LISTEN UP 2024

Children's hearing services in Northern Ireland

A report by the National Deaf Children's Society



Paediatric audiology services in Northern Ireland A report by the National Deaf Children's Society, December 2024



Introduction

This report presents the findings of a survey of Health and Social Care paediatric audiology services in Northern Ireland, which was carried out by the National Deaf Children's Society in Winter 2023. This is the first time that such a data collection has been conducted by the National Deaf Children's Society in Northern Ireland, but there has been an annual survey and report published in England since 2017, which has proved helpful in identifying and tracking trends in paediatric audiology.

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 Northern Ireland *Listen Up* report will also be useful for discussions with other stakeholders, such as Health and Social Care Trusts and the Department of Health, by providing up-to-date evidence about paediatric audiology service provision.

For the 2023 survey in Northern Ireland, questions were adapted from a fuller set of questions for the ongoing English *Listen Up* survey. We are grateful to audiologists in Northern Ireland for their support in completing the *Listen Up* survey.

We sent the survey to all five Health and Social Care Trusts that provide paediatric audiology services in Northern Ireland. As with previous *Listen Up* surveys in England, the National Deaf Children's Society made a Freedom of Information (FOI) request to ensure as many timely responses as possible. All five Health and Social Care Trusts responded to the survey before the deadline and were included in our analysis. Northern Ireland had the highest response rate in this year's UK-wide data collection (see Table 1 for comparison with England, Scotland and Wales).

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 England, N. Ireland, Scotland and Wales for the 2023 report

The aim of separate surveys 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 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 could not obtain the data, or for an unspecified other reason – meaning that the response rate figures, and thus subsequent findings for each question, have been interpreted with care.

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 that all audiology services in Northern Ireland are committed to sharing information, even when their own time and resources may be stretched.

Key findings

Overall, the responses to the survey highlight that paediatric audiology services in Northern Ireland are facing difficult challenges, some unique to Northern Ireland and some common across the UK. The main themes highlighted were:

- Long waiting times for routine first assessments for children referred to audiology via routes other than the Newborn hearing screening programme (NHSP), indicating a significant risk of delayed identification of deafness for these children.
- **Quality assurance is not well embedded** in most audiology services and data may not be routinely reported for many aspects of service provision. Of particular concern is the lack of recommended external Auditory Brainstem Response (ABR) peer review in 60% of services.
- Service capacity challenges because of staff vacancies and increasing demand.
- Not all services offer a wide range of options for assessing children with complex needs, which may lead to **delays in identification of deafness in this cohort of children.**

Executive summary

Waiting times

Some services have long waiting times for routine first assessments. While only one service reported an average waiting time in excess of the target for referrals from NHSP, for referrals outside of the NHSP, two services reported average times that exceeded the maximum expected time of 63 days, with one service reporting a significantly excessive average waiting time of 165 days. The average waiting time for referrals to first assessment for children not referred from the NHSP ranged from 14 to 165 days.

Variation in services offered

Not all services offer a wide range of assessment options and protocols for children with complex needs or where standard behavioural methods do not obtain a definitive result. For services with smaller reported caseloads, this variability may pose a risk, particularly in assessing children with complex needs or neurodiversity, and in managing rarer conditions like auditory neuropathy spectrum disorder (ANSD).

While there is some evidence of good practice in managing temporary deafness, there is still variation across services regarding some of the options offered to children. Additionally, the availability of additional paediatric services, such as for tinnitus and vestibular assessment, differs across services. None of the audiology services offered wax removal themselves and needed to refer elsewhere for this.

Staffing

All five services responded and there was a significant range in staffing levels per service.

Services report capacity challenges because of staff vacancies and increasing workloads. Services reported being unable to recruit new staff, staff reducing hours, having no capacity to train new staff and a lack of appropriate training routes available for paediatric audiologists in Northern Ireland.

