LISTEN UP 2024

Children's hearing services in England

A report by the National Deaf Children's Society

National Deaf Children's Society ENGLAND

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A report by the National Deaf Children's Society, December 2024

Introduction

This report presents the findings of our national survey of NHS paediatric audiology services (children's hearing services) in England, carried out in Winter 2023. There has been a yearly report since 2017, which has proved helpful in identifying and tracking trends in paediatric audiology. For the first time, a similar exercise was also conducted for 2023 in Wales, Scotland and Northern Ireland.

As well as allowing the National Deaf Children's Society to gather evidence to influence national policy debates in England, the *Listen Up* report has been found to be a useful resource for audiology professionals to benchmark their own services, to plan service improvement and as evidence of need for business cases. We hope that the report will also be useful for discussions with other stakeholders in healthcare commissioning and delivering, by providing up-to-date evidence about paediatric audiology service provision.

We sent the survey to 127 NHS Trusts that we knew provided paediatric audiology services at the time of the survey.[1] As with previous *Listen Up* surveys, we made a Freedom of Information (FOI) request to ensure as many timely responses as possible. Of the 127 Trusts we contacted, 115 responded to the survey before the deadline and were included in our analyses. This gave a response rate of 91%, which is comparable to last year's England survey of 92% and the responses from Northern Ireland, Scotland and Wales also included in this year's data collection (see Table 1).

Country/Jurisdiction	Total respondents	% of services responding in time
Scotland	13	93%
England	115	91%
Wales	5	71%
N. Ireland	5	100%

Table 1: Number of responses from services in Scotland, England, Wales and N. Ireland for the 2023 report

The aim of separate surveys for each nation is to allow bespoke reporting, but also to allow some comparison within the UK, where appropriate. However, we recognise differences in results and trends should be interpreted cautiously due to the different size and structure of each country/jurisdiction's healthcare system, and variability in response rates and quality of responses between services. Additionally, not every service answered every question – either because a question was not relevant to their individual service, because they couldn't obtain the data, or for another unspecified reason – meaning that the response rate figures, and thus subsequent findings for each question, have been interpreted with caution.

We are very grateful to all the audiology services that responded to the survey. Although the report reflects some concerning issues and variation across services, it highlights the fact that most audiology services in England are committed to sharing evidence, even when their own time and resources may be stretched.

[1] At the time of the survey, the National Deaf Children's Society was only aware of 127 services that provided children's audiology services in England.

Key findings

The main issues highlighted were:

- The significant variability in caseloads is a potential **clinical risk for services with very small caseloads.**
- There are **regional variations in service provision**, particularly in the assessment of children with complex needs and in the management of temporary deafness.
- **Accessibility for deaf people is poor,** with only 27% of services offering British Sign Language (BSL) as an option for contacting the service, and less than half of audiology services reporting any deaf awareness training for staff.
- Long waiting times for routine first assessments present a **significant risk of delayed identification of deafness in children who are not identified at the time of the newborn screening.**
- Long waiting times for hearing aid reviews are **likely to have a significant impact on the quality of care for deaf children.**
- Significant waiting times for Ear, Nose and Throat (ENT) services are **likely to have a significant impact on the quality of care for children with temporary and mixed deafness.**
- **Quality assurance is not well embedded** in most audiology services. Only 23% of services self-reported having Improving Quality in Physiological Services (IQIPS) accreditation, and there are variable approaches to quality assurance.
- **Service capacity challenges because of staff vacancies and increasing demand** may be affecting the quality of services.
- **Services report a reduction in staff skill level**, with no consistent minimum qualification and training routes between services.

Description of key findings from the *Listen Up* Survey England 2023

Caseload variation

Among the services that told us about their caseloads, the populations they cover were very different. Subsequently, the caseloads of children with permanent childhood hearing impairment (PCHI) that they supported varied hugely, ranging from 40 to 1,490 children a year. There was variability in the age groups seen within paediatric audiology services, with a little over half of services covering 0 to 18 year olds and 41% seeing 0 to 25 year olds.

For services with the smallest caseloads of permanent childhood deafness, there is a clinical risk to the service and staff of not seeing a sufficient “critical mass” of cases to maintain expertise. While, overall, just over half of new PCHI identifications were through newborn hearing screening, as would be expected, there was huge variation between services in this pattern, suggesting that some children in England are at risk of delayed identification of PCHI.

Children with temporary deafness who are aided (fitted with hearing aids) make up around one-fifth of the total audiology caseload. But, again, there is significant variability in caseloads and distributions across services, and a high proportion of services do not record the number of children with temporary deafness who are fitted with hearing aids.

Service provision

The majority of services offer specific clinics or auditory brainstem response (ABR) under general anaesthetic (GA) for children with complex needs or those for whom it was difficult to obtain a definitive

test result using standard behavioural methods. While there is evidence of good practice in considering alternative options to standard behavioural methods, there is variability in the services provided.

The majority of services offer hearing aids to children with unilateral hearing loss, mild hearing loss, moderate hearing loss or auditory neuropathy spectrum disorder (ANSD), but there is variability across England and not all audiology services are commissioned to provide hearing aids. Nearly two-thirds of services said they provide services for tinnitus (65%) and hyperacusis (62%). Almost one-fifth of services are unable to provide, or refer children for, wax removal.

There is variability in the services offered for the management of temporary deafness. While 85% of services reported that they provide hearing aids to children with temporary deafness, only 61% of services reported providing hearing aids to children who are on the waiting list for grommets. Some children are waiting up to 565 days for grommet surgery and may not have access to alternative interventions in the meantime. Very few services mentioned referring to, or working with, education partners, e.g. sensory support, schools or teachers of the deaf (ToD), or providing information and advice to parents about, for example, listening tactics for children with temporary deafness.

Accessibility

Only 27% of services offer BSL as a communication option for families to contact them despite the importance of the needs of deaf people being fully considered in accessibility strategies.

Less than half of the services reported that both clinical and administrative staff had received one-off deaf awareness training (45% and 46% respectively), and even fewer reported that staff received regular deaf awareness updates (30% for clinical staff and 20% for administrative staff).

Waiting times

Most services in England manage to see children referred from the NHS newborn hearing screening programme (NHSP) and urgent new referrals within the target time. However, children outside these pathways can face significant waiting times, particularly those awaiting routine follow-ups after their initial hearing assessment or hearing aid fitting. For 7 out of the 11 clinical pathways that we asked services about, the average waiting times were higher than the target waiting time.

Children waiting for a routine follow-up hearing test, including those monitored for glue ear or at risk of developing PCHI, wait up to 547 days for an appointment. Of the services that responded, 87% reported average waiting times that suggest they were unable to see children at their planned time for follow-up. Only 11 services reported an average waiting time that met the agreed review time.

Similarly, only 11 services reported an average wait that met the planned timescale to review children already fitted with hearing aids, with the delays in planned care ranging from 4 to 600 days. Of the services that responded: 86% reported average waiting times exceeding the agreed time for planned review; 25% reported delays of over 100 days; and 65% reported being unable to see children within two days for new earmoulds.

There are significant waiting times for access to ENT services: 75% of audiology services reported that children they refer to ENT wait an average of more than 100 days for their initial ENT appointment, and 70% of services reported average waiting times over the target time for grommet surgery, with some children waiting up to 565 days.

Quality assurance

Only 23% of paediatric audiology departments in England are IQIPS accredited. Barriers to achieving accreditation include staffing issues, the process and funding. However, 97% of services report, and provide evidence of, quality assurance to their Integrated Care Board (ICB).

The use of quality assurance and improvement methods across England varies. While most services reported participation in external ABR peer review, there is variability in how this is performed, with not all clinicians performing ABR assessment participating in external peer review. Peer review of cases for children seen outside of the NHSP is less common, while quality assurance around other aspects of audiology, such as hearing aid fitting and behavioural testing, is not well embedded within audiology services.

The use of patient feedback and participation is also not well embedded within audiology services, with 63% of services reporting any use of patient surveys or focus groups.

Staffing

Paediatric audiology is a highly specialised service, with Bands 6 to 8 Agenda for Change (AfC) grading accounting for 79% of the paediatric audiology workforce. Half of services reported a reduction in the number of staff or skill level over the past year, with services reporting a total of 96.7 vacant full-time equivalent (FTE) posts across England. There is significant variability between services in the minimum qualifications and training requirements required for AfC posts. Some services have no set continuing professional development (CPD) requirements or training available for staff.

Collaborative working

There was a lack of consistency in criteria for referral and signposting across services. However, aided children with any level of hearing loss are referred to local specialist education services by most audiology departments, with the exception of some aided children with temporary/fluctuating hearing loss.

Many audiology services do not refer children who are not fitted with hearing aids to local specialist education services. In particular, only 30 of the services who responded refer children with temporary or fluctuating hearing loss to education services.

The majority of services reported that they signpost to the National Deaf Children's Society for all categories of children, but again fewer services signposted families in the cases of temporary or fluctuating hearing loss.

There was also a great deal of variation in criteria for referral to other health and social care services.

Patient engagement

All but one responding service reported that they have a Children's Hearing Services Working Group (CHSWG) in their area, but representation varied. The majority had a parent representative but very few had a deaf young person attend.

There is variation between services in how they engage deaf young people in the transition process to adult services. Most services do provide information to deaf young people. Some services use more engaged approaches, such as joint appointments and young people having the opportunity to come into the clinic without a parent/carer, if appropriate. However, this practice is not uniform across all sites.

The average rate of non-attendance/children not being brought to audiology appointments in England for the survey period is 12%, but there is evidence of services using strategies to try to prevent missed appointments. Rates for non-attendance put even more pressure on services trying to tackle backlogs in challenging circumstances, and services should find ways of engaging service users and improving attendance rates.

Changes in demand

Services reported an increased demand on their capacity in all areas:

- The majority of services reported an increase in demand for children requiring more complex assessment or ABR under sedation or GA.
- Services also reported increases in referrals for pre-school aged children.
- The majority of services did not report any change in demand from self-referrals or referrals from the school screening.
- Some services reported increased demand in the management of glue ear, either through aiding more children or due to different pathways.

Tackling the issues reported

Services did provide examples of good practice to meet increases in demand and tackle some of the issues identified. However, services report that they need increased capacity in terms of staffing and available facilities, as well as more funding for service resourcing to be able to cope with increasing demands on the services and tackle the issues reported. These are described more fully in section 10.

Funding and commissioning

There is variability across England in how audiology services are commissioned and funded. These differences are described more fully in section 11.

Section 2: Your caseload

We asked children's audiology services about their caseloads as of 30 September 2023.

Number of births covered by the service per annum

We asked services how many babies were born in the area covered by their service in 2023 and 105 services provided information. There were a total of 602,109 births reported across England, ranging from 1,500 to 24,000 per area. This reflects the different sizes and types of audiology services, from smaller community-based services to large teaching hospitals.

Age range

We asked services to indicate the age range their service covered. All 115 responding services indicated the ages they serve. A little over half (51%) cover ages 0 to 18 followed by 41% that cover 0 to 25.

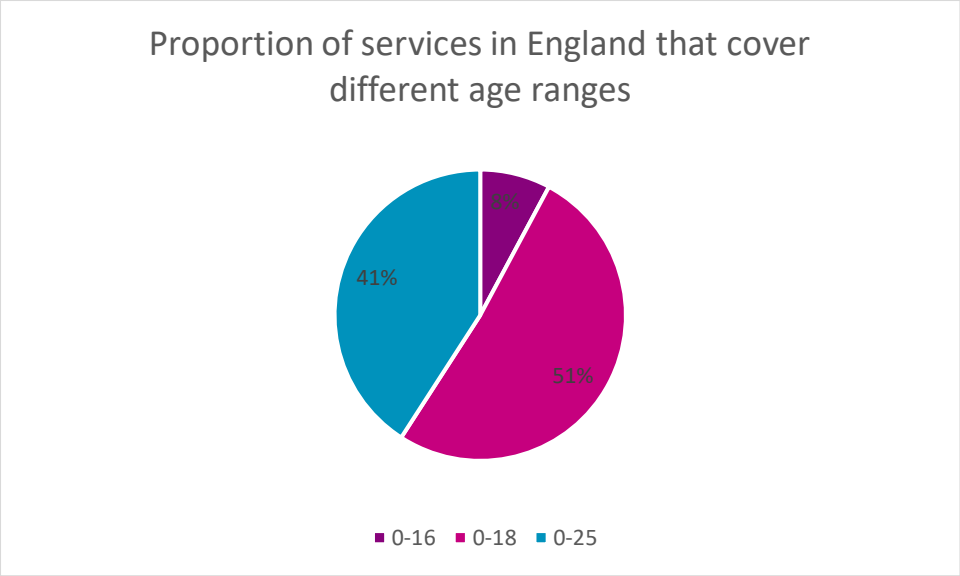

Figure 1. Proportion of paediatric audiology services in England that cover different age ranges (N=115)

Total number of children with PCHI

We asked services to indicate the total number of children with PCHI in their caseload. A total of 30,048 children with PCHI was reported by 95 services[2]. There was a large variation between services, ranging from 40 to 1,490.

Number of children with PCHI referred to service from NHSP and other referral routes

In previous years, we asked services how many children on their caseload were referred to their service from the NHSP. Since 2022, we have asked specifically about the number of children with PCHI referred to their service from the NHSP within a timeframe of a year.

For 2023, we asked services how many children with PCHI were identified via referral to their service from the NHSP between **1 October 2022 and 30 September 2023.** The number of children ranged from 0 to 65.

We also asked services how many children with PCHI were identified via other referral routes, such as referral from GP, health visitor or school screening, for the same period. Fewer services provided data and the number of children ranged from 0 to 182.

Year 2023	Response rate	Total	% Distribution	Range
Total	72% (91)[3]	1,910	100%[4]	0 to 196
NHSP	71% (90)	973	51%	0 to 65
Other referral routes	56% (71)	937	49%	0 to 182

Table 2: Number of children with PCHI referred to services between 1 October 2022 and 30 September 2023 from the NHSP or other referral routes

[2] PCHI caseload data from two responding services were excluded: one service reported a caseload similar to their birth rate and the other reported the same figures for total caseload and PCHI identified via NHSP in the past year.

[3] For this analysis (response rate, total number of PCHIs newly referred from either NHSP or other routes) we excluded services that did not provide data on either of the two variables (NHSP or other referral route; N=24) and included services with data on either variable; for the latter, we assumed that missing data on either was a zero value entry.

[4] Based on 90 services with data on either referral route variable; when a service had blanks in one variable and data on the other, the blanks were replaced by zero; one service had zero on both variables and was excluded from this analysis because percentage distribution of each referral route could not be calculated.

There were a total of 1,910 new PCHI identifications reported for the qualifying period (as reported by 91 services); numbers ranged from 0 to 196[5]. Just over half (51%) of new PCHI identifications were through the NHSP and 49% through other referral routes across 90 services, but there was significant variation between services in this pattern[6].

Number of children with temporary deafness fitted with hearing aids

Services were asked whether they record the number of children with temporary deafness who are fitted with hearing aids[7] and, if they do, how many children on their caseload with temporary deafness are currently fitted with hearing aids.

Year	Response rate	Total	Median	Mean
2023	37% (47)	4,122	76	88

Table 3: Number of children with temporary deafness fitted with hearing aids

Fifty-one services (40%) told us that they do record the number of children with temporary deafness that are fitted with hearing aids and 48 (38%) said they do not.

Forty-seven of the services that recorded this information shared the number of these children in their caseload, reporting a total of 4,122 children, ranging from 3 to 450 children across services.

An estimate of total caseload and distribution of categories of children

An estimate of the distribution of children with PCHI and temporary deafness (aided) in the reported caseload was obtained by adding the numbers of children with the two categories of diagnoses we asked services about. We were able to do this only for 44 services that provided data both on PCHI and temporary deafness (aided). About four-fifths (79%) of the caseload is accounted for by PCHI, with aided temporary deafness accounting for 21% (see Table 4 and Figure 2).

Year 2023	Response rate	Total	% Distribution	Range of % across services
Total	35% (44)	18,214	100%	-
PCHI	35% (44)	14,470	79%	38% to 97%
Aided temporary deafness	35% (44)	3,744	21%	3% to 62%

Table 4: Number of children with PCHI and aided temporary deafness

There is high variability in caseloads and distributions between services. There are important caveats in this approach: services reported estimates, so we may not have accurate data; we only asked services about specific categories, so not all caseload is accounted for (e.g. non-aided children with temporary deafness); and conditions may overlap (e.g. ANSD).

[5] See note above in relation to missing data. When we only included services that had provided data on both referral routes (N=70), total was lower (N=1,667) and the mean (24) and median (N=16) slightly higher (the range was the same, 0-196), all of which was to be expected if a distribution has fewer zero values. Equally, this may be an indication that the missing values could safely be assumed as zero values and/or there may not be a systematic bias in missing values. Such a sample (N=70), however, is only 55% of the total number of services (N=127) we sent the FOI to, therefore representativeness of responses is a caveat. Note that most of the missing responses were for the referrals outside the NHSP (56% response rate). There were 21 services (17%) with data only on one of the two referral route variables (NHSP or other) and 24 services with data missing on both referral route variables.

[6] When we only included services that provided data on both variables (N=69), 44% of new referrals came from the NHSP and 56% from different routes.

[7] Temporary deafness was specified as including those with glue ear who are expected to "grow out" of the condition before the age of 10 years. It also includes those children with glue ear who are not expected to "grow out" of the condition before the age of 10 years, such as those born with a cleft palate, Down's syndrome, cystic fibrosis or primary ciliary dyskinesia. The question about children with temporary deafness who may have been fitted with hearing aids as an alternative to grommet surgery, or while they are waiting for grommet surgery, should include those who are expected to "grow out" of the condition before the age of 10 years.

