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**Title:** Quality Standards for Adult Hearing Rehabilitation Services 2016

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**For Action by:**
Local Health Boards

**Action required by:**
Immediately

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**Enclosure(s):**
1. Quality Standards for Adult Hearing Rehabilitation Services 2016
2. Assessment and Audit Tool 2016.

# Quality Standards for Adult Hearing Rehabilitation Services 2016

A revision of the Quality Standards for Adult Audiology services published in 2009 was undertaken by a multi-professional working group. The group's recommendations were presented to the Audiology Services Standing Advisory Group on behalf of the Welsh Scientific Advisory Committee and endorsed for immediate implementation in Wales by Vaughan Gething AM, Cabinet Secretary of Health, Well-being and Sport. The revised standards will promote continuous improvement of adult audiology services for citizens across Wales.

The Quality Standards for Adult Hearing Rehabilitation Standards 2016 and accompanying Assessment and Audit Tool 2016 replace all earlier versions. Main areas of change are:

- Consideration of the relevance of existing criteria in light of the latest evidence-based practice and advances in technology
- Consideration and development of the Standards in areas that are not sufficiently detailed or specific
- Re-wording of existing Criteria to avoid ambiguity or misinterpretation
- Consideration of the appropriate place of criteria within the Standards
- Scoring and weighting of the criteria and development of guidance on the evidence required to support self assessment scores

All NHS Wales adult audiology services will continue to be audited every two years. Services should use the Assessment and Audit Tool as an aid to preparation for audits.

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# Quality Standards for Adult Hearing Rehabilitation Services

Version 2 July 2016

OGL Digital ISBN 978 1 4734 7101 6  WG29276

# Foreword

Welcome to the Quality Standards for Adult Hearing Rehabilitation Services (Wales) 2016. I am delighted to endorse the Quality Standards as the benchmark for NHS adult audiology services in Wales.

Building on the success of the earlier version published in 2009, the Quality Standards 2016 was designed by Wales' leading audiologists in collaboration with Scottish counterparts. The work supported by representation from Action on Hearing Loss and the Audiology Standing Specialist Advisory Group of the Welsh Scientific Advisory Committee clearly demonstrate a prudent healthcare approach to the provision of audiology services. The Quality Standards support co-production with a greater emphasis placed on evidence base and individual management plans involving patients in decisions more than ever before.

Wales' audiologists leading the development of these Quality Standards have responded to the evolved thinking of NHS service delivery to truly benefit the people utilising audiology services in Wales. I encourage all health boards to drive forward its audiology service delivery by the swift implementation and ongoing compliance.

I wish to thank everyone involved in this important development for audiology services.

**Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon**
**Cabinet Secretary for Health, Well-being and Sport**

# Introduction

## Background

The first version of Quality Standards for Adult Rehabilitation Services were published in 2008. Since 2009/10 all NHS audiology services in Wales have undergone self assessment and external audit against these Standards.

The use of the Standards in Wales has provided a means to measure significant advances in service quality across the country. However, a revision is now required in order for the Standards to remain consistent with advances in technology and practice. This also provides an opportunity to clarify and improve the functionality of the standards materials, ensuring that audit remain robust and efficient.

## Development of Quality Standards Version Two

A Working Group was set up and included senior audiology clinicians, managers, a third sector representative from Action on Hearing Loss and external stakeholder representation. The working group also co-opted an academic to review the evidence base and develop the reference lists.

## Working Group Objectives

The working group's main objective was to jointly develop the Second Version of the Quality Standards for Adult Hearing Rehabilitation Service considering five main areas for change:

1. consideration of the relevance of existing Criteria in light of the latest evidence-based practice and advances in technology
2. consideration and development of the Standards in areas that are not sufficiently detailed or specific
3. re-wording of existing Criteria to avoid ambiguity or misinterpretation
4. consideration of the appropriate place of Criteria within the Standards
5. scoring and weighting of the Criteria and development of guidance on the evidence required to support self assessment scores

## Consultation

The draft version of these Standards has undergone two stages of Consultation. Stage One involved those that had significant experience in using the original version of the Standards. This included Heads of NHS Audiology and Adult Rehabilitation Services and external Auditors from both NHS Audiology Services and Action on Hearing Loss.

The second stage of the Consultation was with service users and included four face to face focus group events, an online qualitative survey and a paper based quantitative questionnaire.

Feedback from both consultation stages was used to further develop and revise the Quality Standards

## Approach and Context to Describing Service Quality

The standards are sequenced to reflect the patient pathway and are as follows:

| Quality Standards for Adult Hearing Rehab Services |
|---|
| Std 1 Accessing the Service |
| Std 2 Communicating with Patients |
| Std 3 Assessment |
| Std 4 Developing an Individual Management Plan (IMP) |
| Std 5 Implementing an Individual Management Plan (IMP) |
| Std 6 Clinical Effectiveness |
| Std 7 Clinical Skills and Expertise |
| Std 8 Collaborative Working |
| Std 9 Service Improvement |

The scope of content is deliberately limited to items that are specific to Audiology or are particularly worthy of emphasis over generic health and care standards, legislative, organisational governance or good practice requirements. These service specific standards should therefore complement other requirements; they provide a more specific and evidence-based contribution to help define a good quality service that will provide the best outcomes for patients.

The standards describe good practice and use of tools to provide evidence of health outcomes. However, compliance with the standards should not be used in isolation to quantify the efficacy of services in terms of health outcomes and patients satisfaction.

## Changes within Version Two

The key changes within this revised version of the Standards include:

- Development of additional rationale and criteria related to non-instrumental interventions
- New scoring range from 1-5 to 0-4 where non-compliance now is identified with a 0 score
- A list of suggested evidence to support compliance with criteria

# The Standards

## Format

The Standards are made up of nine *Standard Statements* that explain the level of performance that needs to be achieved. These are supported by an evidence base that provides the *rationale* for each Standard. The *Standard Statements* are expanded into a number of *Criteria* which specify what must be achieved for the standard to be met. The *Standard Statements* are listed below. The evidence base, the references that support them and the detailed *Criteria* are all detailed within the *Assessment and Audit Tool* that accompanies this document.

## The Standard Statements

### Standard 1. Accessing the Service

All patients with hearing problems and their significant other(s) who require access to Audiology services are able to:

- access an Audiology service that meets their needs,
- conveniently access the services they require,
- see Audiology or specialist medical professionals as first points of contact, as determined by agreed local clinical criteria,
- wait no longer to access Audiology by one referral route than any other.1
- wait no longer if they are an existing patient accessing the service for reassessment than a new patient accessing the service for the first time.
- gain access to the Audiology service as quickly as other comparable medical services.

Service demand and referral data are accurately monitored, reviewed and reported against available indicators and used to guide service planning.

All hearing aid users have access to effective, ongoing lifetime maintenance and support.

### Standard 2. Communicating with Patients

Timely and relevant two-way exchange of information to meet the needs of hearing impaired patients and their significant other(s), in formats that accommodate their communicative abilities.