Accessibility

All five services offered the option of communicating via email as well as telephone. However, there were few other options available to families who struggle to access services via these. Three services reported

having British Sign Language (BSL) and Irish Sign Language (ISL) as communication options, and two use text messaging. No services use an online booking system or web form.

All services reported that both clinical and administrative staff receive some form of deaf awareness training, either one-off training or regular updates.

Quality assurance

Data may not be routinely collected or reported for many aspects of service provision and thus services were unable to provide data for some questions in this survey.

All services reported engaging in internal¹ peer review of ABR results and reporting PCHI to SMART 4 Hearing, a database that records children with PCHI in the UK. However, only two services reported participation in external ABR peer review, which is recommended practice,² to assure the quality and safety of the diagnostic ABR test, essential for identifying deafness in babies and children, which presents a significant risk to maintaining quality and safety of ABR testing.

All services reported audit against national quality standards³, but currently no paediatric audiology services in Northern Ireland are Improving Quality in Physiological Services (IQIPS) accredited, which requires evidence of adherence to multiple overarching standards, assessed by independent external assessors. There is a cost associated with IQIPS accreditation.

Three services reported performing peer review of behavioural testing, peer competency checks and collecting patient satisfaction data, which shows evidence of good practice.

Collaborative working

Most services refer children identified with permanent hearing loss to education support services (Education Authority Sensory Service) regardless of level or type of deafness. Children with temporary or fluctuating hearing loss are only referred to education services by two responding audiology services.

All services could directly refer directly to Ear, Nose and Throat (ENT) for a medical opinion, as well as children's social care (family support and safeguarding). However, there was a lack of consistency in referral to other services. Only one service reported they can refer directly to paediatrician and no service can refer directly to speech and language therapy (SLT).

Most services said they routinely referred or signposted families on to third sector or other organisations for specific support related to having a deaf child.

Patient engagement

The transition to adult services for young people is variable, with most services providing information and completing a formal transition process, but few offering best practices like joint appointments or independent clinic visits.

¹ Internal peer review is the practise of reviewing results by staff members within the same service. External peer review should be organised between a collaborative group of departments willing to peer review each other's work. The British Society of Audiology has practice guidance on the principles of peer review. www.thebsa.org.uk/wp-content/uploads/2023/10/FINAL-Practice-Guidance-Principles-of-external-peer-review-of-auditory-brainstem-response-ABR-testing-in-babies-Nov2019.pdf (accessed November 2024)

² British Academy of Audiology. Quality Standards in Paediatric Audiology (2022). baaudiology.org/app/uploads/2022/07/BAA-Paed-QS-v1-2022.pdf (accessed 16 September 2024).

³ Draft Quality Standards for Paediatric Audiology Services (2019). https://bso.hscni.net/wpfd_file/draftquality-standards-for-paediatric-audiologyservices121119/ (accessed 28 November 2024).

The average rate of non-attendance/children not being brought to audiology appointments in Northern Ireland for the survey period is 15%, which is comparable with England, Scotland and Wales. Services did report on strategies to try and prevent missed appointments, which is important not only to reduce the risk of delayed identification and management of deafness, but also because of the additional pressure this puts on services trying to tackle backlogs in challenging circumstances.

Changes in demand

Services reported an increased demand for most types of appointments, including increased referral rates for preschool and school-aged children for assessment, and increased referrals from school entry hearing screening. Three services did not see any change in demand for children requiring more complex assessment, ABR under sedation or general anaesthetic (GA); and two services reported a decrease in children requiring ABR under sedation or GA, which is at odds with reports from England, Scotland and Wales.

Reasons for changes in demand included a reported increase in referral of children with speech delay, Covid-19 backlogs, changes in protocol (e.g. more referrals directly to audiology rather than ENT) and more demand from paediatrics to rule out hearing loss as part of wider developmental assessments.

Services were also asked what would help them cope with changes in demand. Responses included introducing more testing facilities, more staff, providing specialist training to staff and clear guidance around what assessments should form part of developmental assessments.