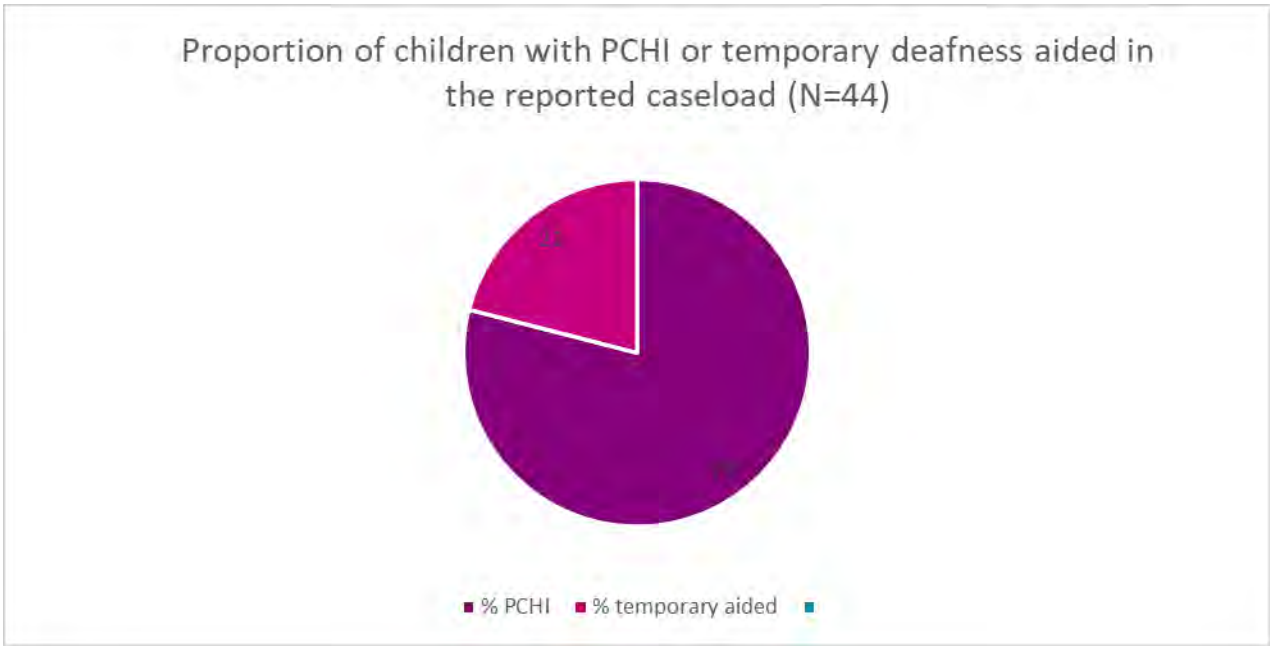

Figure 2. Proportion of children with PCHI and aided temporary deafness in the reported caseload (44 services)

Referrals to ENT

We asked services to give the number of children with glue ear they referred to ENT between 1 October 2022 and 30 September 2023. There were 4,392 children referred to ENT in the past year, as reported by 44 services (35%), with variation across services ranging from 0 to 348.

Year	Response rate	Total	Range
2023	35% (44)	4,392	0 to 348

Table 5: Number of children with glue ear referred to ENT

Number of children with ANSD

Services were asked to provide the total number of children with ANSD on their caseload.

Year	Response rate	Total	Range
2023	76% (97)	931	1 to 69

Table 6: Number of children with ANSD

There were 931 children with ANSD across 97 services that reported their caseload, ranging from 1 to 69. We looked at the number of children with ANSD as a fraction of the PCHI caseload (there were 94 services with data on both variables): ANSD accounted for between 0% and 12% of PCHI cases.

Section 3: What services do you provide?

Assessment options for children with complex needs

We asked services about the assessment options for children with complex needs or those for whom it was difficult to obtain a definitive test result using standard behavioural methods.

Year	Specific clinics, e.g. with longer clinic times or more experienced staff	Use of non-calibrated stimuli, e.g. non-calibrated but band-pass filtered music	Sedated ABR	ABR under GA	Other
2023	82% (104)	43% (55)	49% (62)	69% (87)	18% (23)

Table 7: Services provided for assessing the hearing of complex or difficult-to-test children, as reported by services

Most services (82%) that responded to this question reported that they offered specific clinics for this group with longer clinic times and/or more experienced staff. The second most preferred method (by 69% of services) was ABR under GA. Entries in the "Other" option included (numbers in brackets are the number of responses with that option):

- ABR with use of melatonin (5)
- ABR under natural sleep (4)
- auditory steady state response (ASSR) (5)
- referral onwards to specialist services (3)
- ABR with Super Sedation (dexmedetomidine) for 1 to 10 year olds (1)
- home/school visits (2)
- joint appointments with other professionals such as ToD Services (1)
- dual clinician clinics (1).

While there is evidence of good practice in considering alternative options to standard behavioural methods, there is significant variability in what services provided. We also asked what specific training and protocols services have for each one of those assessment options. Responses centred around availability of trained and experienced staff, following national published and local protocols, and working collaboratively with other departments (Table 8). Some departments also reported that no specific protocols were used.

Protocols for specific clinics (92)	Non-calibrated stimuli (47)	Sedated ABR (56)	ABR under GA (71)
• BSA guidelines • local standard operating procedures (SOPs) centred around assessment of children with complex needs • specific clinics led by more experienced or qualified clinicians • higher-level training • attendance at external training courses • case discussion via audiology governance meetings • IQIPS accreditation • triage phone calls to ensure children booked into correct clinics • staff competency assessments and peer review • no specific protocol.	• BSA guidelines • local discharge criteria to ensure used alongside objective tests • local SOPs centred around assessment of children with complex needs • specific clinics led by more experienced or qualified clinicians • external training courses • use of the frequency-filtered nursery rhymes • in-house training • peer review • clinical supervision • use of dedicated results sheet for reporting • IQIPS accreditation • no specific protocol.	• BSA guidelines • local SOPs centred around pathways, procedures and type of sedation • use of melatonin, chloral hydrate or GA • collaborative working with paediatrics • multiple testers present during assessment • use of more qualified and experienced staff • external training • peer review • IQIPS accreditation • option to refer to neighbouring services • no specific protocol.	• BSA guidelines • use of more qualified, experienced and specialist staff • local SOPs • peer review • multiple testers present during assessment • option to refer to neighbouring services or ENT • external courses • one Trust reported a preference for GA due to safety concerns with sedation • service not available or paused • IQIPS accreditation • external training • higher training scheme • collaborative working with paediatrics • no specific protocol.

Table 8: specific training and protocols used in the assessment of children with complex needs (numbers in brackets denote number of services that responded)

Services for temporary conductive hearing loss

We asked services about the options in their current management pathway for temporary deafness. We recognise that in some services, decisions around management of glue ear may be made by ENT and, therefore, are not within the scope of audiology.

Year	Air conduction hearing aids	Bone conduction hearing aids	Watch and wait	Grommets	Otovent	Other
2023	83% (106)	72% (92)	87% (111)	83% (105)	65% (83)	8% (10)

Table 9: Support available to children with temporary conductive hearing loss (percentages out of N=127 services)

The majority of services offer "Watch and wait" (87%), followed by air conduction hearing aids (83%) and grommets (83%). The 10 services that selected the "Other" option specified the following: referral on to another service; glue ear pamphlets from the National Deaf Children's Society; encouraging nose-blowing for older children; and listening advice tactics (e.g. seating in classroom and reducing background levels).

Alternative options offered for children on waiting lists for grommets

We asked services what alternative they offer if a child is on the waiting list for grommets. Well over half (61%) reported that they provide hearing aids. Some specified that they offer bone conduction hearing aids (31 services) and/or air conduction hearing aids (25 services). Some said they would prefer to offer bone conduction but cannot access funding. Eight services mentioned that they provide all options. Many said that the decision about options will be on a case-by-case basis. Very few mentioned referring to, or working with, education partners (sensory support, school or ToD) or providing information and advice to parents about, for example, listening tactics for children waiting for grommets.

Year	Hearing aids	Watch and wait	ENT referral	Otovent	Educational referral	No alternative
2023	61% (78)	7% (9)	10% (13)	5% (6)	2 (3)	3% (4)

Table 10: Options available to children with temporary conductive hearing loss on grommets waiting list (percentages out of N=127 services)

Provision of hearing aids

We asked services whether they provide hearing aids for the following groups of children and for their reasons if they do not.

Year	Temporary conductive hearing loss	Unilateral hearing loss	Mild hearing loss	Moderate hearing loss	ANSD	Other
2023	85% (108)	87% (110)	87% (110)	87% (110)	84% (107)	20% (26)

Table 21: Groups provided with hearing technology (percentages out of N=127 services)

Most services offer hearing aids for temporary conductive hearing loss, unilateral hearing loss, mild and moderate hearing loss, as well as for ANSD. The "Other" option was selected by 26 services, which listed the following practices: implantable devices, mini-mics for children with symptoms of auditory processing disorder (APD), and sound generators for children aged five years or over who have tinnitus/hyperacusis.

Some respondents told us their service is not commissioned to provide a hearing aid service, but they will refer accordingly.

Additional/non-standard paediatric services

We asked services about additional or non-standard paediatric services they offer and whether they can refer children elsewhere for services they are unable to offer.

2023	Wax removal performed by audiologists	Tinnitus assessment or management	Hyperacusis assessment or management	Fitting and support for implantable devices other than CIs, e.g. BAHAs, middle ear implants	Paediatric vestibular service	Assessment/ management of listening difficulties in the absence of peripheral hearing loss/APD	Other
Offer	19% (24)	65% (82)	62% (79)	29% (37)	28% (36)	34% (43)	22% (28)
Refer	53% (67)	21% (27)	23% (29)	57% (73)	43% (55)	40% (51)	-
Neither offer nor refer	18% (23)	4% (5)	5% (6)	2% (2)	17% (21)	10% (13)	-

Table 12: Number of additional paediatric services offered by services (percentages out of N=127 services)

Nearly two-thirds of audiology services said they provide services for tinnitus (65%) and hyperacusis (62%) in children. All other non-standard paediatric services were only offered by a minority of services, and in some cases audiology departments are not able to refer elsewhere when they are unable to provide a service themselves.

For example, 18% of services are unable to provide, or refer children for, wax removal, and 17% of services are unable to provide, or refer children for, paediatric vestibular services. Some services specified that they cannot refer because no service accepts referrals in their area.

Wax removal was the non-routine service least offered by audiology departments themselves (19%). This is likely to mean delays in wax removal, which is of particular significance for children who use hearing aids. Wax can cause difficulties with the use of hearing aids by, for example, creating feedback from the hearing aid and by making it impossible to take impressions of the ear for new earmoulds.

Section 4: Accessibility

Flexibility for appointments

We asked services about flexible options for appointments that they offer and, if they don't, whether they would like to offer them and what is stopping them from offering it.

2023	Extra appointments in school holidays	Extended opening times (before 9am and/or after 5pm)	Saturday appointments	Deliver some services in schools	Deliver some services in other community venues	Telephone or video appointments	Other
Offer	34% (43)	73% (93)	28% (35)	33% (42)	54% (68)	66% (84)	16% (20)
Would like to	22% (28)	10% (13)	29% (37)	13% (16)	14% (18)	5% (6)	-

Table 13: Number of services offering flexible appointments and number of services wishing they could offer them (percentages out of N=127 services)

Most services (73%) offered some extended opening times on top of their standard opening hours. The second most common flexible option (66%) was offering telephone/video appointments, followed by delivery in the community (54%). The least common option (reported by 28% of services) was Saturday appointments, although it was an option quite a few services (29%) would like to offer. Of the services that did not offer telephone/video appointments, not many (5%) would like to offer that option. It is not known whether these were temporary measures or permanent offerings.

Services that selected the "Other" option reported some alternative flexible provision: Sunday appointments, multi-location services, attending deaf schools and deaf society events, home appointments, only arranging appointments on the phone to ensure suitability, and multidisciplinary clinics.

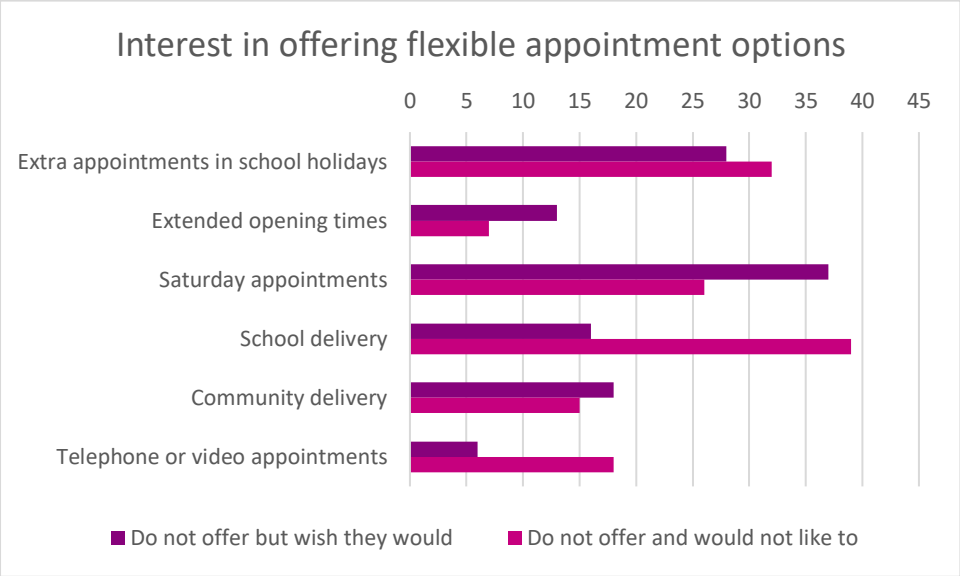

Figure 3. Number of services that do not offer flexible appointment options but said they would like to, and services that do not offer such options and said they would not be interested in offering them

Most services that do not offer the various flexible appointment options offered different reasons why:

- insufficient staffing levels
- staff working patterns and contracts
- facilities and room capacity (room capacity onsite, outpatients closed at weekends and lack of suitable community spaces)
- lack of demand.

Specific concerns that came up in relation to school and community appointments were about efficiency and cost-effectiveness of staff travelling to geographically spread venues. Concerns were also voiced in relation to being unsure whether parents would welcome audiologists in pre-school social groups and how the service would prioritise parents for Saturday appointments, ensuring fairness of opportunity.

Communication options

We asked services about the communication options they offer to families for contacting them.

Year	Email	Text message	Web form	Online diary/booking system	Telephone	BSL	Other
2023	88% (112)	44% (56)	13% (16)	5% (6)	90% (114)	27% (34)	26 (33)

Table 14: Number of communication options offered by services (percentages out of N=127 services)

The majority of services use telephone (90%) and email (88%) for communicating with families. Fewer than half (44%) use text messaging, while a little over a quarter (27%) use BSL as a routine option for contacting them. Entries under the "Other" option included:

- Language Line Text to Speech, via a central hub number
- direct staff mobile access
- BSL interpreters on request
- Wordskii interpreting system
- BSL via video service
- apps
- in person at reception
- national NHS patient portal service available for young adults
- other health professionals ringing on behalf of patients.

Service response time for each communication option

We asked services about the response times (in days) for each of the communication options, both target and actual, and whether there is anything preventing them from reaching their target. Numbers in brackets denote the number of services that provided this information.

2023	Email	Text message	Web form	Online diary/booking system	Telephone	BSL	Other
Target: mean response time (days)	1.8 (96)	1.5 (41)	1.9 (11)	1.0 (3)	1.4 (96)	2.2 (13)	-
Actual: mean response time (days)	2.0 (84)	1.8 (35)	1.7 (11)	1.0 (1)	2.0 (84)	1.6 (9)	-

Table 35: Mean response times for each communication option (number of services providing data in brackets)

Not all services gave us their target response times and even fewer gave us their actual response times. Some explained in their "Other" response that they do not track them. This means that for email and telephone, for example, which were widely used, we only have target response times for 76% of the 127 services we contacted, and actual response times for 66% of the services.

The average target response time ranged from one day for online booking system to 2.2 days for BSL. The average actual response time ranged from one day for online booking system to two days for email and telephone. The average actual response times were generally in line with the target response times. Looking at individual services, while the most common value (mode) was one day and the median for most communication options, both actual and targeted, was also one day, there was variability, with one service reporting response times of 14 days and another reporting seven days.

Reasons for not reaching response targets were provided by very few services (between one and eight for the different options) and responses centred around staffing levels and administrative support in particular. Delays in BSL response times were attributed to relying on external organisations.

Deaf awareness training

The survey asked what deaf awareness training staff have. Numbers in brackets denote the number of services that provided this information.

Year 2023	One-off training	Regular updates
Audiologists	45% (57)	30% (38)
Reception/administrative staff	46% (59)	20% (26)

Table 16: Deaf awareness training

Fewer than half of the services reported that both clinical and administrative staff received one-off training (45% and 46% respectively) and fewer reported that staff receive regular updates (30% for clinical staff and 20% for administrative staff).

Section 5: Waiting times

For this survey, we asked services to report their **average** waiting times (in days) in the period **1 October 2022 to 30 September 2023**. It is necessary to highlight some important caveats that affect the quality of the data:

- An average waiting time does not accurately reflect the variability in waiting times within a service, i.e. it is likely that some children in a service may be waiting longer than, and some less than, the average figure reported.
- The standard is for maximum, not average, waiting times, so a service with an average waiting time of 28 days may not have met the standard for every child within that service.
- We specified that we would accept estimates if services were unable to provide exact numbers, as services told us they did not collect these figures routinely, which may also affect data quality.