[1] Initial referral to Audiology services can be directly from General Practitioner (GP) or from GP via Ear Nose and Throat (ENT) or Audio Vestibular Medicine (AVM). Patients should not wait longer to see Audiology directly than they would if they were referred to Audiology via ENT or AVM. Similarly, patients who need to re-access Audiology for re-assessment should be able to do so by self-referral and should wait no longer than those initial referrals referred by GPs.

## Standard 3. Assessment

All patients receive an individually-tailored Audiological assessment which is carried out to recognised national standards, where available, and includes:

- measurement of hearing impairment,
- assessment of activity limitations related to hearing impairment,
- evaluation of social and environmental communication and listening needs and an evaluation of attitudes, expectation, motivation and behaviours as a result of hearing impairment,
- a relevant medical history.

## Standard 4. Developing an Individual Management Plan

All patients should have an individually developed plan for the management of their needs. This plan:

- is initially based on information gathered at the assessment phase,
- is determined in conjunction with the patient and/or their significant other(s),
- is updated on an ongoing basis,
- is accessible to the clinical team,
- includes recommended interventions to best meet the needs of patients.

## Standard 5. Implementing an Individual Management Plan

The Individual Management Plan is implemented over a series of appointments with the opportunity for revision of needs, actions and outcomes at each stage. The series of appointments is timely and may be multi-disciplinary.

Where provision of hearing aid(s) is required by the IMP the service ensures that:

- nationally agreed procedures and protocols for fitting and verification are followed at a local level,
- hearing aids fitted are functioning correctly,
- patients are offered a hearing aid for each ear where clinically indicated and patients are supported to make an informed choice
- performance of hearing aid(s) is carefully matched to individual requirements and settings are recorded.
- Where provision of hearing related assistive technology is required by the IMP the service ensures that:
- patients are supported to make a choice about their suitability
- patients are effectively signposted to providers of such technologies

The non-technological management of the hearing problem can be used as a sole management tool or to supplement the issuing of a hearing aid(s).

- Where provision of non-technological intervention is indicated, the service ensures:

- Patients and their significant other(s) have timely and convenient access to appropriate intervention(s)
- Non- technological interventions offered effectively meet the needs of patients and their significant other(s)

Following implementation of the IMP, a process of ongoing support and maintenance continues.

### Standard 6. Clinical Effectiveness

The outcome and effectiveness of the Individual Management Plan are evaluated and recorded.

Outcomes and effectiveness of the service as a whole are evaluated and recorded to identify trends and patterns which may inform service development and planning.

### Standard 7. Clinical Skills and Expertise

Each service provides, within a governed team approach, the clinical competencies necessary to safely and effectively support the assessments and interventions undertaken. All tasks are undertaken within an established, nationally-agreed, competency-based framework.

### Standard 8. Collaborative Working

Each Audiology service has in place processes and structures to ensure effective collaborative working.

Collaborations appropriate to patient and service needs should be identified and established and may be with internal and external agencies and services.

### Standard 9. Service Improvement

Each service has processes in place to measure service quality. Quality measures are used to plan and implement service improvements.

Each service has processes in place to regularly consult with patients and stakeholders.

Each service has processes in place to keep up to date with and employ key innovations relevant to Audiology.

## The Individual Management Plan

The Individual Management Plan (IMP) is central to the Quality Standards for Adult Hearing Rehabilitation Services.. It is an idea firmly rooted in good practice. It involves a minute of the conversation between audiologist and patient about what the patient feels, wants or expects; what the audiologist is able to offer; and how the audiologist and patient agree to proceed.

There is no specified form or template for the IMP. It is assumed that services will keep detailed notes of these conversations in their patient records. The IMP is not a case history form or a record of assessment results, although the patient's case history and hearing status will certainly help to inform the IMP and are therefore likely to be summarised within it. What is important is that an audiology service can demonstrate that for each patient any planned assessments, interventions or onward referrals have been properly discussed and agreed with the patient. All of those taking part in the conversation through which a management plan is constructed, need to have the chance to agree that conversation. In other words they should know exactly what has been decided and why, and have a clear understanding of how and when the patient's further assessment treatment will proceed.

An audiologist may list a new patient's needs as: hearing assessment; hearing aid fitting; advice and information about communication tactics; advice about assistive listening devices; leaflets about tinnitus. The same patient may list his/her needs quite differently: get my spouse to stop arguing with me about my hearing; get reassurance that I don't have a serious illness; find out how likely it is that this hearing problem will get worse; find out how I can make the tinnitus go away; under no circumstances get a hearing aid. It is highly improbable that either list will be the one to eventually appear on the patient's IMP. Through conversation and an exchange of information at this and subsequent appointments, the audiologist and the patient will explore what can and cannot be done and the agreed needs and agreed actions for the patient will be reviewed and updated over time.

## The Evidence Base

"Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values," (Sackett et al., 2000 p. 1).

A comprehensive review of the current evidence base has been undertaken. Wherever possible the evidence base has been drawn from peer reviewed, published research. Articles from other literature have been included if deemed appropriate by the working group. To enable the reader to explore the relevant literature that supports each individual standard, the rationale column now contains numbered references. Full details of the references for each standard can be found within the Standard assessment tool. There are also a number of overarching documents that have informed the development of the second version and these are listed below.


Disability Discrimination Act 1995

Sackett, D.L., Straus, S.E., Richardson, W.S., Rosenberg, W. and Haynes, R.B. 2000. *Evidence-Based Medicine: How to Practice and Teach EBM*, (2nd ed.). Churchill Livingstone: Edinburgh

Welsh Assembly Government, 2003. *Fundamentals of Care*. Wales: Welsh Assembly Government

Welsh Assembly Government, 2003. *Signposts 2: Putting Public and Patient Involvement into Practice in Wales*. Cardiff. Welsh Assembly Government

Welsh Assembly Government., 2005. *Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century*. Wales: Welsh Assembly Government.

Welsh Assembly Government 2006. *National Service Framework for Older People in Wales.* Wales: Welsh Assembly Government

Scottish Executive, 2007. *All Our Futures: Planning for a Scotland with an Ageing Population.* Edinburgh: Scottish Executive

Department of Health. 2007. *Improving Access to Audiology Services in England*. London: The Stationary Office.

The Equality Act 2010

Department of Health, 2010. *Equity and excellence: Liberating the NHS (White Paper)*. London: The Stationary Office.

Welsh Assembly Government, 2010. *Doing Well, Doing Better. Standards for Health Services in Wales*. Wales: Welsh Assembly Government

Patient Rights (Scotland) Act 2011

Action on Hearing Loss. 2011. *Hearing Matters*. London: Action on Hearing Loss

The Scottish Government, 2011. *Reshaping Care for Older People: A Programme for Change.* Edinburgh: The Scottish Government

Welsh Government, 2011. *Together For Health. A 5-Year Vision For The NHS in Wales*. Wales: Welsh Government

Welsh Assembly Government, 2011. *Fairer Health Outcomes For All. Reducing Inequities in Health Strategic Action Plan.* Wales: Welsh Assembly Government.

