
Dorset County Hospital NHS Foundation Trust	1	1
Dorset Healthcare University NHS Foundation Trust	1	1
East and North Hertfordshire NHS Trust	1	1
East Cheshire NHS Trust	1	1
East Kent Hospitals University NHS Foundation Trust	1	1
East Lancashire Hospitals NHS Trust	1	1
East Suffolk and North Essex NHS Foundation Trust - Colchester	1	1
East Suffolk and North Essex NHS Foundation Trust - Ipswich	1	1
East Sussex Healthcare NHS Trust	1	1

Epsom and St Helier University Hospitals NHS Trust	1	1
Gateshead Health NHS Foundation Trust	1	1
George Eliot Hospital NHS Trust	1	1
Gloucestershire Hospitals NHS Foundation Trust	1	1
Great Ormond Street Hospital for Children NHS Foundation Trust	NA	1
Great Western Hospitals NHS Foundation Trust	1	1
Guy's and St Thomas' NHS Foundation Trust	1	1
Hampshire Hospitals NHS Foundation Trust	1	1
Hertfordshire Community NHS Trust	1	NA
Hounslow and Richmond Community Healthcare NHS Trust	1	1
Hull University Teaching Hospitals NHS Trust	1	1
Imperial College Healthcare NHS Trust	1	1
James Paget University Hospitals Foundation Trust	1	1
Kent Community Health NHS Foundation Trust	1	1
Kettering General Hospital NHS Foundation Trust	1	1
Kingston Hospital NHS Foundation Trust	1	1
Lancashire Teaching Hospitals NHS Foundation Trust	1	1
Leeds Teaching Hospitals NHS Trust	1	1
London North West Healthcare NHS Trust	1	1
Luton and Dunstable University Hospital NHS Trust	1	1
Manchester University NHS Foundation Trust - MLCO	1	1
Manchester University NHS Foundation Trust - MRI	1	1
Manchester University NHS Foundation Trust - TGH	1	1
Mid Cheshire Hospitals NHS Foundation Trust	1	1
Mid Essex Hospital Services NHS Trust	1	1
Mid Yorkshire Hospitals NHS Trust	1	1
Milton Keynes University Hospital NHS Foundation Trust	1	1
Norfolk and Norwich University Hospital NHS Foundation Trust	1	1
North Cumbria University Hospitals NHS Trust	1	1
North East London NHS Foundation Trust	1	1
North Tees and Hartlepool NHS Foundation Trust	1	1
North West Anglia NHS Foundation Trust	1	1
Northampton General Hospital NHS Trust	1	1
Northern Devon Healthcare NHS Trust	1	1

Northern Lincolnshire and Goole NHS Foundation Trust	1	1
Nottingham University Hospitals NHS Trust	1	1
Oxford University Hospitals NHS Foundation Trust	1	1
Pennine Acute Hospitals NHS Trust	1	1
Pennine Care NHS Foundation Trust	1	1
Portsmouth Hospitals NHS Trust	1	1
Royal Berkshire NHS Foundation Trust	1	1
Royal Cornwall Hospitals NHS Trust	1	1
Royal Surrey County Hospital NHS Foundation Trust	1	1
Royal United Hospitals Bath NHS Foundation Trust	1	1
Salford Royal NHS Foundation Trust	1	1
Salisbury NHS Foundation Trust	1	1
Sandwell and West Birmingham Hospitals NHS Trust	1	1
Sheffield Children's NHS Foundation Trust	1	1
Sherwood Forest Hospitals NHS Foundation Trust	1	1
South Tees Hospitals NHS Foundation Trust	1	1
South Tyneside & Sunderland NHS Trust	1	1
South Warwickshire NHS Foundation Trust	1	1
South West Yorkshire Partnership NHS Foundation Trust	1	1
Southend University Hospital NHS Foundation Trust	1	1
Southport and Ormskirk Hospital NHS Trust	1	1
St George's University Hospitals NHS Foundation Trust	1	1
Stockport NHS Foundation Trust	1	1
Sussex Community NHS Foundation Trust	1	1
Tameside and Glossop Integrated Care NHS Foundation Trust	1	1
Taunton and Somerset NHS Foundation Trust	1	1
The Dudley Group NHS Foundation Trust	1	1
The Hillingdon Hospitals NHS Foundation Trust	1	1
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	1	1
The Princess Alexandra Hospital NHS Trust	1	1
The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust	1	1
The Rotherham NHS Foundation Trust	1	1
The Royal Wolverhampton NHS Trust	1	1
The Shrewsbury and Telford Hospital NHS Trust	1	1