Section 2: Caseload

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

Number of births covered by the service per annum

Services told us how many babies were born in the area covered by their service in 2023 and all five services provided information. This ranged from 3,300 to 4,779.

Year	Response rate	Range
2023	100% (5)	3,300 to 4,779

Table 2: Number of births per year

The total number of births reported was 18,996.

Age range

We asked services to indicate the age range their service covered. One service covered children aged 0 to 16, two services covered 0 to 18 and two covered 0 to 19 (who also saw specific groups of young adults such as those with special educational needs).

Total number of children with PCHI

We asked services to indicate the total number of children with PCHI in their caseload. Three services reported a total of **465 children with PCHI** in their caseloads; there was a large variation between the three services, ranging from 82 to 256. In the context of this large variation in caseload, it is important that services with smaller caseloads consider the idea of "critical mass" to ensure staff competency.

Year	Response rate	Total	Range
2023	60% (3)	465	82 to 256

Table 3: Overall number of children with PCHI in caseload, with the number of responding services in brackets.

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

We asked services how many children with PCHI were identified via referral to their service from the NHSP, and via other referral routes, e.g. referral from GP, health visitor, school screening, etc., between 1 October 2022 and 30 September 2023 (Table 4).

Year 2023	Response rate	Total
NHSP	60% (3)	31
Other referral	60% (3)	24
routes		

Table 4: Number of children with PCHI referred to services between 1 October 2022 and 30 September 2023 from the NHSP or other referral routes

A total of 55 children with permanent deafness were identified during the qualifying period (Table 5). Just over half (56%) were identified through the NHSP, but the data only reflects responses provided by three services.

Year 2023	Total	% Distribution
Total	55	100%
NHSP	31	56%
Other referral routes	24	44%

Table 5: Distribution of children with PCHI referred to services between 1 October 2022 and 30 September 2023 from newborn hearing screen or other referral routes

Section 3: Clinical service variation

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. All five services provided a response.

Year	Specific clinics, for example, with longer clinic times or more experienced staff	Use of non-calibrated stimuli (for example, non-calibrated but band-pass filtered music)	Sedated ABR	ABR under GA	Other
2023	4	1	0	5	2

Table 6: Services provided for assessing the hearing of complex or difficult-to-test children as reported by services

All five services reported that they offer ABR under GA. Four services offer specific clinics for this group with longer clinic times and/or more experienced staff. Only one service reported the use of non-calibrated stimuli. No service reported using sedated ABR, but one service selected "Other" and specified that they use ABR under natural sleep, if appropriate.

In addition, we asked what specific training and protocols services have for each one of those assessment options. Responses centred around availability of trained and experienced staff and the staff skills mix used, following national published and local protocols, having timing flexibility, and working collaboratively with other departments. Specifically, responses included:

- Protocols for specific clinics services reported:
 - using more experienced senior staff with higher level paediatric training, e.g. a clinic led by two senior paediatric audiologists; a minimum of Band 6 for a paediatric audiologist with five years' post-qualification experience and completion of additional training and courses
 - o local Standard operating procedures (SOP) and guidelines
 - o offer of clinic times with flexibility when required, e.g. 45-minute slots.
- Non-calibrated stimuli: Only one service selected this option and further explained that paediatric audiologists are required to undergo additional training in order to use non-calibrated stimuli. Another service added a clarification under "Other" to explain they are currently developing the option for use of non-calibrated stimuli.
- **ABR under anaesthetic:** Four services mentioned that staff have completed recognised specialist training and that British Society of Audiology guidelines are followed. One service specified that the decision to proceed with an ABR under GA lies with the ENT consultant. One service specified under "Other" that ABR under GA can be coordinated if the child is having a GA for another reason.

Services for temporary conductive hearing loss

We asked services about the options in their current management pathway for temporary conductive hearing loss (multiple options could be selected). All five services provided a response.