Aylward, M., Phillips, C. and Howson, H. 2013. *Simply Prudent Healthcare – achieving better care and value for money in Wales – discussion paper*. Wales: Bevan Commission, Simply Prudent Healthcare

The Scottish Government, 2013. *See Hear: A strategic framework for meeting the needs of people with a sensory impairment in Scotland.* Edinburgh: The Scottish Government

Bradley, P. & Willson, A., 2014. *Achieving prudent healthcare in NHS Wales (revised).* Cardiff: Public Health Wales

## External Audit Against the Standards

The process for self assessment and external audit against the Standards is outlined in detail within the *Arrangements for the External Audit of Adult Audiology Services Against the Quality Standards for Adult Hearing Rehabilitation Services* that accompanies this document.

### Principles and Key Features of External Audit Process

- The objective of the audit process is to externally verify self-assessment scores (and evidence) limited to the standards. The objective is not to perform an appraisal of service management and/or make extensive recommendations for improvement.

- The audit process should be robust, relevant, efficient, fair and consistent.

- It is assumed that a full self-assessment will have been completed prior the external visit and evidential materials compiled for ready reference at the time of the visit of the external auditors.

- Visits will be conducted jointly by an external audit team; comprising of Lead Independent Auditor, Senior Audiologist from another service and one Service User.

- All Health Boards will be visited every two years by external auditors.

- The Head of Audiology at each Health Board will select whether to submit one self assessment score for the whole Health Board or whether to submit separate self assessment scores for each 'service' within the Health Board. Services are defined as substantive permanently manned departments (and their peripheral sites) – reflecting those that participated in previous self-assessment. Special provision will be made for Powys LHB whereby individual assessment will be performed on the three distinct services delivered by

different providers. However, there will be one site visit, to the only permanently manned site (to Brecon).

- The visit of the external auditors will be completed over a day (nominally 6-7hrs), with additional time required for travel. Only the base centre would be visited rather than peripheral sites. Where a Head of Audiology has selected to submit one self assessment for the Health Board the audit coordinator will select which Service department to visit to undertake the external audit visit.

- Externally assessed scores must be presented to the Chief Executives and Heads of Audiology for each respective service, prior to being made available to ASSAG and put in the public domain (eg on the WSAC website).

- A coordinator will be appointed by ASSAG to administer the scheme, collate results and report to ASSAG following each audit.

- An appeals mechanism will exist where external scoring or the audit process are challenged.

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# Quality Standards for Adult Hearing Rehabilitation Services

## The Assessment and Audit Tool

version 2 July 2016

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# Quality Standards for Adult Hearing Rehabilitation Services Version 2 January 2016 The Assessment and Audit Tool

## Standard 1. Accessing the Service

| STANDARD STATEMENT | RATIONALE | CRITERIA | Examples of EVIDENCE OF COMPLIANCE<br>**This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.** |
|---|---|---|---|
| **1a.**<br>All patients with hearing problems and their significant other(s) who require access to Audiology services are able to:<br><br>(i) access the correct Audiology service to meet their needs,<br>(ii) conveniently access the services they require,<br>(iii) see Audiology or specialist medical professionals as first | Direct access to Audiology services is a more effective and efficient way of meeting patients' clinical needs where there is no robust evidence of otological pathology [1][2][3][4].<br><br>Allocation to the wrong referral pathways (or absence of alternative pathways) means additional inconvenience to the | **1a.1**.<br>All adult patients have access to Audiology via direct access where this is clinically indicated. | • An agreed protocol for the direct access of new and existing patients directly to Audiology.<br>• Clearly defined referral criteria for both new and existing patients.<br>• An audit including details of the number of new and existing patients referred to Audiology via all routes. |

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| points of contact, as determined by agreed local clinical criteria,<br>(iv) wait no longer to access Audiology by one referral route than any other.[1]<br>v) wait no longer if they are an existing patient accessing the service for reassessment than a new patient accessing the service for the first time.<br>vi) gain access to the Audiology service as quickly as other comparable medical services. | patient and inefficient use of time and resources [5][6].<br><br>Correct information to an Audiology service results in more effective use of available resources [7][8][9].<br><br>Public Health principles promote delivery of services close to patients for their ultimate health care benefit [10][11].<br><br>Simple equity implies that no patient should wait longer for a direct referral to Audiology than they would for a referral via ENT or Audio-Vestibular Medicine [12][13].<br><br>Simple equity implies that patients who have previously accessed an Audiology service must be able to re-access it via self referral [13]. | **1a.2.**<br>Information about referral criteria and pathways, including any changes, is widely disseminated to all potential referrers on a regular basis. | • Copies of at least annual communication with GPs which includes details of referral criteria.<br>• Examples of regular communication with patients detailing how to access Audiology directly e.g. written patient information, posters in waiting area.<br>• Corroboration by staff. |
| | | **1a.3.**<br>The proximity of patients to centres delivering Audiology services is similar to other adult services in the Board/district. | • Maps of Audiology service locations and other service locations such as ophthalmology, podiatry and physiotherapy. |
| | | **1a.4.**<br>Waiting times for direct access (via GP referral or self referral) to Audiology are no longer than waiting times for patients who are referred to Audiology via ENT or Audio-Vestibular Medicine. | • Waiting time data for new patients at monthly points and covering last 12 months.<br>• Will include patients seen by Audiology via GP referral and referral from ENT or AVM. |

[1] Initial referral to Audiology services can be directly from General Practitioner (GP) or from GP via Ear Nose and Throat (ENT) or Audio Vestibular Medicine (AVM). Patients should not wait longer to see Audiology directly than they would if they were referred to Audiology via ENT or AVM. Similarly, patients who need to re-access Audiology for re-assessment should be able to do so by self-referral and should wait no longer than those initial referrals referred by GPs.

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| | | **1a.5.**<br>The maximum waiting time from referral to commencement of treatment meets the national target. | • Wait times compared to national targets. |
| **1b.**<br>Service demand and referral data are accurately monitored, reviewed and reported against available indicators and used to guide service planning. | The number of incorrect referrals to the specialist medical route informs the effectiveness/clarity of the criteria and compliance of referrers to those criteria. Improvements can then be made to ensure that patients are not incorrectly referred to certain services [13].<br><br>Effective allocation of health resources is reliant upon accurate information on the balance between demand for services and available resources. It is important that waiting times for all stages of the patient pathway from referral through to treatment (e.g. hearing aid fitting) for new and existing patients are collected and monitored in an effective manner. The use of IT systems to compute information such as demographic data and waiting times will inform allocation of | **1b.1.**<br>The appropriateness of referrals is monitored. | **A report detailing:**<br>• The number of direct referrals to Audiology that fulfil referral criteria, including the number with problematic wax.<br>• The number of patients coming to Audiology via ENT or AVM who could have come directly to Audiology.<br>• The number of referrals to Audiology that require onward referral to ENT.<br>• The number of self-referrals that fulfil re-assessment criteria. |
| | | **1b.2.**<br>The outcome of referral monitoring is analysed and appropriate action taken. | • An action plan which will include actions related to non-compliance to referral criteria or waiting times.<br>• Evidence of completed actions from previous action plans. |