However, the responses do give us useful insight about waiting times in England, whether these are average or reflect the situation for the majority of caseloads.

Referral to first diagnostic assessment for babies referred from the NHSP

The waiting time target from being referred from the NHSP to attendance at an audiological assessment appointment in England is 28 days[8].

Ninety-six services provided data on the average time from referral from the NHSP to the first diagnostic assessment, which ranged from an average five-day wait at one service to an average 42-day wait at another.

[8] GOV.UK. Newborn hearing screening programme standards: valid for data collected from 1 April 2018 to 31 March 2022. gov.uk/government/publications/newborn-hearing-screening-programme-quality-standards/newborn-hearing-screening-programme-standards-2018-to-2019#nhsp-s05-diagnosisintervention--time-from-screening-outcome-to-attendance-at-an-audiological-assessment-appointment (accessed November 2024).

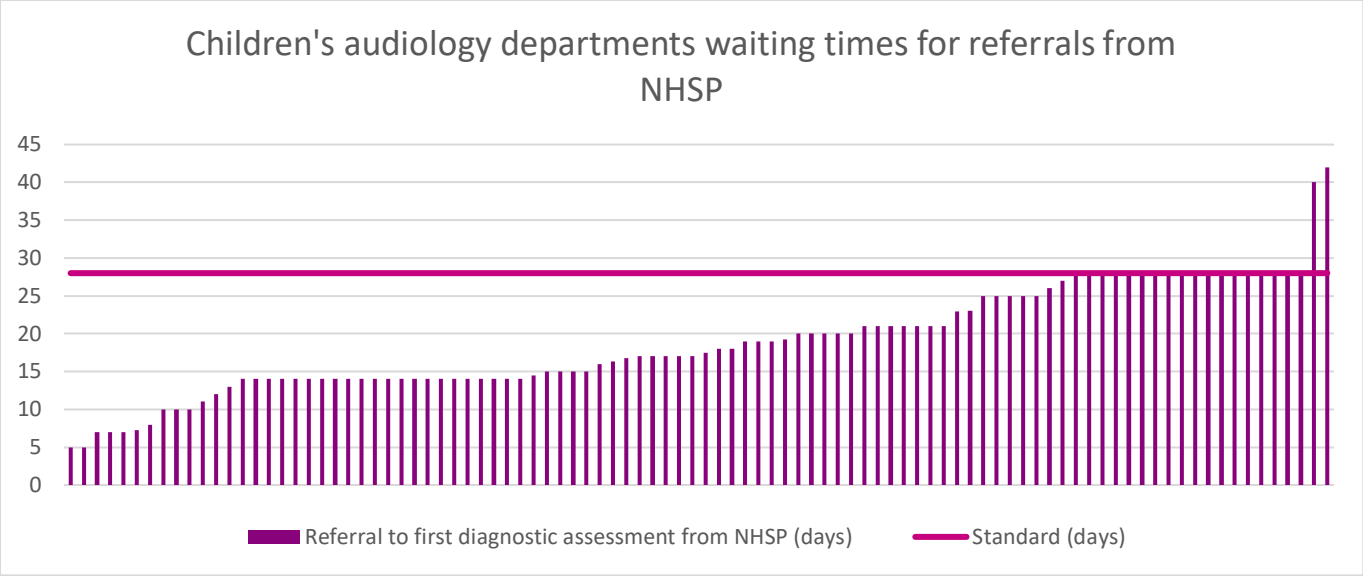

Figure 4. Distribution of average waiting times against the standard (X axis shows individual service responses; Y axis indicates waiting time in days)

Only two services (out of those providing data) did not meet their average 28-day target waiting times.

Urgent new referrals for diagnostic hearing assessment (not from the NHSP)

In England, the waiting time target for urgent new referrals after the window for the NHSP for infants and older children, for whom there is concern or a high risk of hearing loss (following meningitis or head injury, for example), is 28 days[9].

Year	Minimum average waiting time (days)	Maximum average waiting time (days)	Response rate
2023	1	300	69% (88)

Table 17: Average waiting time for urgent new referrals for diagnostic assessment (not from the NHSP) in days

Eighty-eight services' average waiting times for urgent new referrals for diagnostic hearing assessment ranged from 1 to 300 days. Two services reported extreme average waiting times of 119 and 300 days.

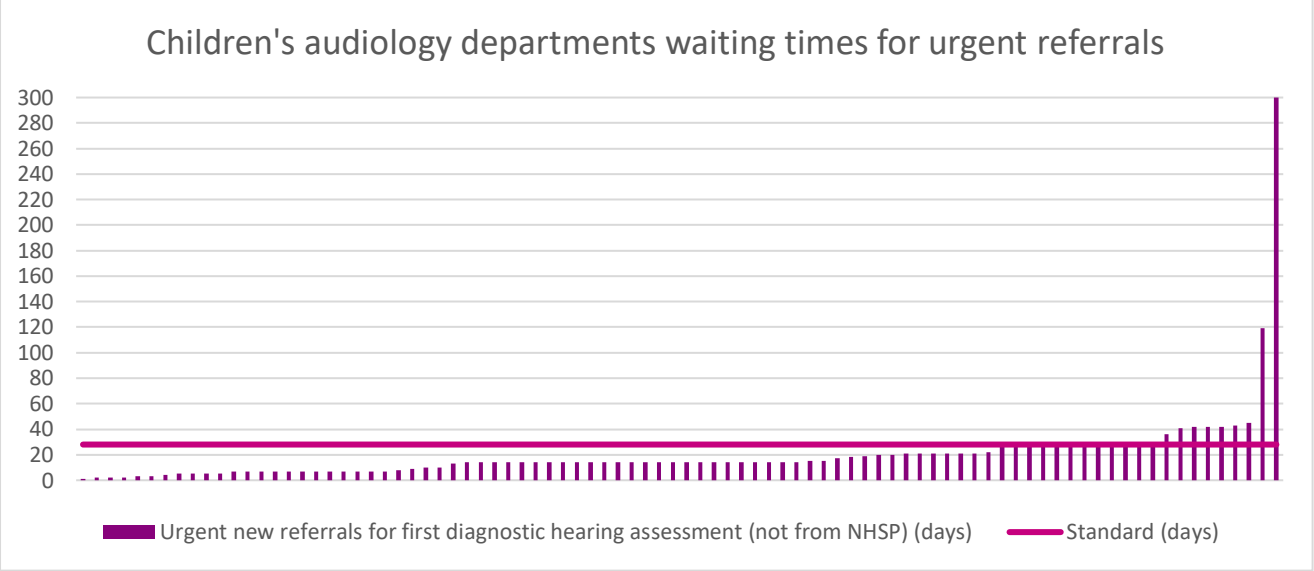

Figure 5. Distribution of waiting times against the standard

[9] British Academy of Audiology. *Quality Standards in Paediatric Audiology* (July 2022). baaudiology.org/app/uploads/2022/07/BAA-Paed-QS-v1-2022.pdf (accessed November 2024)

Eleven services (13% of those with data) reported average waiting times greater than 28 days.

Routine new referrals for first assessment (outside the NHSP)

The waiting time target in England for routine referrals to first diagnostic assessment for infants and older children, for whom hearing loss is suspected after the window for the NHSP, is 42 days.

Year 2023	Minimum average waiting time (days)	Maximum average waiting time (days)	Response rate
Face to face	6	365	74% (94)
Virtual	0	42	8% (10)

Table 18: Routine referral to first assessment (face to face and virtual) for babies and children not referred from the NHSP (percentages are out of 127 services)

Ninety-four services provided data on average waiting times for face-to-face assessments ranging from 6 to 365 days. Ten services provided data on average waiting times for virtual appointments (if offered first), ranging from 0 to 42 days. These appointments do not replace face-to-face assessment appointments but are useful for prioritisation of children on the waiting list, for example.

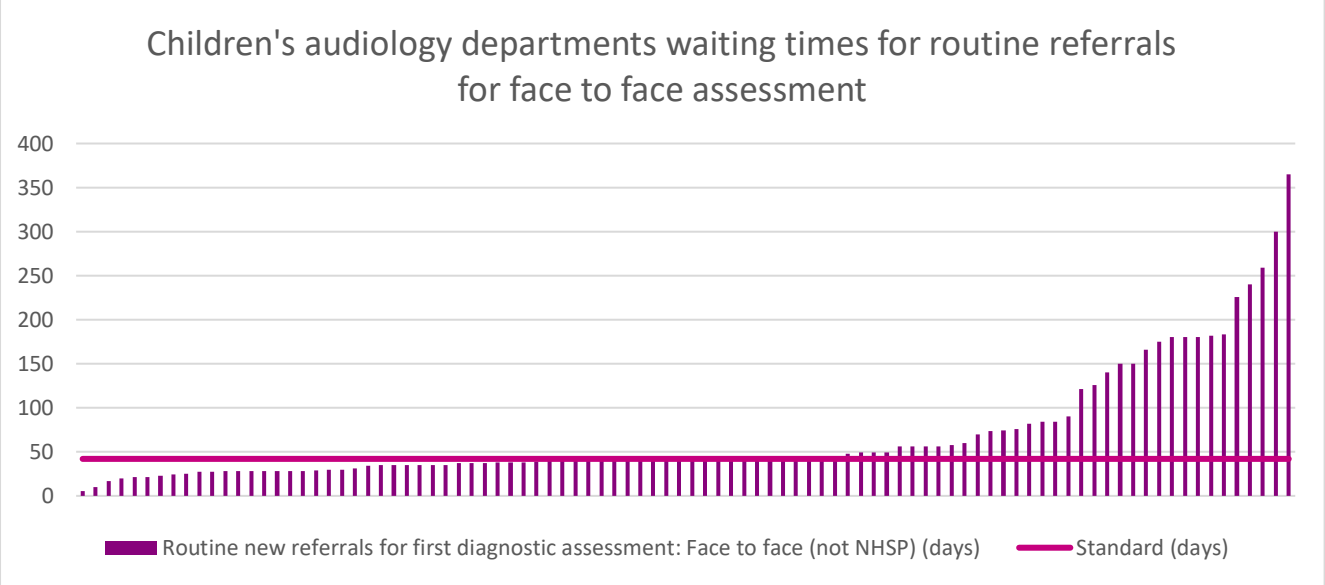

Figure 6. Distribution of average waiting times against the standard

Thirty-six services (38% of those with data) reported average waiting times in excess of 42 days for face-to-face appointments. All services offering initial virtual appointments were able to offer them within 42 days. However, three of these services also reported extreme average waiting times for face-to-face appointments, ranging from 166 to 259 days.

Waiting times from decision to fit hearing aids to fitting of hearing aids (for PCHI)

The standard for waiting times in England, from the decision to fit hearing aids to the time they are fitted for PCHI, is 28 days[10].

[10] British Academy of Audiology. *Quality Standards in Paediatric Audiology* (July 2022). baaudiology.org/app/uploads/2022/07/BAA-Paed-QS-v1-2022.pdf (accessed November 2024).

Year	Minimum average waiting time (days)	Maximum average waiting time (days)	Response rate
2023	4	63	75% (95)

Table 19: Waiting times (in days) from decision to fit hearing aids to time fitted for PCHI (percentages are out of 127 services)

Ninety-five services provided data on their average waiting time from decision to fit hearing aids to the time they are fitted, ranging from 4 to 63 days.

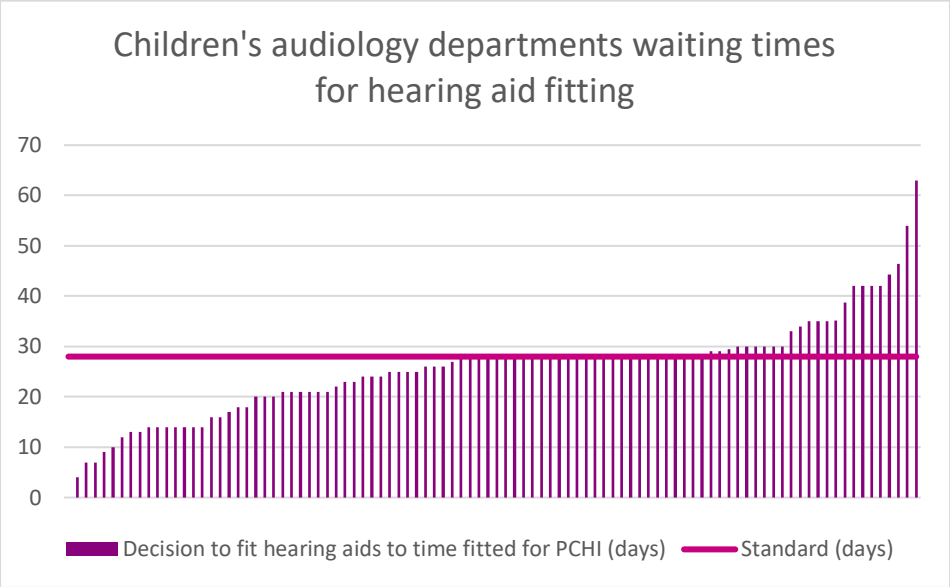

Figure 7. Distribution of average waiting times against the standard

Twenty-four services (25% of those with data) had average waiting times exceeding 28 days.

Routine follow-up hearing aid review

Services were asked about average waiting times for routine follow-up hearing aid review, which was explained as a wait beyond the expected/agreed date, i.e. a child seen for their three-month follow-up at three months would be 0 days, and a child seen at four months for a three-month follow-up would be 30 calendar days.

Year	Minimum average waiting time (days)	Maximum average waiting time (days)	Response rate
2023	4	600	63% (80)

Table 20: Waiting times (in days) for routine follow-up hearing aid review (percentages are out of 127 services)

Eighty services provided data on average waiting times for routine hearing aid review. Only 11 reported average waiting times that met the agreed timescale to review children already fitted with hearing aids. Average delays ranged from 4 to 600 days. There were 25 services with average delays of over 100 days.

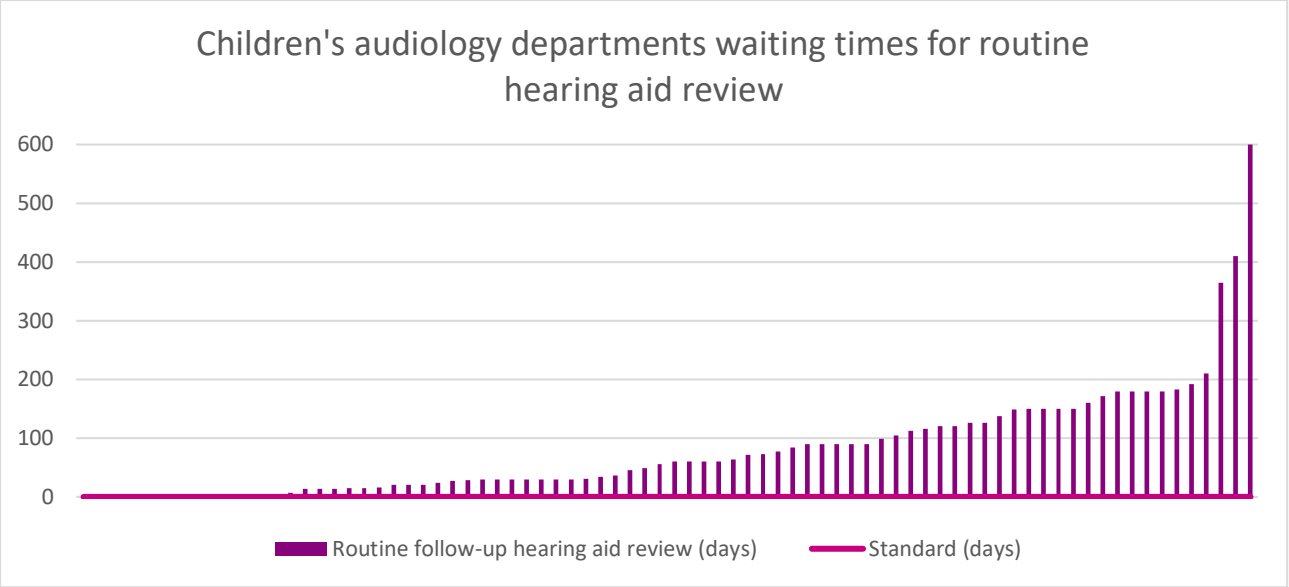

Figure 8. Distribution of average waiting times against the standard

Sixty-nine services (86% of those with data) exceeded their target waiting time on average.

New earmoulds (working days from time notified of need)

Appointments for replacement earmoulds should be within two working days of request in England[11].

Year	Minimum average waiting time (days)	Maximum waiting time (days)	Response rate
2023	1	26	67% (85)

Table 21: Average waiting times (in days) for new earmoulds (percentages are out of 127 services)

Fifty-five services (65% of those with data) exceeded average waiting times of two days.

Hearing aid repairs (working days from time notified of need)

Appointments for hearing aid repair are within two working days of request in England[12].

Year	Minimum average waiting time (days)	Maximum waiting time (days)	Response rate
2023	1	14	68% (86)

Table 22: Average waiting times (in days) for hearing aid repairs (percentages are out of 127 services)

Twenty-eight services (33% of those with data) were unable to see children on average within two days for a hearing aid repair.