Year	Air conduction hearing aids	Bone conduction hearing aids	Grommets	Otovent	Watch and wait	Other
2023	5	3	3	3	5	2

 Table 7: Support available to children with temporary conductive hearing loss

All services offer air conduction hearing aids and "Watch and wait"; three stated they offer bone conduction hearing aids, grommets and Otovent. One service added that for Otovent, audiology cannot prescribe but may recommend and will advise parents to speak to their GP or pharmacist.

Another service specified that they have a local protocol for the management of otitis media with effusion, based on the most recent NICE guidance, which advises "discretion" regarding when to suggest air conduction/bone conduction hearing aids. The same service explained that grommets/otovents are management options discussed by ENT, as this is medical intervention and not included in the audiology protocol. Services for temporary hearing loss provided by ENT may not have been included in all the answers.

Regarding alternatives offered to children on a waiting list for grommet insertion, two services said that they were able to offer hearing aids whilst waiting, while one service said they did not provide this option.

Provision of hearing aids

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

Year	Temporary conductive hearing loss	Unilateral hearing loss	Mild hearing loss	Moderate hearing loss	ANSD	Other
2023	5	5	5	5	4	1

Table 8: Groups provided with hearing aid technology

All five services offer hearing aids for temporary conductive hearing loss, unilateral hearing loss, mild and moderate; four services may offer hearing aids for ANSD.

Additional/non-standard paediatric services

We asked services about additional or non-standard paediatric services they offer and whether they refer children elsewhere if their service does not provide this option. Respondents could select multiple options.

Year 2023	Wax removal performed by audiologists	Tinnitus assessment/ management	Hyperacusis assessment/ 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/auditory processing disorder (APD)	Other
Offer	0	3	3	1	0	0	1
Refer elsewh ere	4	1	1	4	3	3	1

Table 9: Number of additional paediatric services offered by services

Three services said they provide services for tinnitus and hyperacusis and one for implantable devices. Some of the services that do not provide the service refer elsewhere. For wax removal services, all responding services said the referral would be to ENT or a nurse-led service. For tinnitus, hyperacusis and listening difficulties, referrals would be made to ENT. For implantable devices, referrals are made to regional implant centre.

No services provided a paediatric vestibular service but three services reported referring elsewhere. Two services provided extra detail that suggested they refer to ENT, which may then refer to an adult vestibular service. An additional service that selected "Other" explained that there is no commissioned paediatric vestibular service in Northern Ireland but they would refer to ENT, where a consultant can then refer for some tests via other channels.

Section 4: Accessibility

Communication options

We asked services about the communication options they offered families.

Year 2023	Email	Text message	Web form	Online diary/booking system	Telephone	BSL/ISL
N services	5	2	0	0	5	3

Table 10: Number of services offering each communication option

All five services use email and telephone to communicate; three reported using BSL/ISL, and two use text messaging. No services offer options such as enabling families to submit web forms or book appointments on line.

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.

Services generally set their target response times as either 1 or 2 days. The actual average response time ranged from one day for text and sign language to 2.3 days for email. One service reported response times of five days for email and telephone queries. One service did not give us their targets, only their actual response times.

Four services shared what may prevent them from reaching their response target. One referred to the significant volume of telephone calls but limited staff to cover these. Another service referred to seasonal variation and another mentioned lack of weekend cover. A third service said that the wait time for confirmation of the sign language interpreter is approximately 14 days. However, they book appointments within an agreed timescale whilst waiting for the interpreter confirmation, so timings should not affect the patient. That same service also specified that they offer both ISL and BSL for patients and Type Talk telephone system has been used by a select number of clients.

Deaf awareness training

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

Year 2023	One off training	Regular updates
Audiologists	1 (5)	4 (5)
Reception/administrative staff	2 (5)	3 (5)

Table 11: Deaf awareness training

All services reported some form of deaf awareness training for all staff. Most services (4 of 5) reported that they provide regular updates in deaf awareness for audiologists rather than one-off training. For administrative staff, there was a mix of one-off and regular updates.