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| | services and help prevent an overload of patients accessing the same service and resources being strained [12][13][14][15].<br><br>Effective allocation of resources relies upon information on actual demand and potential/projected demand for specific services [12][13][14][15]. | **1b.3.**<br>Waiting times are monitored within the department based upon robust data collection. | • Detail of the source of waiting times data. |
| | | **1b.4.**<br>Key data are identified, collected, reviewed and used in annual service review. | **A report detailing:**<br>• the number and type of referrals to Audiology services,<br>• the uptake and types of intervention in the local population compared with the predictive need for services,<br>• demographics of locally served populations with relevance to hearing impairment.<br>• Action plans to address any gaps that may have been identified |
| **1c.**<br>All hearing aid users have access to effective, ongoing lifetime maintenance and support. | To ensure effective Audiology care, agreed multidisciplinary local ear care / wax management procedures should be in place [16][17][18][19].<br><br>Prompt access for existing hearing aid patients to a basic repair service, replacement batteries, and onward referral as necessary is required to help maintain long term use and | **1c.1.** All patients have access to ear care / wax management services with established protocols agreed between Primary Care, Audiology and ENT services and patients | • Clear protocol that is applicable to all patients. -<br>• Evidence of collaborative working to produce the protocol e.g. early drafts, stakeholder comments, meeting minutes.<br>• Details of how patients are made aware of the protocol e.g. written patient information, posters. –<br>• Evidence of the successful implementation of the |

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| | benefit [20][21]. | | protocol e.g. patient satisfaction, numbers of patients seen for wax management under protocol. |
| | | **1c.2.**<br>All hearing aid repairs are carried out within 2 working days of the repair request being received unless patient requests appointment further in the future for their own convenience. This repair can be a postal repair or a face to face/telephone request.<br><br>**1c.3.**<br>There should be direct open access (no appointment needed) for same day repairs and battery provision in at least one location within the area covered by the service. This should be accessible throughout the core working hours of the Service. | • *Audit* of postal repair turnaround time.<br>• *Audit* of waiting times for repair appointments.<br>• Timetable showing daily open access clinic<br>• Patient feedback |
| | | **1c.4.**<br>Where Audiology services are delivered away from the main Audiology base, patients can access the repair service within a month at each location and a postal service should be available. | • *Audit* of waiting times data for repair appointments at all local clinics. |

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| | | **1c.5.**<br>Audiology departments fulfil requests for replacement batteries within 2 working days of the request being received. | • *Audit* of battery request turnaround time. |
| | | **1c.6.**<br>Patients have access peer support from trained volunteers. | • Evidence of availability of volunteer support.<br>• Data relating to the number of patients referred to and receiving volunteer support. |

# Standard 2. Communicating with Patients

| STANDARD STATEMENT | RATIONALE | CRITERIA with consultation comments | Examples of EVIDENCE OF COMPLIANCE<br>**This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.** |
|---|---|---|---|
| **2a.**<br>Timely and relevant two-way information is possible to meet the needs of hearing impaired patients and their significant other(s), in formats that accommodate their communicative abilities. | Uptake of further care will benefit from promotion of the service to patients [22][23].<br><br>Good communication before, during and after intervention benefits patients and their significant others, through reduction in anxieties/concerns and encouraging appropriate uptake of further care and self management [24][25][26][27][28][29][30][31][32][33][34].<br><br>Written information that is clear, up to date and in a format that is accessible to the individual facilitates understanding of the service and self management options | **2a.1.**<br>Individual communication needs and preferences are identified, recorded and actioned | Patient information screens identifying individual communication needs and preferences. |
| | | **2a.2**.<br>Written information about the service, assessment procedures, types of assessment, possible interventions and clinicians involved is provided by the Audiology service for all new and existing patients at the time of notification of the appointment. | Written information leaflets and letters.<br>*Audit* to check if appropriate information sent and received.<br>Patient feedback |

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| | [24][32][35][36][37].<br><br>To avoid discrimination, services should meet the specific communication and information needs of hearing impaired patients and their significant other(s) accessing the service [38][39].<br><br>Technology should be used to enable Audiology staff to communicate effectively with patients and to ensure that the information is given in a manner that the patient understands [32][40][41]. | **2a.3.**<br>Written information prior to appointment includes a request to contact the department in advance if communication support is required and encouragement to invite significant other(s). | Written information leaflets and letters.<br>*Audit* to check if appropriate information sent and received.<br>Patient feedback |
| | | **2a.4.**<br>During assessment, results are recorded and discussed with the patient. A written copy is offered to patients with an appropriate explanation of the results. | *Audit*, cross checking the date of the appointment with record of test results and journal entries. |
| | | **2a.5.**<br>Written information about self-management and maintenance of hearing aids is available and offered to patients. | For example, information about:<br>Replacing batteries<br>Maintaining and looking after hearing aids<br>FAQs<br>Hearing tactics and how to maximise the listening environment<br>Support in the workplace |
| | | **2a.6.**<br>Information is offered, by Audiology, regarding external services offered by other agencies, including volunteers, ear care, repairs and maintenance and the facility to self-refer for re-assessment. | Written information leaflets or letters.<br>Patient surveys.<br>*Audit* whether the information provided enables access to these services. |

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| | | This is provided verbally and offered in written form | |
| | | **2a.7.**<br>Information is offered, by Audiology, regarding internal services provided Audiology including repair/replacement battery/wax management services. This will include information about locations and opening times.<br>This is provided verbally and offered in written form | Written information leaflets or letters.<br>Patient surveys/*audit.* |
| | | **2a.8.**<br>All written information provided to patients, including information on websites and noticeboards, is developed in collaboration with service user groups and local corporate communications teams, and is reviewed annually. | Minutes of meetings to review information.<br>Plain English (or similar) on all information and letters. |

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| | | **2a.9.**<br>An up-to-date copy of the Individual Management Plan is offered to the patient at each appointment. | *Audit* of patients' journal entries: External audit team to view random journal entry samples. |
| | | **2a.10.**<br>All staff with patient contact are deaf aware. | Staff training records.<br>Written policies.<br>Staff CPD records.<br>Patient feedback |
| | | **2a.11.**<br>Prior to their appointment, up-to-date technology is used to support communication between patients and the Audiology service (e.g. email, text phones, sms messaging, and department websites). All staff responsible for using the technology are trained on how to use it. The application of such technology reflects the advice of local user groups and individual preference. | Technology in place.<br><br>Patient survey. |
| | | | |
| | | **2a.12.**<br>At clinics, up-to-date technology is used to support communication with patients. | Technology in place, e.g message boards, loop systems.<br>Log of staff who have received training on use of technology.<br>Log of regular servicing to |