Routine follow-up hearing tests for children who are not aided

Services were asked about average waiting times for routine follow-up hearing tests for children who are **not** aided (including watchful waits for glue ear, and those who require regular review). It was explained

[11] British Academy of Audiology. *Quality Standards in Paediatric Audiology* (July 2022), p15: "5a. 3. Families requesting routine replacement ear moulds are offered an impression appointment within one week of request. Misplaced/lost earmoulds are treated as hearing aid repairs…" (family should be offered an appointment within two working days). baaudiology.org/app/uploads/2022/07/BAA-Paed-QS-v1-2022.pdf (accessed November 2024).
[12] British Academy of Audiology. *Quality Standards in Paediatric Audiology* (July 2022), p15: "5a. 4. Appointments for hearing aid repairs are offered within two working days of request." baaudiology.org/app/uploads/2022/07/BAA-Paed-QS-v1-2022.pdf (accessed November 2024).

that by wait we mean wait beyond expected date, i.e. for a child seen for a follow-up planned for three months who was seen at three months – the **wait** would be 0 days; for a child seen at four months for a follow-up planned for three months, the **wait** is 30 calendar days.

Year	Minimum average waiting time (days)	Maximum average waiting time (days)	Response rate
2023	0	547	65% (82)

Table 23: Average waiting times (in days) for routine follow-up hearing tests for children who are not aided (percentages are out of 127 services)

Eighty-two services gave a response to the question. Most reported delays in reviewing children who did not use hearing aids but required further assessment and/or monitoring. Twenty-six services had an average delay of over 100 days.

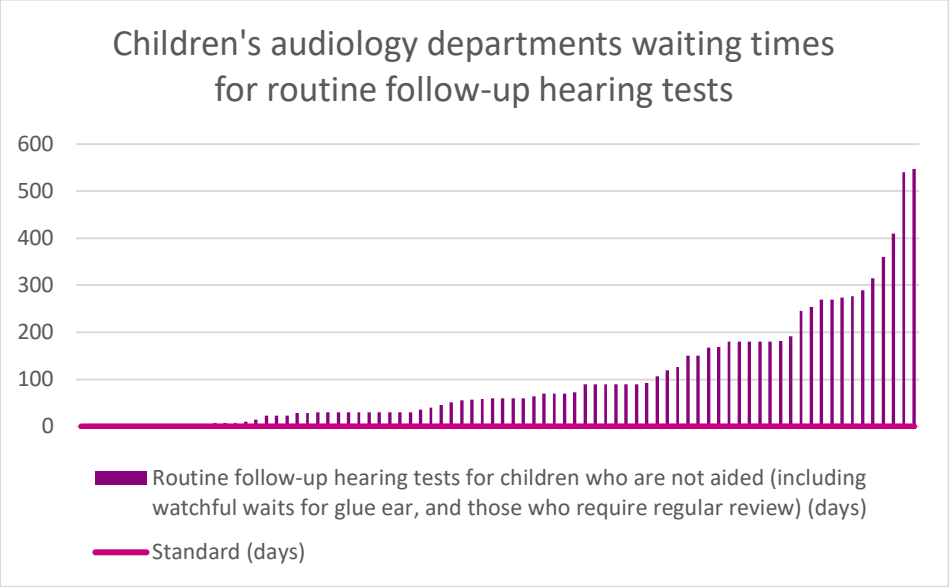

Figure 9. Distribution of average waiting times against the standard

Seventy-one services (87% of those with data) were unable to see children at planned times for follow-up.

Referrals to ENT

We asked services about waiting times for referrals from their service to ENT services, which must meet an 18-week referral-to-treatment (RTT) target, rather than the diagnostic wait target of six weeks[13].

Year	Minimum average waiting time (days)	Maximum average waiting time (days)	Response rate
2023	14.7	427	40% (51)

Table 24: Waiting times (in days) for referrals to ENT (percentages are out of 127 services)

Although waiting times for ENT are not under the remit of audiology services, 51 services reported average waiting times, from referral from their service to being seen by ENT, of 14.7 to 427 days (see Figure 10); 38 services reported average waiting times of over 14 weeks for the first appointment with ENT, and 11 services reported average waiting times of over 300 days before a child was seen for a first consultation with ENT.

[13] GOV.UK. Referral to treatment consultant-led waiting times: rules suite (October 2022). gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks/referral-to-treatment-consultant-led-waiting-times-rules-suite-october-2022 (accessed November 2024).

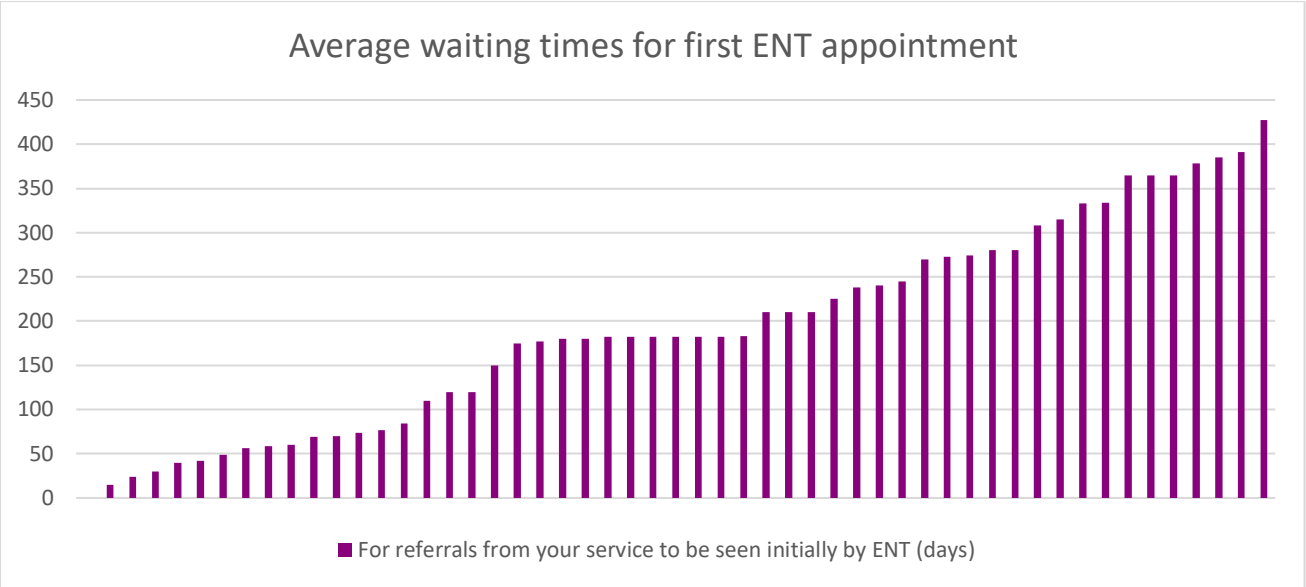

Figure 10. Distribution of average waiting times for an initial ENT consultation

Grommet surgery for glue ear

We asked services about average waiting times for the RTT for grommet surgery for glue ear. In England, ENT services work to the 18-week RTT of 126 days.

Year	Minimum average waiting time (days)	Maximum average waiting time (days)	Response rate
2023	14	565	39% (50)

Table 25: Average waiting times (in days) for grommet surgery for glue ear (percentages are out of 127 services)

Fifty services responded to the question about waiting times for grommet surgery, reporting average waiting times ranging between 14 and 565 days. The majority of responding services did not meet the RTT target, with 17 services reporting waiting times of over 300 days.

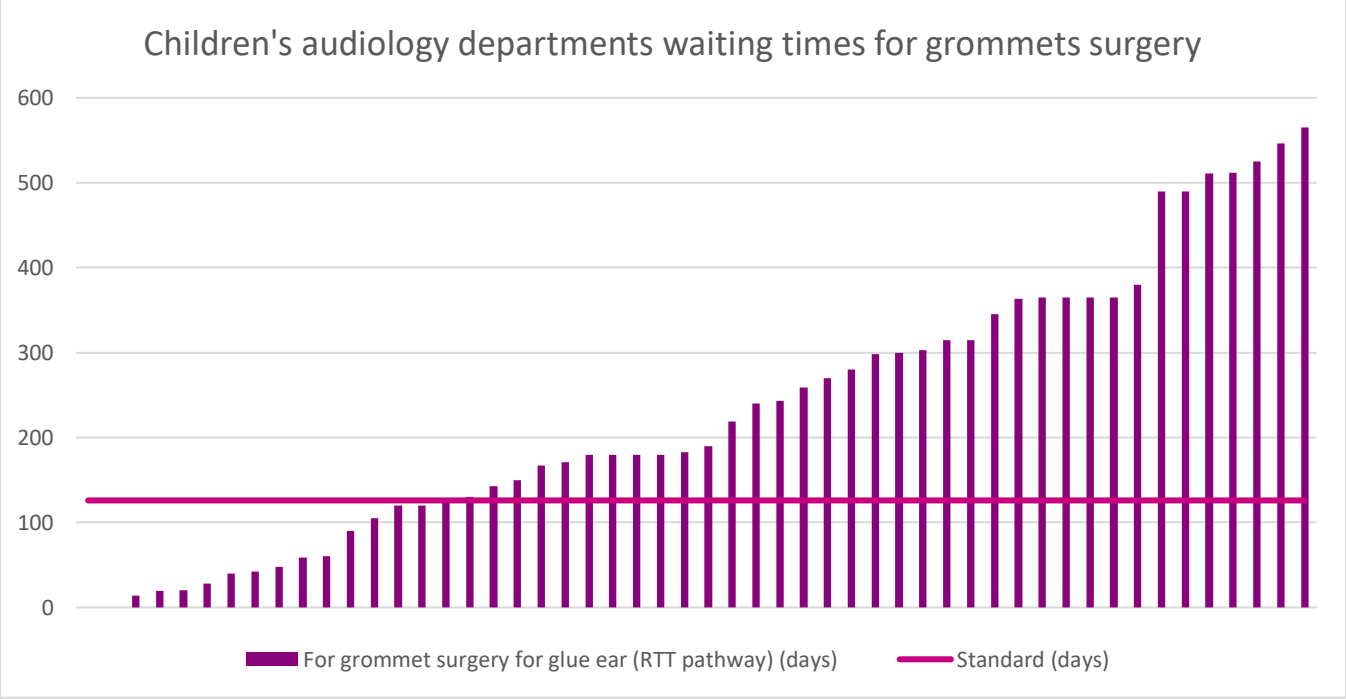

Figure 11. Distribution of average waiting times against the RTT standard

Section 6: Quality assurance and improvement

The survey asked about the methods that services use for quality assurance and improvement. There is no mandatory quality assurance programme for audiology services in England.

However, IQIPS is a professionally led assessment and accreditation scheme that ensures patients receive consistently high-quality care from competent staff working in safe environments. This is managed and delivered by the United Kingdom Accreditation Service (UKAS).

IQIPS accreditation

Of the 115 paediatric audiology services that responded to our survey, only 27 (23%) reported that they were currently accredited by IQIPS. Of those services not currently accredited, eight (7%) said they had been previously accredited and 77 (67%) said they had never been accredited.

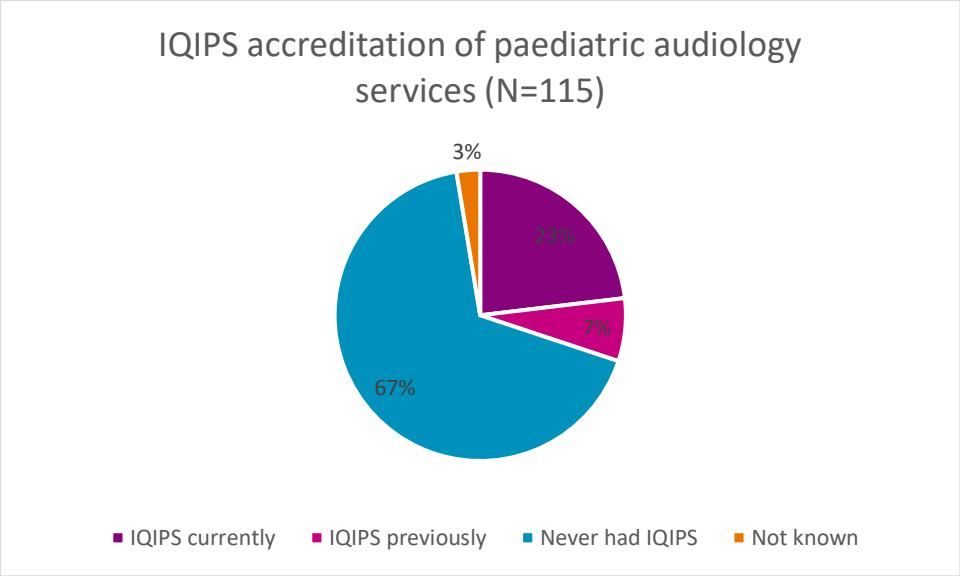

Figure 12. Status of paediatric audiology services in relation to IQIPS accreditation (percentages are out of the 115 services that responded to the survey)

Services that were not IQIPS accredited were asked whether they would like to gain accreditation. Eighty-two (94%) of those not currently accredited said they would like to achieve accreditation, and only three services said they would not be interested.

Services that were previously accredited were asked why they had stopped. Seven services offered an answer. High demands of the process, leadership challenges and service redesign were cited as reasons. All responses indicated that the exit from the scheme was voluntary. Some are working towards re-entering the process.

Services were asked whether there are any barriers preventing them from applying for accreditation. General themes were:

- lack of staff capacity: clinical and administrative staff taken away from core business, with the backlog of children waiting to be seen being cited in particular
- complex and time-intensive process (evidence-gathering and assessment)
- no support or funding from the Trust to apply.

Additional reasons and/or explanations offered by the Trusts without previous accreditation included:

- the IQIPS process requiring specialist staff
- department is “not ready yet”, i.e. unlikely to pass the assessment due to equipment and facilities requiring an upgrade, or through lack of available funding
- some had started looking at the process and going through first steps
- concerns about the quality of the assessments
- leadership issues at the local level (audiology leads absent or overwhelmed).

The three services that were not interested in accreditation cited the same three overarching barriers as the others: staffing, process and funding.

Other quality assurance and improvement methods

Services were asked what methods they use for quality assurance and improvement in addition to, or as an alternative to, IQIPS. Respondents were offered 13 options, including “Other”, and more than one selection was allowed.

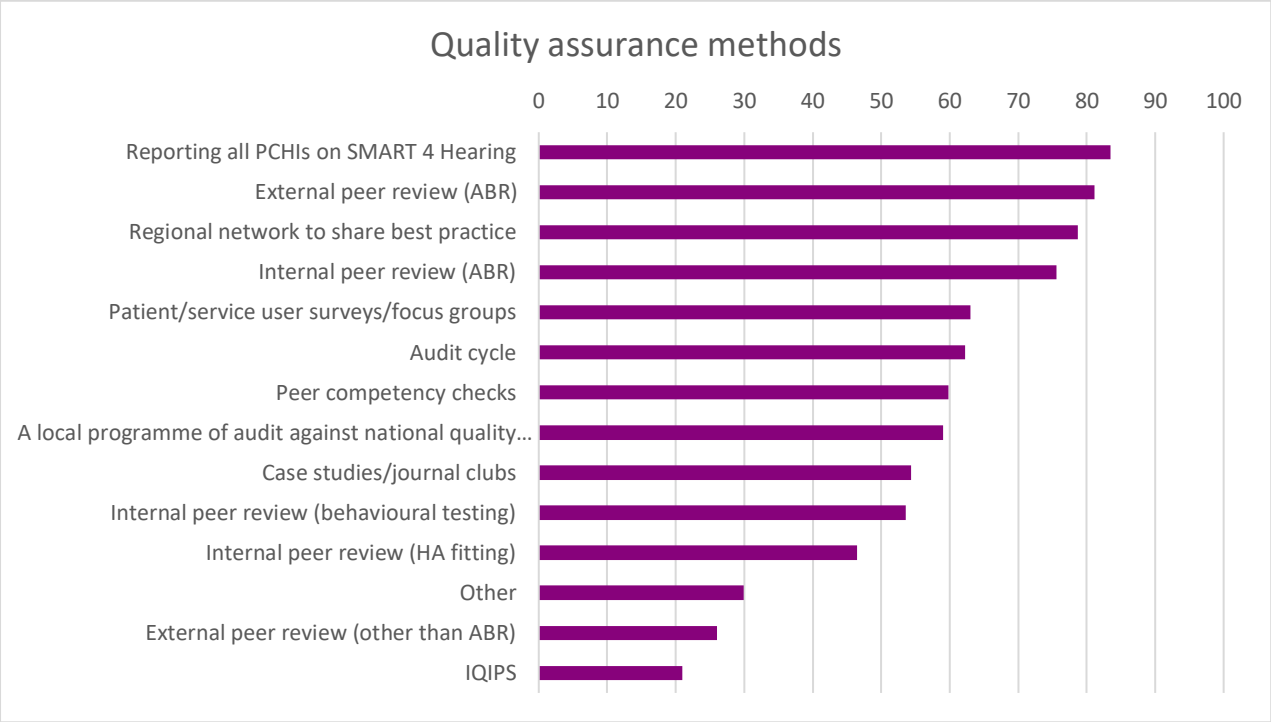

Figure 13. Quality assurance and improvement methods used by services, including external peer review for ABR (percentages are out of 127 services)

The most popular methods, each reported by more than three-quarters of services, were:

- reporting all PCHIs on Smart 4 Hearing (a national database that records NHSP outcomes)
- external peer review of ABR results
- regional networks sharing best practice and internal peer review (ABR).

The least used method (reported by around a quarter of services) was external peer review of other aspects of audiology outside of ABR.

Of the 38 services that selected “Other”, nine explained further and mentioned: ISO9001:2015 accreditation[14], journal publications, patient record reviews and regional visual reinforcement audiometry (VRA) peer review.

[14] ISO. ISO 9001:2015: *Quality Management systems – Requirements* (Edition 5, 2015). iso.org/standard/62085.html (accessed November 2024).