Torbay and South Devon NHS Foundation Trust	1	1
United Lincolnshire Hospitals NHS Trust	1	1
University College London Hospitals NHS Foundation Trust	NA	1
University Hospital Birmingham NHS Foundation Trust	1	1
University Hospital Southampton NHS Foundation Trust	1	1
University Hospitals Bristol NHS Foundation Trust	1	1
University Hospitals Coventry and Warwickshire NHS Trust	1	1
University Hospitals of Derby and Burton NHS Foundation Trust - Queen's Hospital	1	1
University Hospitals of Derby and Burton NHS Foundation Trust - Royal Derby Hospital & others	1	1
University Hospitals of Leicester NHS Trust	1	1
University Hospitals of Morecambe Bay NHS Foundation Trust	1	1
University Hospitals of North Midlands NHS Trust	1	1
University Hospitals Plymouth NHS Trust	1	1
Walsall Healthcare NHS Trust	1	1
West Suffolk NHS Foundation Trust	1	1
Western Sussex Hospitals NHS Foundation Trust	1	1
Whittington Health NHS Trust	1	1
Wirral University Teaching Hospital NHS Foundation Trust	1	1
Worcestershire Acute Hospitals NHS Trust	1	1
Wye Valley NHS Trust	1	1
Yeovil Hospital NHS Foundation Trust	1	1
York Teaching Hospital NHS Foundation Trust	1	1

Some services merged in the 2019 round and have changed their names. These services are listed below.

- Burton Hospitals NHS Foundation Trust merged with Derby and is now known as University Hospitals of Derby and Burton NHS Foundation Trust – Queen’s Hospital.
- City Hospitals Sunderland NHS Foundation Trust merged in 2019 and are now known as South Tyneside and Sunderland NHS Trust.
- Ipswich Hospital NHS Trust has merged and is now East Suffolk and North Essex NHS Foundation Trust – Ipswich.
- Derby Teaching Hospitals NHS Foundation Trust is now University Hospitals of Derby and Burton NHS Foundation Trust – Royal Derby and Others.
- Heart of England NHS Foundation Trust has merged and is now known as University Hospital Birmingham NHS Foundation Trust.
- Hull and East Yorkshire Hospitals NHS Trusts have renamed themselves Hull University Teaching Hospitals NHS Trust.
- Colchester Hospital University NHS Foundation Trust is now East Suffolk and North Essex NHS Foundation Trust – Colchester. However, the FOI return for each year indicates a different

combination of hospitals: 2018 has one unique hospital listed and 2019 has two. Overall, they have two hospitals in common.

- Royal United Hospitals Bath NHS Foundation Trust and the Royal United Hospital Bath NHS Foundation Trust has been combined. The FOI return for one year lists two additional hospitals.
- York Hospitals NHS Foundation Trust is the same as York Teaching Hospital NHS Foundation Trust. The FOI return for 2018 has one additional hospital listed.

Some hospitals did not provide a response in either 2018 or 2019. They are:

- Great Ormond Street (no response in the 2017-18 round).
- University College London Hospitals NHS Foundation Trust (no response in the 2017-2018 round).
- Hertfordshire Community NHS Trust (no response in the 2018-2019 round).