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| | | | ensure that working effectively<br>Minutes of meetings.<br>Patient survey. |
| | | **2a.13.**<br>Up-to-date technology (e.g. video clips, website) is used following appointments to support the self management of technological interventions and communication needs | Examples of support information on website<br>Examples of links to video clips |
| | | **2a.14.**<br>Written information is available that encourages patients and their significant others to engage and communicate with the service through patient forums to facilitate planning, satisfaction auditing and information development etc. | Written information leaflets/posters.<br>Policies.<br>Minutes of meetings. |

# Standard 3. Assessment

| STANDARD STATEMENT | RATIONALE | CRITERIA with consultation comments | Examples of EVIDENCE OF COMPLIANCE<br>**This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.** |
|---|---|---|---|
| **3a.**<br>All patients receive an individually-tailored Audiological assessment which is carried out to recognised national standards, where available, and includes:<br>• measurement of hearing impairment,<br>• assessment of activity limitations related to hearing impairment,<br>• evaluation of social and environmental communication and listening needs and an evaluation of attitudes, expectation, motivation and behaviours as a result of hearing impairment,<br>• a relevant medical history. | The need for, and content of, any Individual Management Plan (IMP) requires knowledge of a patient's hearing status [25][42][43].<br><br>The quality of assessment is more likely to be assured if undertaken in accordance with nationally recommended procedures [44][45].<br><br>Measures are compromised if not gathered using equipment calibrated to national and international standards in a quiet test environment [45][46][47].<br><br>A relevant medical history is | **3a.1.**<br>Patients are encouraged to consider the impact of their communication difficulties prior to their assessment appointment | Appointment letters/information<br>Pre-assessment questionnarie |
| | | **3a.2**.<br>The following are established for every patient, where clinically indicated:<br>hearing thresholds by air and bone conduction,<br>thresholds of uncomfortable loudness levels,<br>additional/further diagnostic procedures as required,<br>a relevant medical history,<br>co-morbidities affecting condition or its management,<br>Need for aetiological investigation. | Written protocols.<br>Case *audit*.<br>Summary of discussions about medical history, aetiology and further diagnostic assessment within journal entry that lead to development of IMP and onward referral<br>Examples of onward referral letters |

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| | required to develop an IMP [48][49].<br><br>Hearing status is a necessary prerequisite, but is not sufficient information alone to configure an IMP [25][50][51].<br><br>Understanding the patient's activity limitations, their social and environmental communication needs, their attitudes, expectations, motivation and behaviours as a result of hearing impairment will enable an appropriate Individual Management Plan to be developed [25][52][53][54][55][56].<br><br>Validated self-report questionnaires can support the assessment of activity limitations related to hearing impairment [25][57][58][59].<br><br>Situation-specific structured questionnaires (e.g. Glasgow Hearing Aid Benefit Profile) have been shown to offer significant advantages in clinical settings over more general disability and handicap inventories [25][60][61][62][63]. | **3a.3.**<br>There are written BAA/BSA recommended procedures or protocols being used by all staff in the department and these include air and bone conduction testing, thresholds of uncomfortable loudness levels, and tympanometry. | Written protocols. |
| | | **3a.4**<br>Equipment is calibrated annually and documented to international standards, and daily checks are carried out and documented to international standards. | Calibration and equipment check logs/certificates.<br>Clear protocols for calibration (daily and annually) including how and where to report faulty equipment |
| | | **3a.5.**<br>Hearing tests, with the exception of domiciliary visits, are always carried out in acoustical conditions conforming to national and international standards.[1] | Calibration and equipment check logs/certificates.<br>Results of acoustic testing to demonstrate compliance with the above acoustic requirement must be available. Such ambient noise level measurements shall be made at a time when conditions are representative of those existing when audiometric tests are carried out, including operation of the air-conditioning/ heating system and lighting. |
| | | **3a.6.**<br>Information relating to social circumstances; psychological impacts; communication and listening needs; co-morbidites affecting condition or its management; expectations and | Completed questionnaires.<br>Case *audit* showing the gathering and recording of information outlined in 3a.5.<br>Random samples of cases selected by auditors. |

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| | | motivation is routinely gathered and reported at each assessment. | |
| | | **3a.7.**<br>Information is recorded within the clinical record in a standardised way and is used to develop the content of the IMP. Included in this information are details of why an assessment or intervention could not be carried out. | Relevant service policies and procedures regarding standardised gathering of information.<br>Staff training |

[1] 'For air-conduction audiometry the accommodation (in use) must satisfy ISO 8253-1:1989 (E) for max permissible ambient noise levels (Lmax), testing from 250Hz to 8KHz, down to 0dBHL, with a maximum uncertainty of +2dB due to ambient noise.'

# Standard 4. Developing an Individual Management Plan

| STANDARD STATEMENT | RATIONALE | CRITERIA with consultation comments | Examples of EVIDENCE OF COMPLIANCE<br>**This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.** |
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| **4a.**<br>All patients should have an individually developed plan for the management of their needs. This plan :<br>• is initially based on information gathered at the assessment phase,<br>• is determined in conjunction with the patient and/or their significant other(s),<br>• is updated on an ongoing basis,<br>• is accessible to the clinical team,<br>• includes recommended | An Individual Management Plan approach is most effective if it takes into account a range of factors in addition to the type and level of hearing loss. An effective IMP relies on consultation between the Audiology professional, the hearing impaired person and his or her significant other(s). Only when all parties are committed to the joint goals is an optimal outcome achieved [25][56][64][65][66][67][68]. | **4a.1**.<br>Within the Audiology service there is an agreed approach to IMP development.<br><br>**4a.2**<br>The IMP includes agreed needs, actions and outcomes. | Service-wide guidelines on use, development and implementation of IMPs, including reference to agreed needs, actions and outcomes.<br>*Audit* of clinicians' compliance with service guidelines on use, development and implementation of IMPs.<br>*Audit* of clinical records to ensure inclusion of information on each individual's hearing status, expectations, social status, options for rehab, referral to other agencies and specific goals.<br>Results from individual clinicians' |

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| interventions to best meet needs of patients. | To be successful, IMPs need to be flexible. Flexibility within the structure of the IMP is beneficial because the content and the goals of the IMP may change over time, reflecting the positive outcomes of interventions [56][69][70][71].<br><br>An effective IMP will detail specific actions associated with agreed goals that take into account a listener's social, communication and listening needs, in addition to their hearing impairment and related activity limitations, e.g. living alone vs family setting vs sheltered accommodation [25][56][72][73][74].<br><br>The IMP is flexible so that different goals can be set if the patient's circumstances/environment changes [56][71][75][76]. | **4a.3.**<br>The clinical record contains details of:<br>auditory status,<br>expectations,<br>social circumstance<br>health status – physical, vision or cognitive issues.<br>recommended technological intervention,<br>recommended non-technological intervention,<br>referral to other agencies and/or services and<br>specific goals associated with assessment information (the IMP). | peer review (7a.4.) demonstrating compliance with service approach to IMP use. |
| | | **4a.4.**<br>The IMP is agreed and updated with the patient and significant other(s) at each appointment as actions are completed, new actions are agreed and new needs are identified | Service procedures referring to development and provision of IMP.<br>*Audit* of IMP provision.<br>Feedback from patients and/or significant others within service satisfaction questionnaire relating to their participation in development of agreed needs and the provision of a copy. |