The number of different quality assurance methods per service was also looked at, including IQIPS. Services used nine methods on average, ranging from 1 to 14, as reported, respectively, by one service and five services (median nine); 70% of services (81) employed eight or more different quality assurance methods.

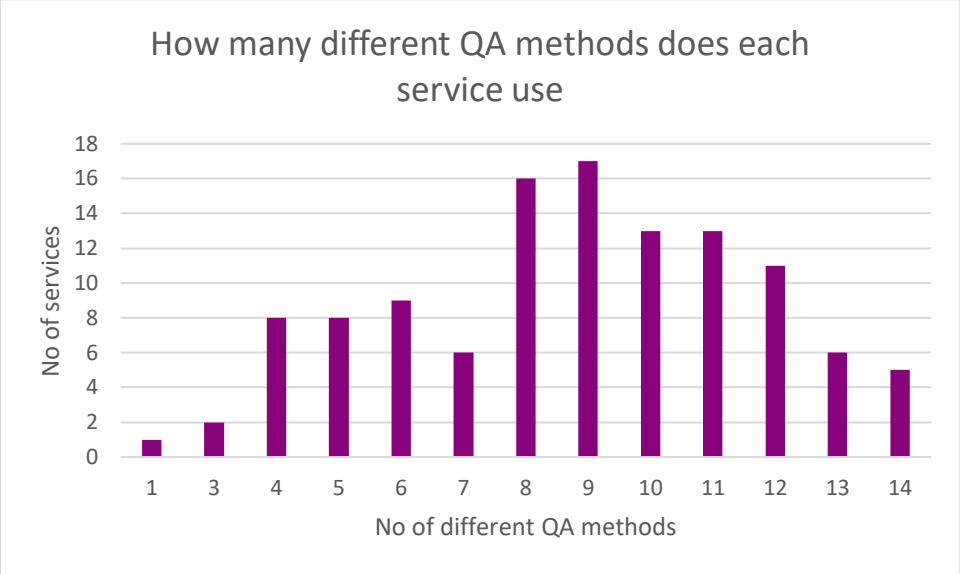

Figure 14. Number of different quality assurance and improvement methods used by services (including IQIPS)

Of the 112 services that responded, 97% said they report and provide evidence of quality assurance to their ICB.

External ABR peer review

Most of the services actively participating in external ABR peer review reported that they submit traces for review of all hearing losses and a sample of discharge (98 out of 103). There were 344 ABR testers reported across the services that responded to the question, ranging from 0 to 10 per service (average three), and 329 of those were reported as participating in peer review.

When asked about how they act on peer review findings, 101 services reported the following themes:

- record outcome on patient record
- patient recalled, if appropriate
- change patient management plan, if appropriate
- internal case discussion
- if disagreement, escalation to clinical panel
- individual tester reflection and integration into daily practice
- consider training needs and support requirements
- incident raised and investigated, if appropriate
- adjust protocols/change guidance
- record outcome on internal system to inform audit/review of performance indicators
- benchmark with other services.

Some explanations were also offered:

- SONAR (the online ABR peer review system used in the East of England) does not currently offer review of traces for babies seen following unilateral referral from the NHSP, so it is not possible to submit traces for all hearing losses.
- Experienced testers do not participate in peer review.

We also asked services to explain why they do not actively participate in external regional peer review for ABR. Of the seven services that provided an answer, six said they do not perform ABR as part of their service. One said that they only do ABRs for older children who are challenging to assess and that they are seeking alternatives to their local peer review system, which only reviews traces for babies referred from the NHSP. They added that they previously used an external consultant but this ended after the Covid-19 pandemic.

Section 7: Staffing and training

We asked about staff working in paediatric audiology services as of 30 September 2023. Services were asked to report on clinical staffing levels (including AfC grades of staff), staff vacancies, any observed reduction in skill, reasons for that reduction and steps taken to address such challenges. 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 in a five-day week would be 1.6 FTE.

Number of permanent staff

The total number of FTE posts reported by services was 793.

Number of FTE clinical staff at all AfC levels

The graph that follows shows the number of staff at each AfC band working in the paediatric audiology services responding to the 2023 survey.

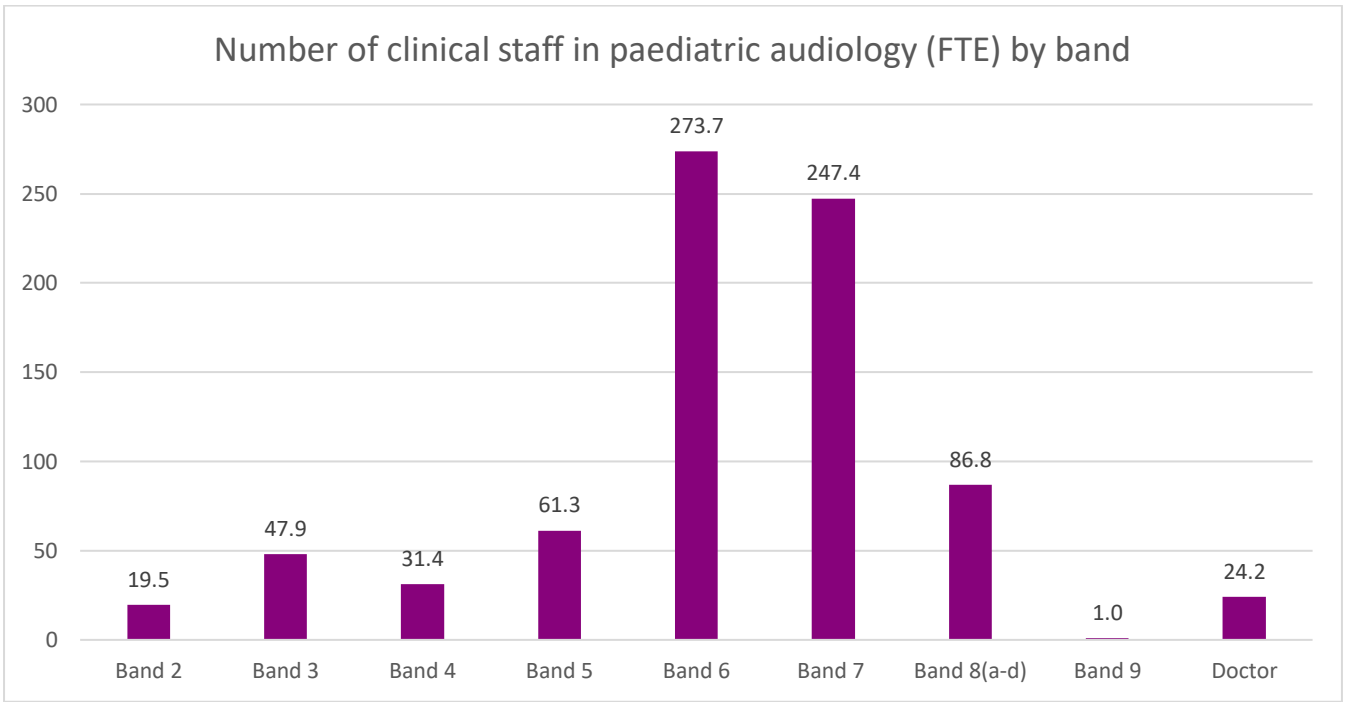

Figure 15. Number (FTE) of clinical staff working in paediatric audiology, by AfC band – not every service responded with banding at each level, but it is assumed that the services that responded to give figures for any band were submitting a nil return for those bands with no response

The majority of paediatric audiology staff were employed as Band 6 AfC, followed by Band 7 AfC. Together, they accounted for two-thirds (66%) of the posts reported by services. Bands 6 to 8 AfC account for 79% of the paediatric audiology workforce (Figure 16).

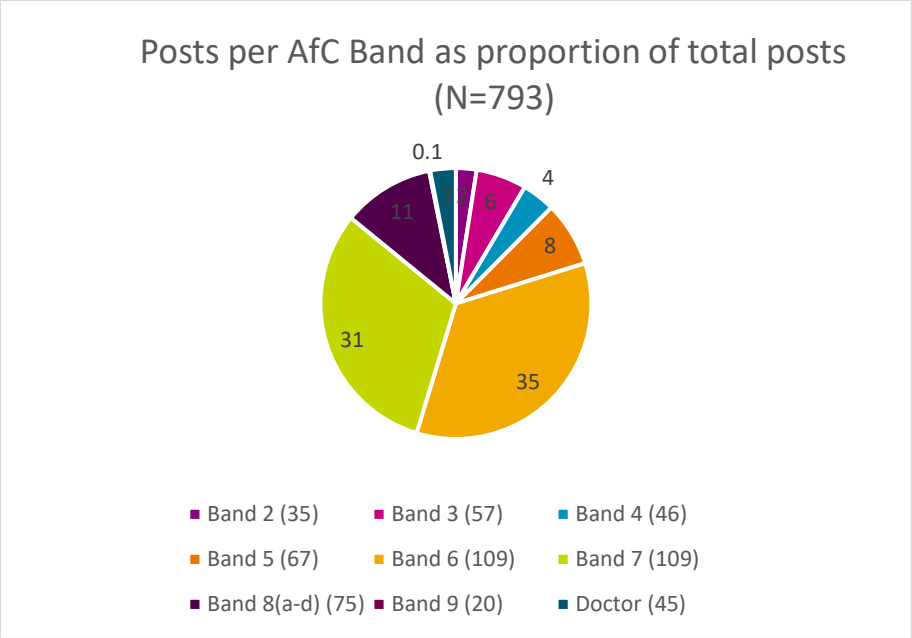

Figure 16. Distribution of posts (FTE) across AfC bands (number of responding services with data in brackets)

Vacant posts

Services were asked how many vacant FTE posts they have.

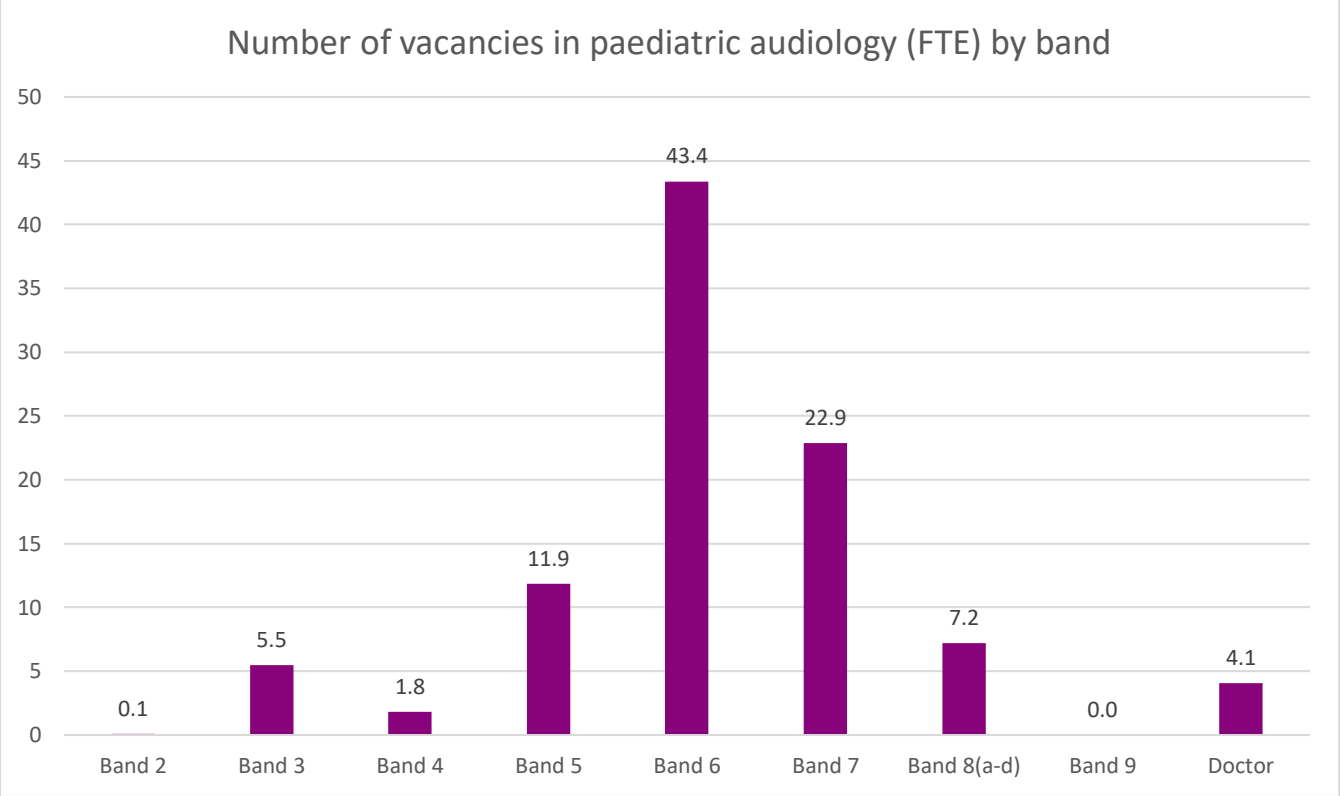

Figure 17. Number (FTE) of clinical post vacancies in paediatric audiology, by AfC band – not every service responded with banding at each level, but it is assumed that the services that responded to give figures for any band were submitting a nil return for those bands with no response

The total number of reported vacancies (including doctors) across services and bands was 96.7. The highest number of vacant posts was at Band 6, followed by Band 7.

Reduction in the number or skill level of staff compared to last year

Services were asked whether they observed reduction in the number or skill level of staff compared to last year and to explain the reasons for any reduction. Half the services[15] reported reduction in staff/skill level in the past year.

Reasons for reduction in the number or skill level of staff compared to last year	Number of services
Unable to recruit staff	33
Posts have been frozen or deleted	1
Staff leaving or reducing hours	40
Maternity leave or sick leave	28
Trust decision or cost-improvement plan	4
No capacity to train new staff	13
Other	6

Table 26: Reasons for the reduction in the number or skill level of staff compared to last year

Paediatric audiology services are facing significant staffing challenges, primarily due to staff leaving or reducing hours, difficulties in recruitment and maternity/sick leave. Services reported additional factors, including staff promotions, retirements, career breaks and a national shortage of experienced paediatric audiologists. Some services have had to reconfigure staff working patterns to cover shortages elsewhere (e.g. the adult service). Services reported relying heavily on part-time workers and temporary staff. Poor pay increases within the NHS were also reported as a reason for reduced staffing.

To address these challenges, services have implemented various strategies, including overseas recruitment, apprenticeships and hiring graduates at Band 5 AfC for training. They are also improving supervision and offering training and development opportunities. Financial incentives like recruitment and retention premiums are being used, and roles are being diversified to maximise available skills. Additionally, some services are conducting demand and capacity analyses to better understand staffing needs, and organising outreach initiatives to raise awareness of career opportunities in the sector.

A few services noted that it had been difficult for them to report staffing levels and vacancies for paediatrics, as they deliver services jointly with adult audiology.

CPD

We asked services questions in relation to CPD in their teams. Questions were more open ended compared with previous years.

CPD that is required to meet development needs and stay competent

Responses were provided by 102 services. CPD required to meet their development needs and stay competent included the following topics but there was variation between services:

- mandatory CPD set out by their NHS Trust[16]
- courses on diagnostic paediatric assessment
- courses on paediatric habilitation and hearing aid verification
- tinnitus and hyperacusis
- balance assessment and rehabilitation

[15] 114 services had data and 57 said they had experienced reduction in skill.

[16] NHS England. Statutory and Mandatory Training. The UK Core Skills Training Framework (CSTF) sets out 11 statutory and mandatory training topics for all staff working in health and social care settings. e-lfh.org.uk/programmes/statutory-and-mandatory-training/ (accessed November 2024).

- wax management
- conferences and webinars
- peer review
- case reviews
- management training
- sharing the news.

Some services reported that they had no set CPD requirements or training available.

CPD that staff accessed

The following topics were mentioned (across 108 services):

- sharing the news
- online webinars and conference**s**
- training days provided by hearing aid and equipment manufacturers
- clinical educator training
- paediatric vestibular courses
- IQIPS
- leadership and management
- paediatric assessment courses
- paediatric habilitation courses
- hearing aid verification
- wax management
- observing speech and language therapy (SLT) sessions
- ABR training
- journal club
- case discussions.

CPD that is lacking or difficult to access

Specific demand for CPD included:

- refresher courses
- attending conferences
- formal qualifications or accredited courses
- managing quality assurance
- journal clubs
- deaf awareness
- ANSD
- APD
- tinnitus
- competency assessments
- training for more specialised tests
- wax management
- peer review training
- development of junior staff/upskilling
- assessment of children with complex needs.

Barriers to accessing CPD

Services reported several barriers to accessing CPD, including:

- funding for CPD
- time to attend CPD (staffing levels and high service demand)
- lack of relevant courses
- opportunity to put learning into practice, as some may have associated equipment costs or lack of regular access to certain test methods
- location of courses (requirement to travel, no online access to formal training)
- scheduling of courses (in relation to working patterns and commitment outside work)
- low number of courses with limited availability
- lack of clear training standards.

Roles and skill mix

We asked services to indicate what roles the different members of the team can have at each grade in paediatrics. The vast majority of services use Band 6 and Band 7 staff to carry out activity relating to paediatric audiology. Band 7 staff are used by the majority of services to lead more complex clinics, such as newborn diagnostic assessment, advanced clinics and assessment of children with complex needs.