Section 5: Waiting times

Referral to first diagnostic assessment from the NHSP

The waiting time target from being referred from the NHSP to attendance at an audiological assessment appointment in Northern Ireland is 28 days⁴. This is a target that should be met for each individual child, and this should be monitored by Health and Social Care Trusts themselves.

For this survey, we asked services to report their **average** waiting times (in days) from referral via the NHSP to the first audiology diagnostic assessment in the period 1 October 2022 to 30 September 2023. There are some important caveats to highlight that affect the quality of the data:

- An average waiting time will not accurately reflect variability in waiting times within a service, i.e. that it is possible some babies in a service may be waiting much longer, and some less, than the average figure reported.
- The standard is for maximum acceptable waits not an average wait, so a service with an average wait of 28 days is unlikely to 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 information about waiting times in Northern Ireland, despite these being averages and not reflecting the situation for the entire caseload.

Year	Response rate	Maximum wait	Minimum wait
2023	100%	34	17

Table 12: Reported average waiting times for referral to first diagnostic assessment from the NHSP in days

All five services provided data on their average time of referral to first diagnostic assessment from the NHSP, ranging from 17 to 34 days. Only one service reported an average waiting time in excess of the 28-day target.

Referrals to first diagnostic assessment for referrals outside the NHSP

The waiting time target for referrals to first diagnostic assessment for infants and older children not identified by the NHSP in Northern Ireland is 63 days.

Year	Response rate	Maximum average waiting time (days)	Minimum average waiting time (days)
2023	80%	165	14

Table 13: Referral to first diagnostic assessment for those not referred from the NHSP in days

Four services provided data on their average time for referrals to first assessment for children not referred from the NHSP, ranging from 14 to 165 days. Two services reported average times that exceeded the maximum expected time of 63 days, with one service reporting a significantly excessive waiting time of 165 days.

Section 6: Quality assurance and improvement

The survey asked what methods services use for quality assurance and improvement.

⁴ Draft Quality Standards for Paediatric Audiology Services (2019). https://bso.hscni.net/wpfd_file/draftquality-standards-for-paediatric-audiologyservices121119/ (accessed 28 November 2024).

Quality assurance and improvement methods

The most popular methods, each reported by all five services, were a local programme of audit against national quality standards, internal peer review (for ABR) and reporting all PCHIs on SMART 4 Hearing.

Internal peer review (behavioural testing), peer competency checks and patient/service user surveys/focus groups were selected by three services. External peer review for ABR was selected by only two services, while no service selected external peer review (other than for ABR) or IQIPS. The "Other" option was reported by one service as 10,000 Voices (Public Health Agency feedback process for service users)⁵.



Figure 1. Quality assurance and improvement methods used by services

The number of different quality assurance methods per service was also looked at (Figure 2). Services used six methods on average ranging from four to nine per service.



Figure 2. Number of different quality assurance methods used by each service

⁵ 10,000 voices can be understood as a patient/service user survey and so has been included in this option in the Figures 1 and 2. .

The services that reported active participation to external ABR peer review reported that they submit regularly traces of **all** identified hearing losses **and** a sample of discharge. There were seven ABR testers reported across the two services that responded to the question, and all were reported as participating in some peer review. One service reported that they are currently in discussions for setting up peer review with a neighbouring Health and Social Care Trust.

When asked about how they act on ABR external review findings, services reported that they apply it to practice and learn for future cases, and that the cases are reviewed using a peer review tool and against the BSA guidelines.

Section 7: Staffing and training

We asked about staff working in paediatric audiology services (including the Agenda for Change (AfC) band levels of staff) as of 30 September 2023, clinical staffing or skill levels, vacancies, reasons for that 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 45.6. There was significant variation between services from 4.4 to 29.3.