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| | | **4a.5.**<br>The clinical record includes details of:<br>• the decision making process leading to IMP development and<br>• proposed timescales of IMP delivery. | Service procedures referring to clinical record keeping.<br>Case study *Audit* of clinical record<br>Results from individual clinicians' peer review (7a.4.)<br>Decisions making tools |

# Standard 5. Implementing an Individual Management Plan

| STANDARD STATEMENT | RATIONALE | CRITERIA with consultation comments | Examples of EVIDENCE OF COMPLIANCE<br>**This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.** |
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| **5a.**<br>The Individual Management Plan is implemented over a series of appointments with the opportunity for revision of needs, actions and outcomes at each stage. The series of appointments is timely and may be multi-disciplinary. | Planned and coordinated intervention leads to better outcomes. Such an approach requires recording of interventions and their effectiveness to guide on-going development of the IMP [42][77].<br><br>In order for agreed interventions to be effective, referral to another agency/service for interventions should be prompt so as to be based upon an up-to-date appraisal of need [43][78]. | **5a.1**.<br>The clinical record and IMP includes the details, justifications and effectiveness of interventions implemented be they technological or non-technological interventions. This includes referrals to other agencies. | Data relating to the numbers and proportions of people being provided with and referred for technological and non-technological interventions.<br><br>Service procedures referring to clinical record keeping.<br><br>Case study *Audit*<br><br>Service procedures on referral to and feedback from agencies.<br><br>Service user feedback |

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| | | **5a.2.**<br>Where referral to another agency/service for technological or non technological intervention is indicated, referral is made from Audiology within 7 days of appointment in at least 95% of cases. | *Audit* of time from patient appointment to referral being sent. |
| **5b.**<br>Where provision of hearing aid(s) is required by the IMP the service ensures that:<br>• nationally agreed procedures and protocols for fitting and verification are followed at a local level,<br>• hearing aids fitted are functioning correctly,<br>• patients are offered a hearing aid for each ear where clinically indicated and patients are supported to make an informed choice<br>• performance of hearing aid(s) is carefully matched to individual requirements and settings are recorded.<br>Where provision of hearing related assistive technology is required by the IMP the service | Audiologists should be confident that the aid is working to specification before fitting it to a patient so that the aid does not cause harm [79][80][81][82].<br><br>Professional bodies and national guidelines should be followed to ensure provision meets the needs of the individual [74][77].<br><br>Evidence suggests that hearing aids are most effective when their performance is carefully matched to the requirements of the individual [83][84][85].<br><br>Hearing related assistive technology can be used along side or in some cases instead of hearing aids to support effective | **5b.1.**<br>Hearing aids are offered to all patients who have been identified as potentially benefiting from one within their IMP.<br>Patients are supported to make an informed choice.<br>Criteria for eligibility for hearing aids are evidence-based. | Copies of local evidence based criteria and policies<br>*Audit* against these criteria/policies<br>Examples of journal entries within PMS<br>Copies of information/decision aids shared with patients relating to informed choice about hearing aids<br>Patient survey |
| | | **5b.2.**<br>Local protocols are in operation concerning selection, fitting and verification of hearing aids. These comply with the latest professional body and/or national guidance. | Service protocols for selection, fitting and verification of hearing aids compliant with latest national guidance.<br>*Audit* of compliance of all staff to service protocols.<br>Results from individual clinicians' peer review (7a.4.) demonstrating compliance with service guidelines on clinical record keeping. |

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| ensures that:<br>• patients are supported to make a choice about their suitability<br>• patients are effectively signposted to providers of such technologies | communication and in meeting individual needs [70][73][75][76]. | **5b.3.**<br>Where identified and agreed in the IMP that bilateral aids will best meet the patient's need, 2 aids are offered and patients are supported to make an informed choice. | Service eligibility criteria for bilateral hearing aid fitting.<br>*Audit* of compliance of all staff to eligibility criteria.<br>*Audit* of IMP to include record of eligibility, individual need and patient choice.<br>Results from individual clinicians' peer review (7a.4.) demonstrating compliance with service guidelines on clinical record keeping.<br>Copies of information/decision aids shared with patients relating to informed choice about unilateral or bilateral hearing aids. |
| | | **5b.4.**<br>Real Ear Measurement (REM) or Real Ear to Coupler Difference Difference (RECD) measurements of hearing aid performance is used to verify all hearing aid fittings. | *Audit* to ensure use of REM to verify all hearing aid fittings. |
| | | **5b.5.**<br>Where REM is contraindicated at the time of fitting, it is completed at the earliest opportunity within the patient journey. | Service protocol that includes contraindications to REM at first fitting and guidance on management of these patients.<br>*Audit* of above protocol. |

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| | | **5b.6.**<br>REM/RECD is performed at earliest opportunity within patient pathway and adheres to BSA/BAA protocols. | *Audit* to ensure use of REM to verify all hearing aid fittings.<br>*Audit* to ensure compliance to BSA/BAA protocols.<br>Service protocol that includes contraindications to REM at first fitting and guidance on management of these patients.<br>*Audit* of above protocol. |
| | | **5b.7.**<br>A subjective evaluation of the hearing aid will be performed at fitting. This will include:<br>Sound quality, binaural balance and loudness discomfort. | Journal entry templates<br>Examples of journal entries<br>*Audit* to ensure use of subjective evaluation of hearing aids |
| | | **5b.8.**<br>Hearing related assistive technology options are discussed with individuals when identified within their IMP | Local procedures/policies related to assistive technologies<br>Example journal entries on PMS identifying need for assistive technologies within the IMP |
| | | **5b.9**<br>Patients are effectively signposted to external agencies for demonstration or provision of assistive technologies where identified within the IMP | Information about local agencies supporting/providing assistive technologies<br>Template referral letters/forms to external agencies<br>Examples for PMS showed referral for hearing related assistive technologies |

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| **5c**<br>The non-technological management of the hearing problem can be used as a sole management tool or to supplement the issuing of a hearing aid(s).<br>Where provision of non-technological intervention is indicated, the service ensures:<br>• Patients and their significant other(s) have timely and convenient access to appropriate intervention(s)<br>• Non- technological interventions offered effectively meet the needs of patients and their significant other(s) | Evidence suggests a range of non instrumental aural rehabilitation interventions can improve outcomes for patients and their significant other(s). This can include improvements in function, activity, participation and quality of life through:<br>• Increased use of aids [86][87]<br>• Better speech perception in noise [88][89]<br>• Lower perception of hearing handicap [87][90]<br>• Improvement in psychosocial factors [75][87][90]<br>Interventions shown to be effective are:<br>• Group and/ or individual Aural Rehabilitation sessions for patients and their significant other(s) / communication partners, including information provision, clear speech training, communication tactics, counselling [86][90][91][92][93][94][95] | **5c.1**<br>All patients reporting hearing problems have access to appropriate non- technological intervention(s), including patients unsuitable for aiding, but reporting difficulties. | Service eligibility criteria for non instrumental intervention<br>*Audit* of provision or referral against above criteria |
| | | **5c.2**<br>Local protocols are in operation concerning the selection and provision/referral of appropriate non-technological intervention(s). These are informed by the current evidence base, and available interventions should include:<br>• Group and/ or individual Aural Rehabilitation sessions for patients and their significant other(s)<br>• Auditory Training<br>• Lipreading classes | Pathways for group or individual aural rehab sessions, auditory training and lip-reading training<br>Evidence through *audit* of appropriate provision/referral for non instrumental interventions to aural rehab sessions, auditory training and lip reading training<br>Results from individual clinicians' peer review (7a.4.) demonstrating appropriate identification and provision/referral for non-instrumental interventions |