AfC band	Lead newborn diagnostic assessment and/or immediate follow-up	Lead routine assessments	Assist routine assessments	Lead routine assess-ments	Provide routine testing only (e.g. no history-taking) for ENT clinics	Lead assessment of children with complex needs	Assist assessment of children with complex needs	Lead pre-school and/or complex needs hearing aid clinics	Lead school-age hearing aid clinics	Lead additional/ advanced clinics, e.g. for tinnitus, hyperacusis or APD
		<4 years	<4 years	school age						
1	0	0	0	0	0	0	0	0	0	0
2	0	0	12	0	0	0	6	0	0	0
3	0	0	33	0	2	0	14	0	0	0
4	0	0	29	4	15	0	21	0	0	0
5	0	2	53	31	71	1	33	2	16	1
6	35	96	94	108	88	60	97	60	97	38
7	94	102	82	103	82	102	94	98	99	86
8a	53	52	44	51	43	57	51	55	55	41
8b	19	20	15	18	14	22	18	19	20	16
8c	4	5	4	4	4	4	6	4	4	2
8d	2	2	0	2	0	2	0	2	2	1
9	0	0	0	0	0	0	0	0	0	0
Doctor	1	5	6	3	0	12	9	2	2	13
Response rate	**90% (104)**	**97% (112)**	**97% (111)**	**98% (113)**	**84% (97)**	**100% (115)**	**99% (114)**	**95% (109)**	**97% (111)**	**84% (97)**

Table 27: Roles performed by staff at different grades (number of services reporting by role and grade; response rate is out of 115 services)

Lower band staff typically assist more senior experienced staff with clinical work and would usually not be expected to lead clinics, but two services reported Band 5 AfC staff being able to lead routine paediatric

clinics for children under four years old, and one service reported Band 5 AfC staff being able to lead assessment of children with complex needs.

Thirty-one services reported Band 5 AfC staff being able to lead routine paediatric clinics for school-age children. Four services reported Band 4 AfC being able to lead routine paediatric clinics for school-age children. Some services also reported Band 5 AfC staff being able to lead hearing aid clinics and additional advanced clinics. This reflects the reported reduction in skill level.

Staff qualifications

Services were asked about the minimum training qualification and training requirements at the following levels:

Band 2: The majority of responding services reported secondary equivalent qualifications such as GCSEs, NVQ or BTEC. No services reported any formal audiology training or qualifications.
Band 3: There was significant variation between responding services, with nine services reporting a requirement for an audiology assistant or formal audiology-related qualification.
Band 4: There was significant variation between responding services, with some reporting a requirement of education to GSCE level and others requiring a foundation degree.
Band 5: There was variation between services but the majority required Band 5 staff to have a BSc in audiology.
Band 6: There was variation between services but the majority required Band 6 staff to have a BSc in audiology.
Band 7: There was significant variation between services, but almost all services specified a BSc and/or MSc (or equivalent), with some specifying additional training such as the clinical scientist training programme.
Band 8a: There was significant variation between services, but the majority of services require staff in this band to have an MSc or equivalent, with some specifying additional management or clinical training.
Band 8b: There were limited responses for this level but these included a fairly even mix of MSc, BSc and clinical scientist training programme (or equivalent).
Band 8c: There were limited responses for this level but these included MSc, BSc and clinical scientist training programme (or equivalent).
Band 8d: There were limited responses for this level but these included clinical doctorate, clinical scientist training programme and MSc (or equivalent).
Band 9: There were limited responses for this level. One service reported: “MSc in audiological science or BSc in audiology or healthcare scientist or equivalent with significant extended practice and management experience/qualification.”

Section 8: Collaboration

Referrals to local specialist education services

We asked services about referrals to the local specialist education service for deaf children in their area (services could select multiple options). We asked about aided (fitted with hearing aids) and non-aided children separately. For each group we asked about children with different degrees and types of deafness. We recognise that education referral criteria are outside the remit of audiology services.

Figure 18 presents the number of services referring children in each group (aided and non-aided) across categories and a comparison between the two groups of children.

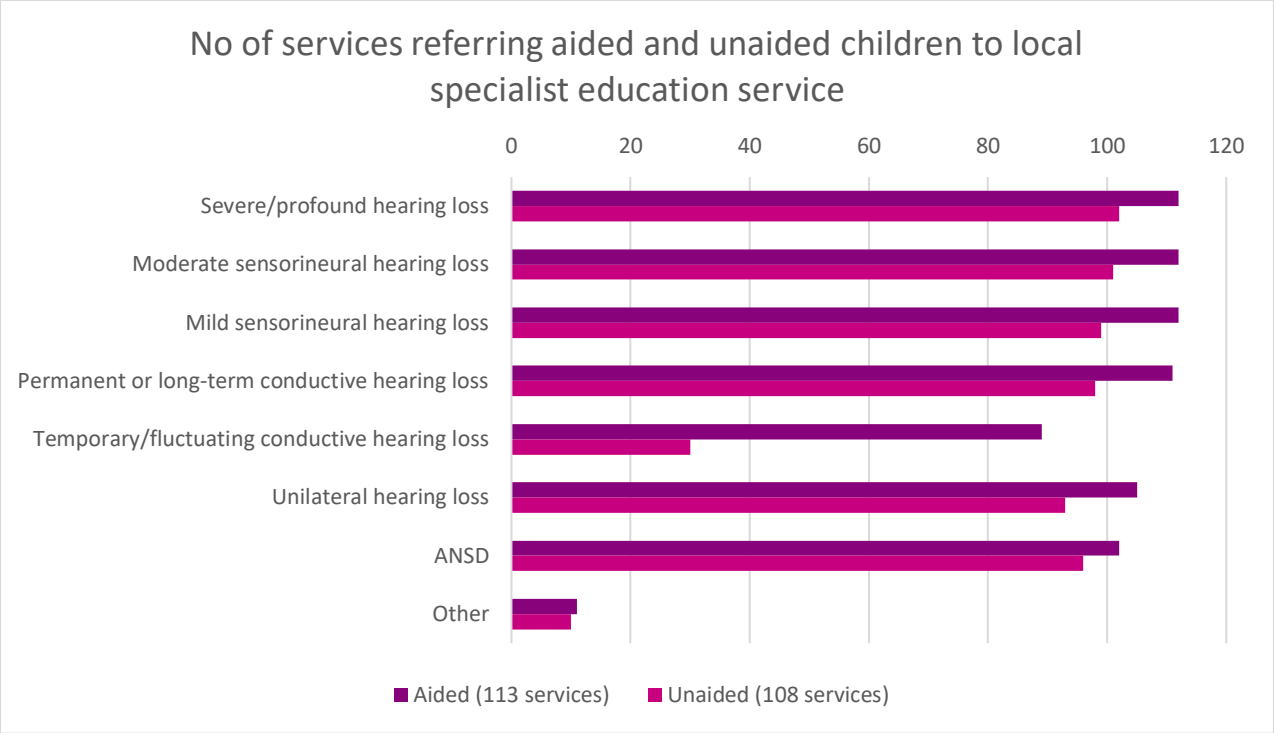

Figure 18. Aided and unaided groups of children that hearing services refer to the local specialist education service for deaf children (numbers in brackets show the number of responses received)

Aided children with any level of hearing loss are referred to local specialist education services by most audiology departments with the exception of some aided children with temporary/fluctuating hearing loss.

Many audiology services do not refer children who are not fitted with hearing aids to local specialist education services. In particular, children with temporary or fluctuating hearing loss are referred to education services by only 30 of the services who responded.

Referrals to non-audiology or external professionals

We asked if services were able to routinely refer directly to external professionals.

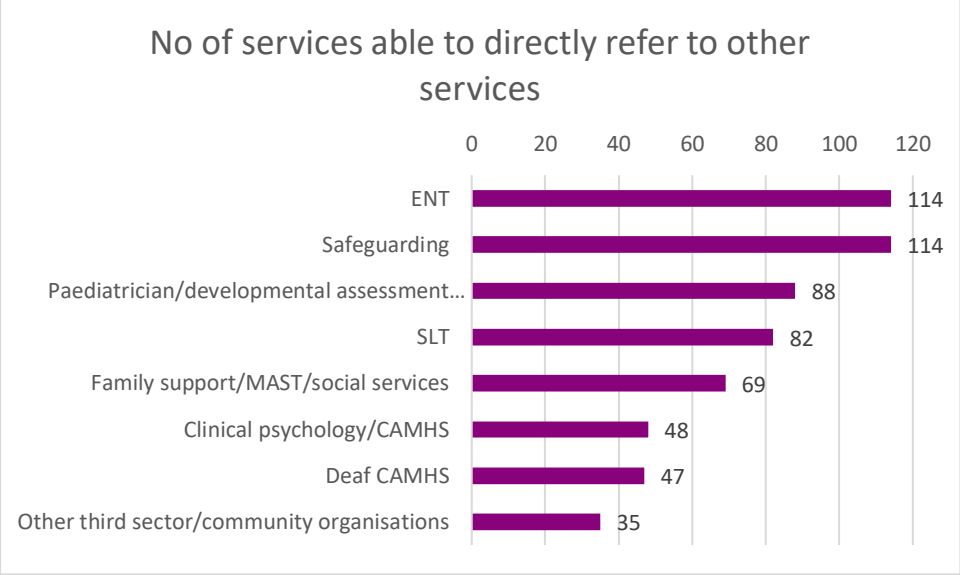

Figure 19. Referrals to non-audiology/external professionals

Not all services gave a response in each category, but the vast majority of services (114) referred directly to ENT and safeguarding, followed by paediatrician/developmental assessment and SLT. Fewer than half reported they can refer to clinical psychology/Child and Adolescent Mental Health Services (CAMHS) and

Deaf CAMHS (48 and 47 services respectively), and only 35 reported that they can refer to "Other" third sector/community organisations.

Services were asked which children they refer onwards to other services and these are detailed further in Appendix 3.

Signposting to the National Deaf Children's Society

We asked services about the categories of children with hearing loss and their families that they routinely signpost to the National Deaf Children's Society. We further asked them to specify whether they signpost or provide them with information from the National Deaf Children's Society.

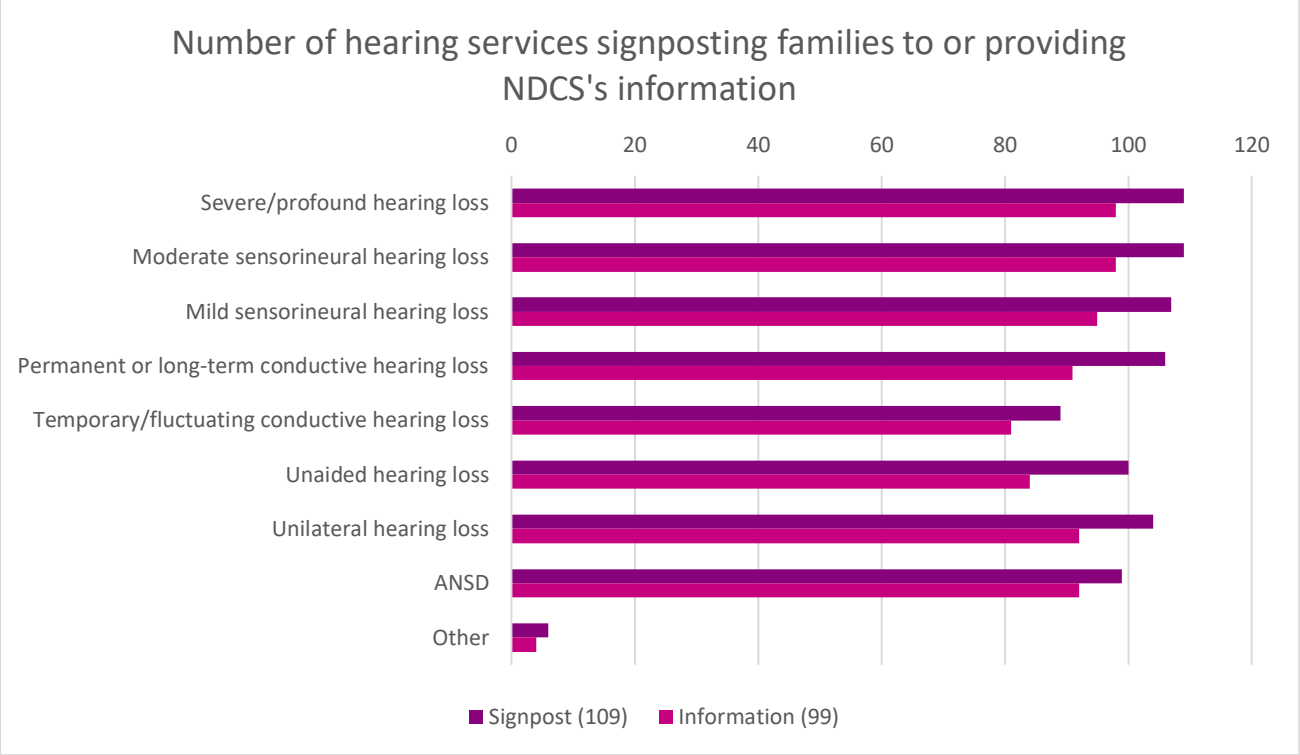

Figure 20. Signposting to the National Deaf Children's Society and providing information from the charity (numbers in brackets show the number of responses received)

Most services reported that they signpost all categories of children to the National Deaf Children's Society. Responses ranged from 109 services referring children with severe/profound or moderate sensorineural hearing loss to 89 services referring for temporary/fluctuating conductive hearing loss. The picture was similar in relation to routinely providing the National Deaf Children's Society information, with the observed tendency for fewer services to do so across all categories of children. The largest differences between the number of services signposting to, versus sharing information from, the National Deaf Children's Society were for children with permanent conductive hearing loss and unaided hearing loss.

We also asked services about when they signpost families to the National Deaf Children's Society. There were 114 responses, most of which specified that they signpost at diagnosis (105) and whenever the need arises (102). Six services signpost at every appointment.

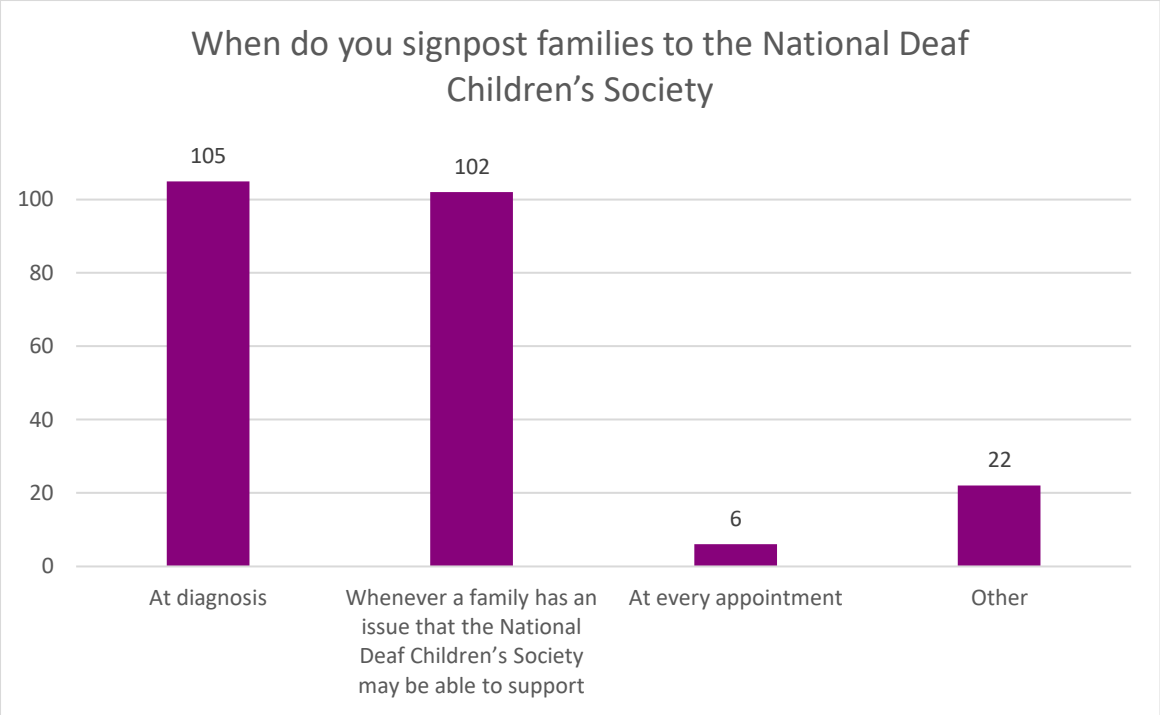

Figure 21. Point of signposting to the National Deaf Children's Society (114 services had a response)

CHSWGs

We asked services whether they have a CHSWG in their area. All but one service (114) reported that they have a CHSWG in their area. We also asked about representation in their group.

Specialist education services (114) and ENT (110) were represented in the majority of CHSWGs in the services areas, with parent representation in 101 of them. On the other hand, presence by Trust senior management teams (25), deaf young people (19) and commissioners (19) was much lower.

