Position statement

Title	School Entry Screening
Approved by	NDCS Trustee Board
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Review date	
Executive director owner	Brian Gale
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In the light of the government expectation that in England all children should be offered a hearing screen around the time of starting school and the findings of the Health Technology Assessment 2007, NDCS policy on school entry screening (SES) is as follows.

In areas of the UK which have school entry screening NDCS shall:

- oppose any proposal to cease school entry screening unless it can be demonstrated that it will be replaced by more effective screening processes
- seek assurances about the quality of the screening programme, including asking for details of the numbers of children identified by school entry screening and what happens to the data
- ask that services should work to improve the quality of their screening programmes and implement audit of screening performance.

In areas that do not have school entry screening NDCS shall:

- urge for the introduction of an effective way of screening the child population
- ask what processes the health service has in place to ensure children are given prompt hearing assessment – e.g. do they offer open referral for parents concerned about hearing, do they have targeted screening for 'at risk' groups
- ask that whenever SES is re-introduced this is done with robust protocols, data collection and audit processes in place.

At January 2010, the National Institute of Health Research was commissioning research to find out "w*hat is the likely cost effectiveness of a school entry audiometric screening programme for permanent childhood hearing loss"?* It is unlikely that screening will be introduced in areas without a programme until this research is completed.

1. Background

Child Health Promotion Programme (CHPP)

In England, in its CHPP the government expects that all children should be offered a hearing screen around the time of starting school: **"By 5 years - to be completed soon**

after school entry: 'Hearing screening should be carried out using an agreed, quality-assured protocol in appropriate surroundings. Parental concern about hearing should always be noted and acted upon.'" (p56, CHPP, 2008).

2. Health Technology Assessment (HTA)

Recent research describing in detail current practice of SES across the UK was published in 2007. Key findings included:

- Just over 10% of services are no longer providing hearing screening at school entry. Coverage and referral rates are variable.
- Test techniques and protocols were very variable and tests are often done in poor listening conditions.
- There is no national approach to data collection or audit and quality assurance, and there are variable approaches at local level.
- Approx 1.89/1000 children have an acquired or progressive permanent deafness that requires identification after the newborn screen. 80% of these children could be identified using targeted screening if appropriate protocols, services and professional vigilance are in place. However, 20% (0.37/1000) of all permanent impairments may be missed without SES or reactive referral.
- SES was found to be cost-effective when compared to not having SES or using other types of hearing screen.

The lack of good-quality evidence in this area remains a serious problem and the National Screening Committee (NSC) is expected to provide additional guidance in the future based on the HTA findings. In the meantime, NDCS will be supporting the retention of school entry screening.

3. National Institute for Health Research - Health Technology Assessment Programme HTA no 09/113: Are screening programmes for permanent hearing loss in children at school entry cost effective?

This research is being commissioned by NIHR in 2010. The research question is:

"What is the likely cost effectiveness of a school entry audiometric screening programme for permanent childhood hearing loss?"

The research will cover:

"Technology: *A screening programme utilising one of two alternative test variants of the pure tone listening task; the pure tone sweep and a variant of the pure tone screener with fixed frequencies and three levels (Siemens).*
Patient group: *Children at or around school entry in the UK.*
Setting: *Schools in the UK.*
Comparator: *Children not subject to a school entry screening programme.*
Design: *A diagnostic accuracy study with an economic evaluation to identify and compare the positive predictive value (PPV) and negative predictive value (NPV) of the two technologies. Sufficient cost data should be collected to enable a model of cost effectiveness to be developed specific to each technology and both should be modelled against 'no active school entry screening'. The protocols for carrying out*

the tests and for subsequent management and referral should be clearly specified and researchers should differentiate between the identification of unilateral and bilateral hearing loss. It will be important to identify the costs of managing true and false positives as well as the harm resulting from false negatives. The analysis of findings should enable conclusions to be made by policy makers as whether or not a school hearing screening programme would be cost effective in the UK given the existing neonatal programme and if so, which would be the most appropriate test regime.
Primary outcome: *Diagnostic accuracy of the different tests and positive and negative predictive value of different screening protocols. Other outcomes: Cost per case identified, cost effectiveness, referral rates and treatment or intervention rate, measures of quality of life or of other benefit".*

4. References

Current practice, accuracy, effectiveness and cost-effectiveness of the school entry hearing screen, Bamford, J. et al, Health Technology Assessment 2007; Vol. 11: No. 32.

The Child Health Promotion Programme, DfES & DH, 2008.