Number of FTE clinical staff at all AfC levels

The graph that follows shows the number of substantive posts (FTE) at each AfC band working in the paediatric audiology services responding to this question.



Figure 3. Number (FTE) of clinical posts in paediatric audiology, by AfC band

The numbers in brackets under each Band in Figure 3 show the number of services that provided an answer.

The majority of paediatric audiology staff were employed as Band 6 AfC, followed by Band 7 AfC.

Vacant posts



We asked services to specify the number of FTE equivalent posts that are vacant.

Figure 4. Number (FTE) of vacant posts by AfC bands

In total, 9.8 FTE posts were reported to be vacant across services with the highest number (five) at Band 6 AfC.

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

Three services reported reduction in staff/skill level in the past year. Inability to recruit staff and maternity/sick leave were identified as the reason by three services; staff leaving or reducing hours and no capacity to train new staff were identified by two services.



Figure 5. Reasons for the reduction in the number or skill level of staff compared to last year

Services commented on wider challenges, such as difficulty with recruitment (one respondent said that the service had attempted unsuccessfully to recruit twice in the last year for Band 5 staff) and on the fact there is no audiology qualification available in Northern Ireland.

Services reported steps taken to address challenges:

- recruitment drive at BAA Annual Conference and social media recruitment campaign
- offer training positions for trainee audiologists; one service specified that after unsuccessful
 recruitment exercises at Band 5 level, they recruited at trainee level, with the expected time frame
 being three to four years to gain the qualification, and once qualified as a Band 5 audiologist training
 will begin in paediatrics for, on average, five years.

Section 8: Collaboration

Referrals to Education Authority (EA) Sensory Service

We asked services about which children they referred to the local specialist education service that support deaf children (services could select multiple options). We asked about whether they referred children with different levels and types of deafness, and whether they referred children without hearing aids as well as those fitted with hearing aids (aided).

Figure 6 presents which children are referred to specialist education services (for different types and levels of hearing loss, and for both aided and non-aided children in these categories). One service did not provide data about unaided children.



Figure 6. Groups of children that hearing services refer to education

All services reported that they referred children fitted with hearing aids with any type and degree of hearing loss to the EA Sensory Service, except for one service that did not refer children with ANSD. One service also mentioned that they refer aided children with APD, tinnitus and hyperacusis, and that although there may not be intervention by the EA Sensory Service, at least these children will be known to that service.

Most categories of children identified as deaf who are not fitted with hearing aids are still generally referred to local specialist education services, although one service did not provide data. Children with ANSD are referred by four services, regardless of whether they are aided or not. Children with temporary or fluctuating hearing loss are an exception, as they are referred to education services by only two responding audiology departments.

We do recognise that education referral criteria are usually outside the remit of audiology services.

Referrals to other non-audiology professionals and third sector

We asked if the audiology services were able to routinely refer directly to other appropriate health and social services, e.g. SLT, ENT, early family support/social services, child protection, clinical psychology/ Child and Adolescent Mental Health Services (CAMHS), and paediatrician/developmental assessment service. We also asked if they routinely signposted families to appropriate third sector/community organisations, such as the National Deaf Children's Society.



Figure 7. Referrals to non-audiology/external professionals

All services could directly refer directly to ENT for a medical opinion, as well as children's social care. There was some variation in onwards referral of children to other non-audiology services. Only one service reported they can refer directly to paediatrics and no service can refer directly to SLT.

Services were asked which children they refer.