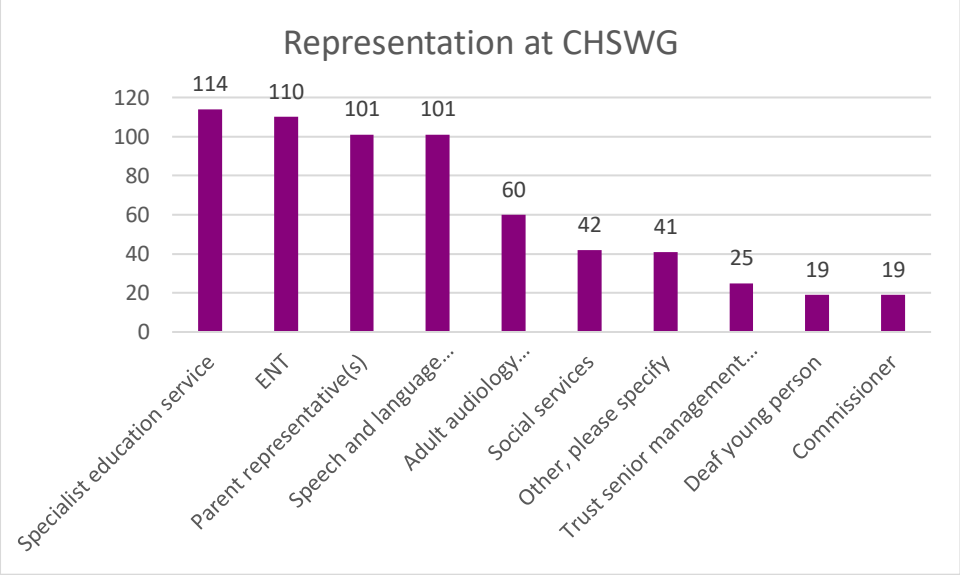

Figure 22. Groups represented in local CHSWGs (114 services had a response)

Forty services selected "Other" and provided further detail:

- **Other professionals and groups that attend:**
  - NHSP
  - other health professionals, e.g. implant programme, paediatrician, Deaf CAMHS, audiovestibular physician

- other local authority, e.g. safeguarding
- third sector, e.g. the National Deaf Children's Society, local deaf charities and other charities
- college representative

- **Issues with membership:**
  - Different CHSWGs may have different membership and variation between meetings, which needs to be taken into consideration if a service falls within more than one jurisdiction.
  - Not all groups that are invited attend.

Section 9: Patient engagement

Transition to adult services

Services were asked about how they prepare young people for transition to adult services.

Most services stated that they provide information on the adult service for young people (110), including: starting to talk about the transition process from age 14 (92); offering young people the opportunity to come into the clinic without parent/carer if appropriate (83); and completing a transition assessment/process (82). Few services offered the rest of the options, with local school visits offered by only two services. One service offered all eight options.

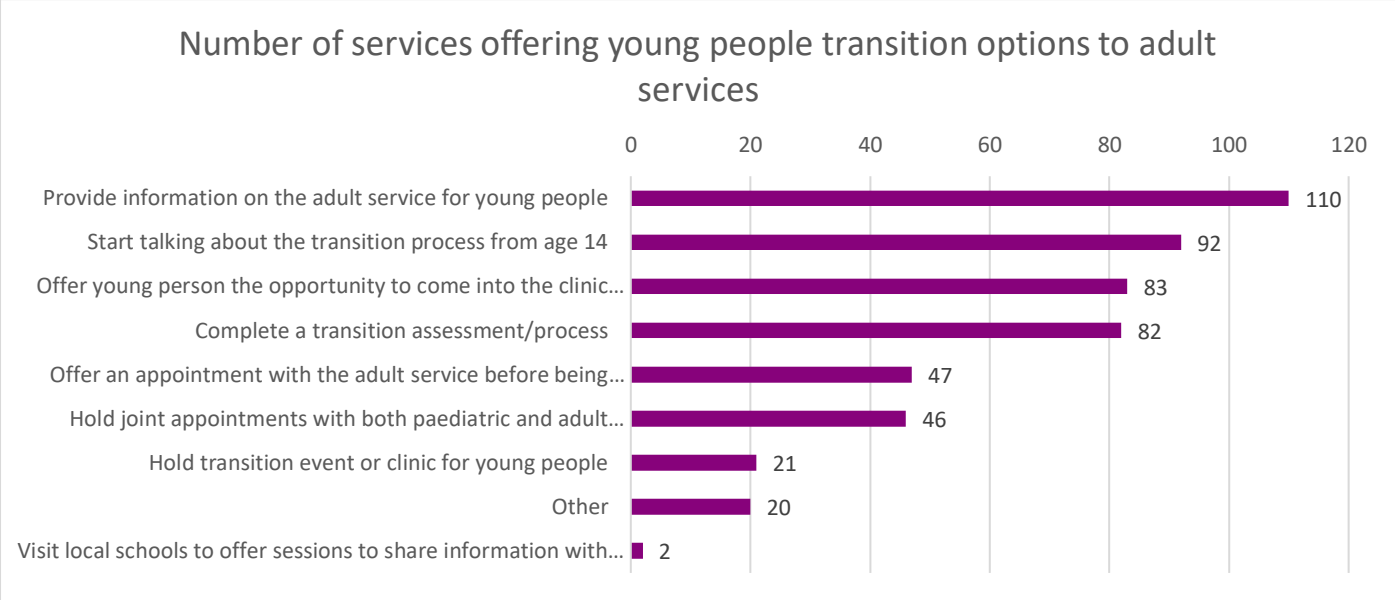

Figure 23. How paediatric hearing services prepare young people for transition to adult services (114 services had a response)

Twenty services that chose "Other" explained further:

- paediatric and adult transition leads in post
- provision of Personal Hearing Aid Passport
- department covers children and adults
- the paediatric and adult audiologist/team is the same person
- transition for some adults with additional needs to adult services at a resource centre for adults with additional needs
- complete Ready Steady Go Checklist
- transition happens at 15 to 16
- transition pathway begins when children reach Year 7 at school
- liaise with ToD services and catch the children in the last few years of school
- virtual discussions with transition child, ToD and audiology
- joint appointments previously offered but not taken up.

Missed appointments

We asked services how many appointments they offered in the period 1 October 2022 to 30 September 2023 and the proportion of them that were classed as "Was Not Brought" (WNB) or "Did Not Attend" (DNA).

2023	Total number
Number of all appointment types for children	389,136
Number of appointments classed as WNB or DNA[17]	45,203
Percentage WNB/DNA	12%

Table 28: Total number of appointments and appointments classed as WNB or DNA

Services reported a DNA/WNB rate of 12%. This is comparable to other services in England, where the average DNA/WNB rate for paediatric clinics ranges from 6.7% to 11%, while it can be as high as 68% for patients with the highest risk of non-attendance[18].

Strategies for missed appointments

We asked services what strategies they used to prevent missed appointments.

Strategy	No of services
Partial booking	38
Text reminders	100
Phone reminders	78
Other	39
None	0

Table 29: Strategies for missed appointments

In total, 113 services provided a response. Most reported they use text reminders, followed by phone reminders. The "Other" responses included the following:

- **Working with other services:**
  - tasking health visitors to encourage newborn families to attend
  - contacting social worker with appointment details for children under social care
  - support from ToDs
  - liaising with other agencies involved with the child, e.g. social services/local safeguarding team
- **Using systems:**
  - patient hub notifications
  - moved to Auditbase
  - email/mycare
  - DrDoctor
- **Tactics:**

[17] Services were only asked about the percentage of appointments classed as WNB/DNA, consequently the number of WNB/DNA appointments was calculated from that information

[18] https://childrenshospitalalliance.co.uk/wp-content/uploads/2023/07/EvaluationOfTheWasNotBroughtProgramme.pdf

- pre-appointment questionnaire
- full booking to verbally confirm appointment dates with parents/agreed at clinic
- email used too if needed
- text cancel and rebook option
- reminder letters, including in other key languages
- book all appointments at short notice (most often, less than four weeks ahead)
- appointments booked with parents on the phone
- double reminders
- additional slip enclosed with appointment letter to remind patients to cancel if they cannot attend, with phone number and email address clearly highlighted
- opt-in system

- **Flexibility/convenience:**
  - locations close to home
  - offered choice of appointments.

Section 10: Issues affecting service provision

Changes in demand

We asked services whether there any areas where demand has changed significantly in the last year.

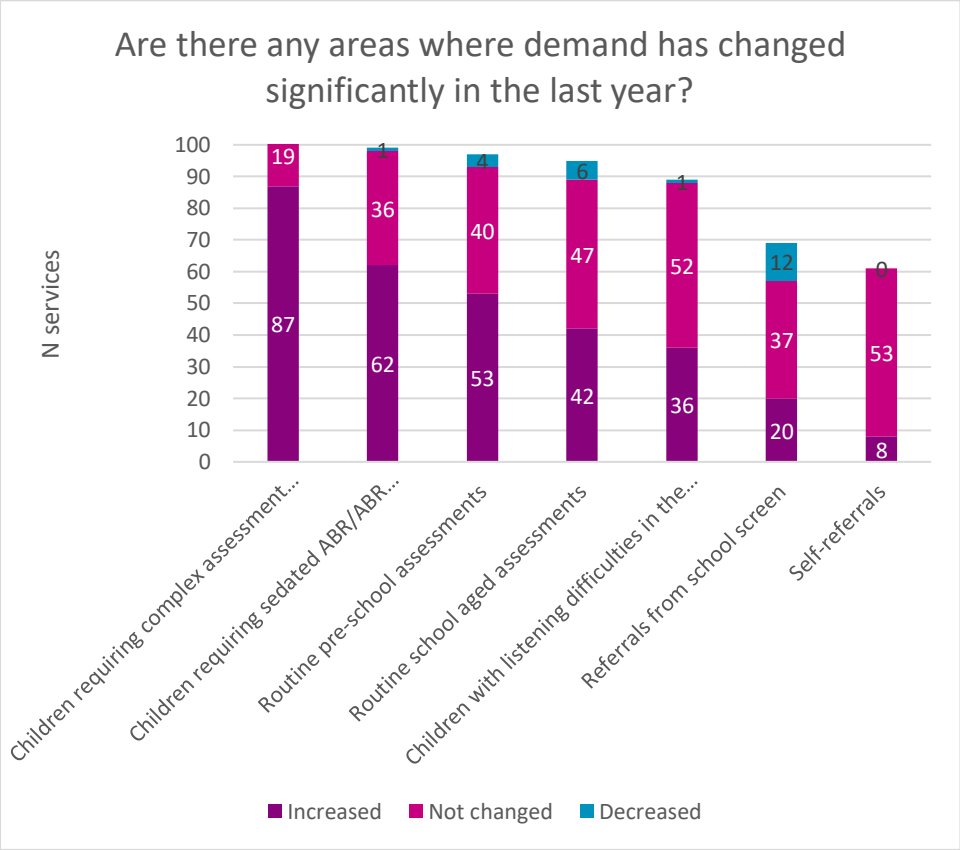

Figure 24. Service areas that have seen changes in demand

Responses ranged from 107 for children requiring complex assessment techniques/multiple appointments to 61 for demand for self-referrals. Services reported increases in all areas. The area reported as increasing in demand by most services (87) was children requiring complex assessments. More services than not also reported an increase in demand in children requiring sedated ABR and routine pre-school assessments (62 and 53 services respectively). Demands for self-referrals and children with listening difficulties were reported as not having changed by more than 50 services.

Entries in “Other” response option included:

- increase in number of children that are being referred for glue ear management
- increase in young people of secondary school age describing hearing difficulties/tinnitus
- Increase in demand for PCHI management, particularly mild and unilateral deafness.

The lower response rate in relation to referrals from school screen and self-referrals appears to be due to the former having ceased to be universal since 2023 and the latter not offered by many Trusts.

Coping with changes in demand

Services were also asked what would help them cope with changes in demand. The main themes were around staffing, facilities/resources, and guidance and training, and are listed in more detail in Appendix 2.

Areas of good practice or innovation

Services were asked about any good practice or an innovative solution that they would like to share with others. Services talked about being family friendly, utilising technology and initiatives to improve pathways, increase capacity and tackle waiting times.

Being family friendly

Services reported initiatives such as providing home visits for babies who have been referred for a diagnostic ABR. One service reported: “At a previous IQIPS visit, the paediatric service was commended for this as a family friendly option.”

Some services work with schools to provide hearing aid maintenance:

- “We also work closely with schools to provide drop-in ‘Sip and sign’ where a large number of impressions can be taken within a short time in a patient friendly and easy to access environment.”
- “Hearing aids repairs are undertaken in school to reduce clinical visits and missed time in education.”

Some services are improving waiting areas for families:

- “decorated children’s waiting area with colourful images”
- “plan to decorate a quiet sensory waiting area supported by Lego as part of magic rooms charity”
- “plan hearing wall – for children to play with to get them used to the headphone”.

One service reported a training and development plan specifically for “improving patient experience for children and their carers, using role play scenarios with audiologists”.

Utilising technology

Audiologists are using technology in a number of ways to improve the service they offer, such as implementing appointment text reminder services, which “has had a positive effect on the WNB rate”. Other examples include using QR codes to provide patients with up-to-date information about the National Deaf Children’s Society and using technology to support triage. One service shared an open-source video reinforcement software they created: www.videovra.com. Another service said they use Microsoft Teams for external ABR peer-review, which allows “multiple editing simultaneously live on secure connection”.

Initiatives to improve pathways, increase capacity and tackle waiting times

Services reported approaches such as joint appointments with other professionals and specific clinics, as well as pathways for assessing children with complex needs and also for aetiology. Some novel approaches around management of glue ear included:

- "Direct listing for grommets" via audiology rather than needing an intermediate appointment with ENT.
- "We provide Otovents free of charge to any child who fits criteria to try these during watchful wait period. In August 23 we started a joint Glue Ear Clinic with ENT. We have been able to increase capacity as well as streamline the diagnosis and treatment for children with glue ear."
- "We have implemented a number of initiatives to increase capacity and to tackle waiting times. These include 'quick glue ear clinic', split hearing aid appointments and validation of glue ear waiting list."

One service reported that audiologists have attended wax irrigation training, reducing the amount of referrals to ENT for wax removal.

Current and anticipated challenges

Services were asked about challenges they are experiencing now and the ones they anticipate in the future.

Current challenges

Services consistently report **staff shortages** and difficulties in filling vacancies, and the impact this has on service delivery. There was a particular concern about the lack of experienced paediatric audiologists, and that increasing workload is leading to burnout among existing staff.

Capacity issues are a recurring theme. Services describe struggling to meet the demand for both initial assessments and follow-up appointments. A shortage of staff, space and resources all contribute to this capacity challenge. They report a growing need for more complex assessments, requiring specific expertise and potentially longer appointment times.

Services highlight **a need for more training and development** opportunities in paediatric audiology. There are concerns about newly qualified audiologists lacking specific paediatric skills, and a desire for more experienced staff to engage in CPD. The need for time and resources to implement service improvements, audits and quality assurance programs like IQIPS is also emphasised. One service reported that "newly qualified audiologists do not have the skills required".

Services frequently mentioned the **lack of appropriate facilities, resources and equipment** as a major challenge, including:

- a need for more soundproof booths for accurate testing
- limited room capacity for clinics and assessments
- concerns about outdated equipment and technology
- difficulties in finding suitable testing venues, especially in community settings
- the need for investment in IT systems and data management.

Financial constraints are a significant barrier to improving paediatric audiology services. Services point to:

- difficulty securing funding for service improvements, equipment upgrades and staff training
- financial pressures at the Trust level impacting staffing decisions
- the need to find cost-effective solutions to meet the growing demand for services.

Lack of adequate funding limits an audiology service's ability to address workforce shortages, invest in facilities and technology, and provide necessary training and development opportunities.

Anticipated challenges

The anticipated challenges largely mirror the current challenges facing paediatric audiology services, with staffing, demand, capacity and funding remaining prominent issues but also challenges around quality assurance.

Staffing was the most dominant theme and services highlighted anticipated shortages due to difficulties in recruitment and retention.

The impact of **increasing demand coupled with limited capacity** is another major concern. Many services anticipate a continued surge in referrals due to factors like a growing population, more complex caseloads and changes to guidance. This increased demand is expected to strain already limited capacity in terms of workforce, facilities and funding. Comments included:

- "Growing population hence larger number of referrals. Continued staff shortages. Continued long waits due to high demand and very reduced capacity."
- *"*Following changes to NICE [National Institute for Health and Care Excellence] guidelines for glue ear we expect to see an increase in demand for audiology services with regards to watchful waits and hearing aid management. Do audiology services have the capacity and finances to support this increase?"
- "Insufficient workforce to deal with number of referrals."
- "High referral rate, limited access to facilities, difficulty recruiting experienced staff."

Increased scrutiny and quality assurance requirements are also putting additional pressure on services. While IQIPS accreditation is viewed as a positive step towards quality improvement, many express concerns about the resources required to achieve and maintain accreditation. One service reported: "Increased scrutiny of paediatric audiology will mean increased surveillance and quality assurance methods that will require more time, resource and increased funding pressures."

The time commitment involved in preparation, coupled with existing staff shortages and workload pressures, poses a significant barrier to accreditation. One service reported: "Having to prepare for IQIPS in a community service that only provides an assessment service for paediatric audiology. The time it will take, taking time away from clinics with waiting lists getting worse. The time to complete multiple audits. Still potential difficulties being fully staffed."

Obtaining funding specifically for the accreditation process is also identified as a concern, with one service reporting "resources to support IQIPS accreditation" as a challenge.

Services report anticipated **funding obstacles**. Securing sufficient funds for staff recruitment, cover and training, as well as for necessary facilities, equipment upgrades and resources, is anticipated to be a challenge. One service reported: "Financial pressure at the Trust means that although we would like to put a business case together for more paediatric staff, we are unlikely to have this approved."

Another service reported*:* "A national drive to improve paediatric audiology services is overdue and much needed. However, there is as yet no additional funding or resources pledged to support the significant increase in workload for already extremely short staffed audiology teams currently struggling with long waiting lists and reduced services."

Several responses highlighted the influence of broader contextual factors on service delivery and concerns regarding staff morale stemming from the national climate in paediatric audiology.

Section 11: Funding and commissioning

Services were asked how their funding is provided.