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| | • Auditory training [75][92]<br>• Lipreading classes [93][96][97]<br><br>Promotion of self efficacy and management will result in increased independence [73][90][98][99] | **5c.3**<br>Where group and/or individual Aural Rehabilitation sessions are in use, these should include:<br>• Encouraged participations of significant others / communication partners<br>• Information provision<br>• Clear speech training<br>• Communication tactics<br>• Counselling.<br>• Self management support | Programme for group or individual aural rehabilitation sessions that include information provision, clear speech training, communication tactics and counselling |
| | | **5c.4**<br>The service ensures that staff are aware of currently available non–technological interventions, any criteria for referral, and details of referral pathway(s). | Results from individual clinicians' peer review (7a.4.) demonstrating compliance with local protocols<br>Discussions with staff during audit visit<br>Agenda and minutes from Staff training sessions<br>Rates of provision/referral |
| **5d.**<br>Following implementation of the IMP, a process of ongoing support and maintenance continues. | On-going use of and benefit from a hearing aid is likely to be increased if the process of support and maintenance includes routine Audiological reviews and potential for updating | **5d.1.**<br>Each patient is given a follow-up appointment following hearing aid fitting within a maximum time of 12 weeks and local protocols are used to determine the most appropriate method of follow-up. | Follow up waiting times<br>Direct observation of wait times within Patient Management System (PMS) during external audit<br>Where different methods of FU are used (e.g. face to face, telephone, group) a local protocol |

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| | the IMP. Such provision is required to accommodate the changing rehabilitation needs of individuals [25][56][71][100] | | outlining the process for determining appropriate method of FU.<br>Audit against above protocol |
| | | **5d.2.**<br>Follow-up appointments are comprehensive. | Local protocols for follow-up that include:<br>• Evaluation of individual outcomes directly related to individual needs within the IMP.<br>• Identification of further actions required, eg onward referral to external agencies for volunteer support, communication training etc.<br>• Comfort and appropriate handling of any devices is observed.<br>• Provision of advice on long-term maintenance and care.<br>• Provision of information on long-term access to the service for battery replacement, repair and re-assessment.<br>• Evaluation of the reports of the significant other where possible and appropriate. |

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| | | | Data relating to the number and proportions of patients that receive follow-ups.<br>*Audit* of follow-up appointment to ensure compliance with all elements of comprehensive follow-up set out in local protocols. |
| | | **5d.3.**<br>.Following fulfilment of IMP needs, all hearing aid patients are contacted every 3 years, to offer a re-assessment appointment. | Copies of standard invitation letters sent to patients who haven't self-referred for reassessment in 3 years.<br>Current timetable bookings of patients who have responded to invitation for 3 year review.<br>Data related to uptake of invitation to attend and outcomes following 3 year reviews. |

# Standard 6. Clinical Effectiveness

| STANDARD STATEMENT | RATIONALE | CRITERIA with consultation comments | Examples of EVIDENCE OF COMPLIANCE<br>**This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.** |
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| **6a.**<br>The outcome and effectiveness of the Individual Management Plan are evaluated and recorded.<br><br>**6b.**<br>Outcomes and effectiveness of the service as a whole are evaluated and recorded to identify trends and patterns which may inform service development and planning. | The management of hearing impairment, within a comprehensive management plan, involves more than a simple technical matter of hearing aid fitting. It involves the provision of a systematic approach, supported by evidence, which addresses not only the hearing impairment, but also other related activity limitations and consequent reductions in quality of life (QoL) [25][64][70][73][67][90][101].<br><br>Subjective outcome measures, in the form of disease-specific questionnaires, can assess the impact of a hearing impairment on | **6a.1**.<br>Individual outcomes are evaluated and recorded for all patients. Outcomes are directly related to the needs within the IMP and are recorded within the IMP | *Audit* of IMP and related outcome measures<br>Direct observation within PMS during external audit<br>Local policies and procedures relating to recording individual outcomes<br>Outcome statements for each need for each individual |
| | | **6a.2.**<br>The outcomes contain information on the *extent* to which the specified goals have been met and include a validated quantitative measure which is appropriate for all the interventions implemented. | Quantifiable outcome scores being used for all identified needs.<br>*Audit* of outcome tools used to measure instrumental and non instrumental interventions |

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| | the patient's communication, functioning and activity limitation. This can then be used in the evaluation process to measure how effective the IMP has been [57][62][63][102][103].<br><br>IMP's help to record multiple outcomes, such as functional benefit, satisfaction and QoL. Measurement of outcome is required to shape further progression of IMP's [25][53][67][74].<br><br>Measurement of outcome is required to obtain feedback (including a progressive evidence base) on the effectiveness and benefit associated with the service delivered to the patient group[21][87][104][105][106]. | **6a.3.**<br>Outcomes are used to monitor patient progress and to further develop the IMP which may result in the identification of further actions required. | *Audit* of the development of a patient's IMP based on their individual outcomes |
| | | **6b.1.**<br>Outcomes are analysed at service level to identify trends and patterns within the data and are compared against different factors. | Report of outcomes v factors<br><br>Variables may include:<br>• hearing loss<br>• age<br>• initial disability<br>• postcode<br>• expectations<br>• clinic location<br>• staff involved<br>• use of volunteers<br>• bilateral v monaural aids<br>• other factors |

# Standard 7. Clinical Skills and Expertise

| STANDARD STATEMENT | RATIONALE | CRITERIA with consultation comments | Examples of EVIDENCE OF COMPLIANCE<br>**This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.** |
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| **7a.**<br>Each service provides, within a governed team approach, the clinical competencies necessary to safely and effectively support the assessments and interventions undertaken. All tasks are undertaken within an established, nationally-agreed, competency-based framework. | To help ensure a safe and effective service, all people working with Audiology patients should work within their agreed Scopes of Practice and have the skills required for their contribution towards patient care [107][108][109][110].<br><br>Regulatory Bodies' 'Standards of Proficiency' statements detail requirements for registered practitioners to remain registered. These are produced for the safe and effective practice of the professions they regulate and are | **7a.1**.<br>All eligible, clinical staff working in Audiology are registered with a registration body. [2] | List of all staff including temporary, part time and locum<br>Registration numbers<br>Reasons for not registering |
| | | **7a.2.**<br>Nationally-agreed Scopes of Practice are adhered to. | *Audit* of appointments<br>Crystal report of people v tasks<br>Discussions with staff during external audit visit<br>Just check job descriptions |
| | | **7a.3.**<br>All volunteers are registered with a third sector organisation or managed within local Health Board volunteering policy. | List of volunteers and associated organisations<br>HB volunteering policies<br>Evidence of adherence to HB volunteering policies |

[2] This includes Clinical Scientists, Audiologists, Associates and Assistants, plus locum staff.