- ENT referrals:
 - Reasons for referral include following guidance, children that require clinical ENT follow-up or monitoring and children diagnosed with hearing loss.
- Children's social care and family support services:
 - All five services reported that they refer to children's social care when there are safety or welfare concerns, or to receive family support services or access to children with disability teams, e.g. for children who require adaptations in the home, such as fire alarms.
 - Reasons for referral included struggling parents;
- Paediatrician/developmental assessment referrals:
 - \circ $\,$ It was not clear from the response what the criteria for referral is.
- Other third sector/community organisations referrals:

- Reasons for referral included a child being diagnosed with hearing loss or fitted with hearing aids.
- Referrals are made to the National Deaf Children's Society or Action Deaf Youth.
- Clinical psychology/CAMHS referral:
 - Parent or child requires mental health support.
- Deaf CAMHS
 - \circ $\;$ Any deaf child who requires mental health support.

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 with information.



Figure 8. Signposting to the National Deaf Children's Society

All services signpost to the National Deaf Children's Society and provide information to families of children with severe/profound, moderate or mild sensorineural hearing loss and with permanent or long-term conductive hearing loss. For the other categories 4 of 5 services either signpost or provide information.

When asked about the timing of signposting families to the National Deaf Children's Society, all services reported that they signpost families to the National Deaf Children's Society at diagnosis and whenever a family has an issue that the National Deaf Children's Society may be able to support.

Section 9: Patient engagement

Transition to adult services

Services were asked about how they prepare young people for transition to adult services. They were offered nine options including "Other" and could select all that apply. Figure 10 displays the number of services that responded to the question and highlights how variable the transition process is between services.

All five services stated that they provide information on the adult service for young people; four start talking about the transition process from age 14; three complete a transition assessment/process. No services hold transition events or clinics for young people or offer school visits.

A minority of services offer the following options: offering joint appointments with both paediatric and adult audiologist present; offering the opportunity to come into the clinic without parent/carer, if appropriate; and offering an appointment with the adult service before being discharged from the paediatric service.

Of the two services that selected "Other" one specified that they only offer the over-16s the opportunity to come into the clinic without parent/carer, if appropriate, for safeguarding reasons; and they explained that, in relation to joint appointments with both paediatric and adult audiologist, no staff work in both adults and paediatrics.

The other service explained that a personal profile is completed by the young person to discuss their hopes/goals for the future, which also explores how much parental involvement the young person would like; as the adult and paediatric staff work on the same site and work across both teams, they stated it is not necessary to hold joint appointments.



Figure 9. How paediatric hearing services prepare young people for transition to adult services

Overall, the dominant practice across services seems to be more of information offering and completion of a transition process.

Missed appointments

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

Year 2023	Total number
Number of all appointment types for children	11,391 (4)
Number of appointments classed as WNB or DNA ⁶	1,688 (4)

⁶ 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.

Percentage WNB/DNA	15% (4)
--------------------	---------

Table 14: Total number of appointments and appointments classed as WNB or DNA (numbers in brackets denote number of services with data)

Four services provided data about the number of appointments. A total of 11,391 appointments for children were offered in the year covered in this FOI request.

The rate of WNB/DNA reported across four services was 15%. This is significantly higher than the figure of 7.3% for outpatient appointments generally (2023/24⁷). However, it reflects that non-attendance rates tend to be higher for children and young people, as they need to be brought by adults. The figure is comparable to WNB/DNA rates in England, Scotland and Wales.

Strategies for missed appointments

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

Strategy	No of services
Partial booking	3
Text reminders	3
Phone reminders	1
Other	3

Table 15: Strategies for missed appointments

Three services reported they use partial booking and text reminders, and one uses phone reminders. Three services selected "Other". Responses included: all letters copied to parent/guardian and GP/referrer; greater flexibility for parent/guardian, with appointments offered across all their sites and with extended opening times (from 8:15am until 6pm); text reminders are to be introduced shortly with a new system.

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. There was a list of seven areas to consider and an "Other" option was also provided. All were multiple-choice responses.