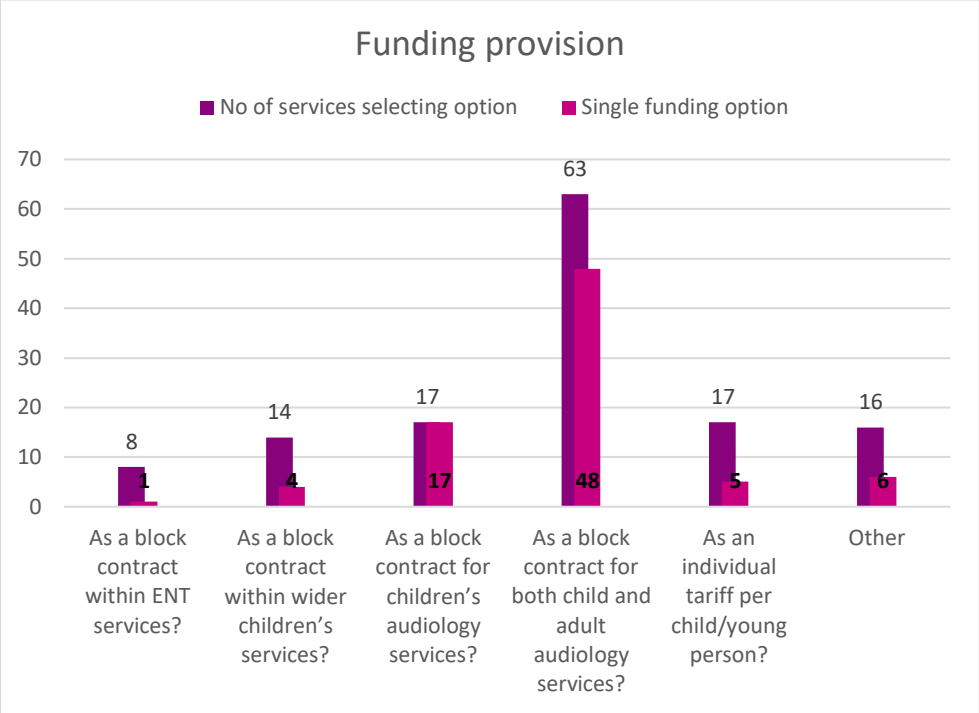

Figure 25. Number of services reporting their funding configuration (111 services with responses)

The majority (57%) of services are funded as a block contract for both child and adult audiology services, with 43% of services reporting a block contract for both child and adult audiology services as their only arrangement. Also, 15% of services are funded as a block contract for children's audiology services as their only arrangement.

Within "Other", some services reported a hybrid of block and tariff contracts. Some expressed uncertainty about exactly how paediatric audiology is funded/commissioned.

Conclusion

This report does present evidence of some issues of concern likely to affect children and young people requiring timely access to good quality audiology services in England, and variations in clinical practice and quality assurance. Services are experiencing significant capacity challenges due to staff vacancies and increasing demand, likely contributing to long waiting times for appointments. Less than half of all services reported any deaf awareness training.

The National Deaf Children's Society is very grateful to audiology services for sharing these insights, particularly in the light of all the challenges that audiology professionals and services face in the current economic climate within the NHS. This evidence will be instrumental in helping us to influence national policy affecting the areas of concern in audiology.

If you have any questions about this report or our work, please contact professionals@ndcs.org.uk.

Appendix 1: Drivers for changes in demand

Routine pre-school assessment – 49 services offered reasons:

- greater number of referrals for speech delay and social communication concerns:
    - Some services attributed this to less social interaction during the pandemic, while others reported a rise in the number of children with autism and complex health needs.
- demand on other services leading to more referrals to audiology, e.g. long waiting times for ENT, SLT and other backlogs
- Covid-19 backlog
- increased population
- increase in referrals from other audiology services that do not feel confident to manage certain patient groups or where local service provision is missing.

Routine school-aged assessments – 39 services offered reasons:

- **School screening:**
    - lack of school screening
    - more school screening being performed
    - quality of school screening
    - more children not able to complete school screening
- **Population:**
    - larger class numbers
    - increased population
    - increased demand on paediatric services due to developmental delay
    - developmental delays arising from pandemic
    - Covid-19 backlog
    - increased viral illness
- **Service:**
    - opening up of access to services
    - increased referrals from all professionals
    - increase in referrals from SLTs and communication difficulties not necessarily concerned with hearing
    - ENT waiting times.

Complex assessment/multiple appointments – 69 services offered reasons for the increase:

- **Population/context:**
    - increased referrals for pre-school children with speech delay and/or developmental delay
    - increase in numbers of neurodiverse children
    - anecdotal increase in children not being able to perform standard testing with standard stimuli (e.g. VRA or play audiometry) and requiring modified testing or objective testing
    - greater awareness of importance of hearing checks
    - increased awareness of social communication disorders
    - increased anxiety in children (target-driven schooling) impacting on mental health and manifesting in APD/hyperacusis/misophonia
    - children new to country/area who have additional complex needs are on the rise
    - some services attributing the rise in children with social communication disorders to the pandemic and increased screen time
- **Services/system:**

    - children referred from other audiology centres or local providers not being able to meet their needs
    - hearing assessments are a prerequisite for autism spectrum disorder (ASD)/speech assessment or other wider investigations
    - change in discharge criteria
    - change in skill levels of staff.

Sedated ABR – 50 responses were received:

- **Specific cohort challenges:**
    - children more challenging to test, not responding to traditional or adaptive techniques
    - children will not tolerate examination or assessment while awake and often will not sleep for an ABR under natural sleep
- **Population:**
    - a perception that there is an increasing population of children with autism
    - increased population
- **Service:**
    - change in departmental guidelines/more refined pathway
    - referrals from community audiology/SLT/early years services/other centres
    - increase in theatre cases to tackle backlogs.

Listening difficulties (under normal hearing) – 23 responses were received:

- greater awareness among more education, health professionals and parents of auditory processing difficulties
- more children with anxiety after the pandemic
- increased population
- increased screen time and headphone use
- increase in the number of children with social/communication disorders
- possibly related to time in isolation during the Covid-19 pandemic making return to noisier listening situations a problem.

Self-referrals – six responses were received:

- open access and don't need to see GP
- school hearing screening stopped
- new introduction of a self-referral pathway
- more patients are aware of self-referral pathways
- parents struggling to get appointments with GPs
- GPs and other community professionals telling families to contact us themselves to make a self-referral
- more parents requesting reviews.

Referrals from school screening – three responses were received:

- **Issues with school screening:**
    - increased failure rate from school screening due to an equipment problem
    - more children were not able to do the test-screeners used in the first term of reception when children were not used to the school routine/demands
    - new providers taking over the service with limited training/staff skills issues
    - large increase in the number of school nurse referrals for the 2022 to 2023 year due to challenges with the screening programme

- school screeners having no access to our data – lots of referrals for children known to have hearing loss or already on our books
- referral criteria from school screeners – lots of children with foreign language needs being sent through to us who hear perfectly well but may not understand the brief for school screening
- more private schools accessing private firms to run school screening
- screeners currently not performing repeat screening
- more sensitive referral criteria from school screening

- **Other:**
  - school screenings being performed again after pandemic
  - increased population
  - higher class numbers
  - increased viral illness
  - no school screening anymore.

Appendix 2: Coping with changes in demand

Coping with changes in demand

Services were also asked what would help them cope with changes in demand.

Routine preschool assessment – 38 services offered ideas:

- **More staff:**
  - increase in staffing levels
  - more paediatric audiologists
  - difficulties with recruitment/no suitably experienced applicant pool or locums
  - appropriately trained staff
- **More capacity:**
  - more facilities
  - have had to quadruple sedated ABR capacity to cope
  - more sound proof test rooms
- **Changes in services:**
  - these children have been redirected to local community audiology services
  - more clinical time
  - an established clinic for complex children
  - multidisciplinary team (MDT) for complex needs children
  - information leaflets available to families
  - promote awareness of the impact of screen time use for 0 to 2 year olds.

Routine school-aged assessments – 32 services offered ideas:

- **School screening:**
  - reinstate school hearing screening
  - quality of school screening (ensuring screeners are well trained and use soundproof rooms for testing)
  - repeat screening by screeners
  - audiometrician supporting screening
- **Service:**
  - more staff
  - outsourcing
  - more test booths
  - more capacity
  - technology investment for pre-appointment work-ups
  - these children have been redirected to local community audiology services
  - lower ENT waiting times
  - information leaflets available to parents on how we test children.

Complex assessment/multiple appointments – 58 services offered ideas:

- **Staffing:**
  - more paediatric audiologists/qualified staff/additional Band 7 staff with the experience to manage complex testing situations
  - ability to recruit
- **Facilities/resources:**
  - more booths/testing facilities

    - more up-to-date equipment
    - more provisions to be able to offer GA/sedation ABRs so we can assess children who cannot perform behavioural testing
    - resources such as calibrated non-standard stimuli
- **Service:**
    - implement sedated ABR pathway/nursing staffing issues
    - longer appointment times
    - better-quality referrals/more awareness in the community so referrers can manage better and stop inappropriate referrals, and more information on the referrals themselves
    - shorter ENT waiting times to support us if the need arises for ENT support, i.e. ABR under GA if our testing is unsuccessful
    - funding
    - additional funding for home visit appointments
- **Guidance:**
    - better guidance on using non-standard stimuli, i.e. TV theme tunes/national guidance on non-standard discharge criteria, e.g. use of filtered music signals
    - a formal position on where audiology input fits in the ASD assessment pathways would be useful – parents are often given the impression that other assessments cannot go ahead without the hearing assessment being completed first
    - research into new ways of testing techniques for complex assessment:
        - new tests that are of interest to children with social communication/interaction concerns or who are diagnosed with autism
        - calibrated, non-routine stimuli – often these children won't respond to the traditional warble tones for VRA and require more familiar stimuli, but these are neither frequency specific nor intensity calibrated, so do not help clarify and complete the hearing picture
    - national guidelines for complex children:
        - when to refer for ABR or other testing
        - consensus on what "good" looks like.

Sedated ABR/under GA – 33 responses were received:

- more staff, ability to recruit, trained/experienced staff, more paediatric audiologists, more ABR testers
- acute services that we refer to for ABR under GA or sedation are also short of staff
- update equipment and facilities
- more appointments slots on children's day unit/more theatre slots/more flexible slots
- shorter waiting times in ENT
- support to establish a sedation pathway
- more streamlined service to support children with ASD from a young age without delays
- introduction of sedated ABR with regular sessions.

Listening difficulties (under normal hearing) – 17 responses were received:

- better training for teachers/education providers to avoid unnecessary referrals
- more staffing/ability to recruit
- better pathways and guidance on how to assess and manage these children:
    - APD protocols and testing and APD treatment protocols
    - national guidelines
- more local services that can do APD assessment
- more sound proof test rooms
- more clinic time
- specialist testing equipment

- access to educational psychology/dyslexia testing and investment in testing strategies
- involvement of wider MDT
- further studies around why children struggle to hear in noise
- better mental health provision
- staff training on basic advice for parents around listening difficulties for children with normal hearing.

Self-referrals – three responses were received:

- more capacity with soundproofing/more paediatric test rooms
- more specialist paediatric staff.

Referrals from school screening – 21 responses were received:

- **Timing of screening:**
    - screeners are going to screen from January this year to see if this helps, as the children will be a bit older and more settled in school
    - screening can take place during optimum times of the year and not during the peak winter months
- **Resourcing of screening:**
    - more staff in audiology and also school screening
    - audiometrician supporting screening
    - ensuring screeners are well trained
    - standardised training for screening services across all boroughs
    - use of soundproof rooms for testing
    - repeat screening.

Appendix 3: Criteria for onward referral to other services

SLT referrals – 74 services provided a response:

- PCHIs
- aided children
- children with/without hearing loss not meeting expected speech progress
- moderate or greater bilateral sensorineural loss
- those with communication difficulties
- APD
- from six months old and at 18 months old
- following parental or professional concerns
- self-referral option in different areas
- referral mostly via GP or health visitor/school nurse, or consultant paediatrician
- rarely refer to SLT because of the complexity of the referral pathway
- different SLT services have different acceptance criteria.

ENT referrals – 102 services provided a response:

- all PCHI
- ANSD
- any new diagnosis of hearing loss of any description
- aetiology following identification
- abnormal presentation on otoscopy
- conductive hearing loss after a watchful wait period
- conditions including:
    - foreign body in ear
    - large perforations
    - permanent conductive hearing losses, e.g. otosclerosis
    - two instances of glue ear
    - ongoing ear infections
    - nose or throat problems not addressed by GP, e.g. sleep apnoea/snoring or nasal congestion
    - impacted wax
    - asymmetrical hearing loss
- difficult to test children (ABR under GA)
- those who need surgical intervention, e.g. grommets, adenoidectomy or middle-ear surgery such as for cholesteatoma
- children with Down's syndrome or cleft palate
- local protocol/NICE guidance
- referral is case by case
- following parental or professional concerns.

Family support/multi-agency support team/social services – 56 services provided a response:

- frequent WNBs, housing concerns, safeguarding concerns and family wellbeing concerns
- parents not engaging with aid for children with a PCHI, moderate or worse
- for assistance where there are issues, e.g. Disability Living Allowance applications, housing, etc
- social services hearing impairment team for support/equipment relating to hearing loss
- request from parents
- for early help – pathways for children who may need processes in place for additional support

- following local authority guidance/criteria for referral.

Safeguarding referrals – 99 services provided a response:

- children with hearing loss who are not brought to multiple appointments
- children who meet Trust safeguarding criteria, e.g. signs of neglect or abuse
- concerns generally around lack of hearing aid usage
- via a triage hub
- via consultant paediatrician referral.

Clinical psychology/CAMHS referral – 37 services provided a response:

- children with mental health concerns who do not meet deaf CAMHS referral criteria
- patients with behavioural concerns/psychological concerns:
    - children showing significant levels of anxiety, stress or self-harming
    - concerns regarding a child's wellbeing
- misophonia, significant tinnitus or hyperacusis
- families/children with diagnosis of permanent hearing impairment are offered psychology support
- any child from 0 to 19 years
- parental/professional concern
- via GP/education.

Deaf CAMHS – 34 services provided a response:

- children with hearing loss with mental health concerns who meet Deaf CAMHS referral criteria
- mental health concerns in children and young people related to deafness
- where BSL is the predominant communication mode
- via GP/education
- those with audiovestibular medicine/ENT concerns
- via social services team.

Paediatrician/developmental assessment – 76 services provided a response:

- all new diagnosis of PCHI or ANSD
- concerns about development (e.g. autism), known syndromes (e.g. Down's syndrome), behavioural difficulties or communication concerns
- aetiological investigation
- confirmed sensorineural hearing loss for aetiology but not regarding development concerns
- pre-school children who are already under SLT but not in an educational setting
- ENT first port of call
- via health visitor
- via GP
- according to locally agreed protocols and pathways
- following family/professional concerns
- only able to refer following diagnosis of hearing loss/for aetiological investigations, and can't refer for other developmental concerns, with parents being directed towards health visitor/GP/nursery
- rare for audiology to refer.

Other third sector/community organisations referrals – 26 services provided a response:

- all children are signposted to the National Deaf Children's Society for advice, information and support, and children with other conditions, e.g. Down's syndrome, are signposted to relevant organisations
- Deafness Support Network, Elizabeth Foundation, local deaf children's societies, Cleft Lip and Palate Association (CLAPA), BSL Support, Changing Faces, Microtia UK, local voluntary services, hearing aid company support offers, Cued speech and Signpost
- oncology, genetics and local sensory services.

Services were asked whether there are any other services they refer to or struggle to refer to – 24 services responded:

- can only refer to paediatricians via SLT if there are social communication concerns, and to an audiovestibular physician if there are developmental concerns
- very long waiting lists for paediatricians and SLT
- unsure if able to routinely refer directly to Deaf CAMHS
- refer to University College London for hyperacusis, tinnitus or auditory processing assessment
- social services, ToD, safeguarding and CAMHS often reject our referrals as not meeting threshold
- currently there is no local paediatric social services pathway
- due to commissioning arrangements, unable to refer directly to acute Trust services such as ENT and community paediatrics
- refer to orthoptics (visual processing) and occupational therapy
- recent update of management system to SystmOne allows direct requests for further appointments via health visitor/school nurse and other professionals involved
- the SLT referral form is very long and requests information about many aspects of the child we do not have expertise in
- no local provision for children who need help with tinnitus, hyperacusis, APD or misophonia
- no commissioned service for aetiological investigations for those over 16 years, and have to refer to adult clinics, which have long waiting lists
- unsure if able to refer directly to social services.

List of abbreviations used in: Children's hearing services in England (2023)
A report by the National Deaf Children's Society

ABR: auditory brainstem response

AfC: Agenda for Change

ANSD: auditory neuropathy spectrum disorder

APD: auditory processing disorder

ASD: autism spectrum disorder

ASSR: auditory steady state response

BAHAs: bone-anchored hearing aids

BSA: British Society for Audiology

BSL: British Sign Language

CAMHS: Child and Adolescent Mental Health Services

CHSWG: Children's Hearing Services Working Group

CIs: cochlear implants

CPD: continuing professional development

DNA: "Did Not Attend"

ENT: Ear, Nose and Throat

FOI: Freedom of Information

FTE: full-time equivalent

GA: general anaesthetic

ICB: Integrated Care Board

IQIPS: Improving Quality in Physiological Services

MDT: multidisciplinary ream

NHSP: NHS newborn hearing screening programme

PCHI: permanent childhood hearing impairment

RTT: referral-to-treatment

SLT: speech and language therapy

SOPs: standard operating procedures

ToD: teachers of the deaf

UKAS : United Kingdom Accreditation Service

VRA: visual reinforcement audiometry

WNB: “Was Not Brought”