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| | deemed to be the minimum standards which are necessary to protect members of the public [111][112][113][114].<br><br>Registration bodies and some employers require demonstration of regular CPD activity. Facilities to access CPD close to the point of work and in association with colleagues is advantageous [115][116][117].<br><br>Peer review provides a useful approach to help ensure clinical competencies are maintained [118][119].<br><br>To ensure safe and effective outcomes for patients it is important that there are safeguards in place governing the employment and deployment of volunteers [120][121][122][123]. | **7a.4.**<br>Local Scopes of Practice and competency based training are implemented for all volunteers | Volunteer scopes of practice<br>Examples of volunteer referral form and feedback from volunteers following pateitns contact<br>Volunteer training materials<br>Volunteer competency assessment materials |
| | | **7a.5.**<br>All clinical staff and volunteers participate in CPD activity. | Local systems for ensuring staff attend and record CPD<br>Discussions with staff during external audit visit |
| | | **7a.6.**<br>Competency is verified formally by peer review observation annually for some procedures ensuring all procedures are covered over a two year period for all clinical staff undertaking such procedures. | Local procedure/process for peer review<br>Peer review checklist for all procedures and/or appointment types<br>List of details/dates of completed peer reviews |
| | | **7a.7.**<br>There is a department process for dealing with the outputs of the peer review observations. | Local procedure/process for peer review includes dealing with findings<br>Evaluation of peer review observations<br>Action plans linked to peer review observations |

# Standard 8. Collaborative Working

| STANDARD STATEMENT | RATIONALE | CRITERIA with consultation comments | Examples of EVIDENCE OF COMPLIANCE<br>**This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.** |
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| **8a.**<br>Each Audiology service has in place processes and structures to ensure effective collaborative working.<br><br>Collaborations appropriate to patient and service needs should be identified and established and may be with internal and external agencies and services. | Understanding the collaborations required to deliver an effective, joined up service will improve service user experience and outcomes [123][124][125][126][127][128][129][130][131].<br><br>Having awareness of and appropriate links to specialist Audiological services, other health services, Social Services, peer and voluntary sector support is more likely to result in the hearing, communication and additional health needs of patients being met [30][90][132][133][134][135][136]. | **8a.1**.<br>Audiology services identify a comprehensive list of the collaborative partners it needs to work with in order to provide a joined up service for service users. | List of collaborative partners and reasons for collaborations. |

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| | Planning and coordinating services in collaboration with other relevant partners (including service users and their significant others) is more likely to result in services that better address the needs of hearing impaired patients [137][138][139][140][141]. | **8a.2.**<br>Written protocols/processes are in place to support referral to other services/agencies: | Copies of referral protocols for the collaborative partners listed previously.<br>Evidence through referral rates to collaborative partners |
| | | **8a.3.**<br>Evaluation of individual's outcomes specific to these referrals is undertaken. | Patient feedback/outcome reporting<br>Evidence of actions and patient outcomes following outward referral recorded within the patient record. |
| | | **8a.4.**<br>Evaluation of service level outcomes specific to referrals to collaborative partners is undertaken and acted upon | Reports related to service level evaluation of outward referrals.<br>Action plans linked to the above reports |
| | | **8a.5.**<br>Audiology works strategically with collaborative partners. Membership and shared group objectives for these collaborations should be clearly stated within group Terms of Reference. There may be a number of separate collaborations relevant to different aspects of the service being provided | Copies of Terms of Reference (ToR) for all collaborative partnerships identified in 8a.1.<br><br>Reference to membership and shared group objectives of the collaborations should be clearly stated within the ToR. |

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| | | **8a.6.**<br>Action plans to meet shared group objectives should be developed, implemented and monitored | Examples of action plans developed to deliver group objectives.<br>Evidence of progress against action plans |
| | | **8a.7.**<br>Service users are included within membership of collaborative working groups | Service users listed as part of the membership within Terms of Reference |

# Standard 9. Service Improvement

| STANDARD STATEMENT | RATIONALE | CRITERIA with consultation comments | Examples of EVIDENCE OF COMPLIANCE<br>**This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.** |
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| **9a.**<br>Each service has processes in place to measure service quality.<br><br>Quality measures are used to plan and implement service improvements. | Measurement of qualitative and quantitative data helps to inform ongoing service improvement [106][142][143][144]. | **9a.1**<br>The Audiology service has a framework in place to ensure ongoing collection of qualitative and quantitative data relating to service performance and service user experience and the annual reporting of this data | Service review framework that outlines the what, when, where and how this data will be collected and reported |
| | | **9a.2**.<br><br>Patients and significant others are encouraged to complete anonymous surveys on at least an annual basis to determine satisfaction with different elements of the service received. | Evidence of coverage that ensures an acceptable proportion of patients has participated and a representative sample of the local population is covered (including gender,ethnicity, and all locations of service delivery).<br><br>Annual self-assessment and/or external audit scores. |

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| **9b.**<br>Each service has processes in place to regularly consult with patients and stakeholders. | Audiology services that seek, consider and respond to the views of users will be more likely to meet the needs of their patients [141][145][146][147]. | **9b.1.**<br>The Audiology service has a mechanism in place to capture views of patients and stakeholders. | Local framework for consultation<br>Agendas and minutes of consultation events |
| | | **9b.2.**<br>Results of satisfaction surveys and service QRT scores remain on public display in Audiology waiting rooms and are discussed with patients on an annual basis. | Direct observation during external audit visit<br>Minutes of events in 9b.1. include discussion of SSQ and ARQS |
| **9c.**<br>Each service has processes in place to keep up to date with and employ key innovations relevant to Audiology. | Use of up to date technology and models of service delivery is integral to effective service delivery and ongoing improvement [100][106][148][149][150][151]. | **9c.1.**<br>The Audiology service has a systematic approach to the coordination, identification and appraisal of Audiological innovations. | Local procedure/policies for appraisal of innovations<br>Examples of use of the approach (identification to implementation) |
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| **9d.**<br>All relevant information is used to develop and implement a comprehensive service improvement plan. | | **9d.1.**<br>Using all of the information gathered above, information gathering within 6b1 and the outputs of the Quality Standards visit, an ongoing programme of service improvement is in place. | Service improvement Plan including reference to all elements within Std 9<br>Direct discussions with staff during external audit visit<br>Timescales for implementation of service improvements<br>Key Performance indicators for service improvements |

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