⁷ Department of Health. Release of Northern Ireland Inpatient, Day case and Outpatient Hospital Statistics for 2023/24. <u>Northern Ireland Outpatient Activity</u> <u>Statistics 2023/24</u>



Figure 10. Service areas that have seen changes in demand

Services reported increase in most areas: all five saw increases in referrals for pre-school hearing assessments, four reported increases in school-aged assessments and referrals from school screenings. Three reported a stable demand to assess children with listening difficulties with normal hearing. Two services saw no change in relation to self-referrals (these were the only responses in relation to self-referrals). Two services reported a decrease in children requiring sedated ABR/ABR under GA which differs from reports from England, Scotland and Wales.

Drivers for change in demand

Services were also asked about likely reasons for changes in demand. Services consistently reported similar reasons for increased demands across assessment clinics.

Themes identified were a perceived increase in referrals for assessment of hearing in children presenting with communication difficulty, and/or suspected neurodisability – both of which require hearing loss to be ruled out as a factor contributing to their difficulties.

One service reported that there had been an increase in communication difficulties and sound sensitivities due to a rise in rates of autism diagnosis. Others identified that health professionals are more aware of hearing loss and particularly of the need to check hearing first before assuming social-communication difficulties. The effect of certain assessments now coming to audiology that would have previously been referred to ENT was also noted.

Coping with changes in demand

Services were also asked what would help them cope with changes in demand. Not all services provided a response in each category.

- Responses across all categories included the following: introducing more testing facilities and more staff trained in paediatrics.
- In relation to school-aged assessments, one service reported a regional plan for Primary 1 school screening with protocols and referral criteria, as well as an electronic test with noise-cancelling headphones.
- In relation to children requiring complex assessment techniques, one service noted that they would welcome clear guidelines on what assessments are required as part of an autism spectrum disorder (ASD) assessment. For example, if a child has passed NHSP and there is no parental concern regarding hearing, and given hearing assessment can be a very stressful process for both parent and child, and in many instances results in an ABR under GA, the necessity of completing a hearing assessment is questioned.

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. Examples shared included:

- remote switch-on and monitoring of cochlear implants led to very positive patient/user feedback
- implementing 10,000 Voices report on paediatric audiology
- a four-week pilot to tackle waiting times where they prioritised a group of pre-lingual children as the most at-risk group to focus resources, which resulted in earlier diagnosis and intervention, and reduced waiting time to within target time of 9 to 13 weeks
- aim to see diagnostic ABRs within three weeks to enable testing for congenital cytomegalovirus
- ongoing auditing to ensure a quality service is being provided
- maintain targeted waiting times.

Current and anticipated challenges

Services were asked about challenges they are experiencing now and the ones they anticipate in the future. All five services provided responses.

Challenges you are experiencing now	Challenges you anticipate in the future
-------------------------------------	---

 recruitment challenges/unable to fill vacant posts long-term staff sickness and no maternity cover increased workload/demand linked to other services such as for ASD assessment access to training – no audiology degree course in NI staff time for audits low staff morale no support from outside the service high demand and low capacity across all services accommodation availability for testing to address waiting lists and unsuitable facilities low staff or address low staff or address low staff or address low staff or address 	staffing levels ding retirement of highly skilled staff ant staff posts not being filled easing demand/further increases in referrals for assessment technology staff morale and burnout ess to training in NI cerns about sustainability of paediatric audiology blishing Children's Hearing Services Working up and audiological multi agency support teams
no wax removal available in primary care. lack o	of investment in audiology services and facilities.

Conclusion

This report presents evidence of some issues of concern likely to affect children and young people requiring timely access to good quality audiology services in Northern Ireland, and of variations in clinical practice and quality assurance.

Several services provided examples of good practice to tackle increases in demand and some of the issues identified. However, services reported significant concerns around the challenges they face, particularly around training, recruitment and retention of paediatric audiology staff. This is a common theme across the UK. Services report that they need increased capacity in terms of staffing as well as investment in audiology services and facilities to be able to cope with increasing demands on services and tackle the issues reported.

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 affecting health and social care. This evidence will be instrumental in helping us to influence policy in Northern Ireland affecting the areas of concern in audiology.

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