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Enclosure(s):
1. Quality Standards for Children's Hearing Services 2016
2. Assessment and Audit Tool 2016.

Quality Standards for Children's Hearing Services 2016

A revision of the Quality Standards for Paediatric Audiology services published in 2010 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 Gethin AM, Cabinet Secretary for Health, Well-being and Sport. The revised standards will promote continuous improvement of children's audiology services for citizens across Wales.

The Quality Standards for Children's Hearing Services 2016 and Assessment and Audit Tool 2016 replace all earlier versions. Main areas of change are:

- Development of additional rationale and criteria related to care for children with hearing aids
- Inclusion of NBHSW quality assurance of diagnostic assessment and early audiological management
- New scoring range from 1-5 in version one to 0-4 where non-compliance now is identified with a 0% score
- Incorporation of a list of suggested evidence to support compliance with criteria

All NHS Wales children's 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 Children's Hearing Services

Version 2 July 2016

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Foreword

Welcome to the National Quality Standards for Children's Audiology Wales 2016. I am delighted to endorse the Quality Standards as the benchmark for NHS children's audiology services in Wales.

The first version of the Standards was launched in 2010 and has resulted in significant improvements in provision of children's audiology services throughout Wales. The revised document fine-tunes the original Standards, retaining key features and also incorporating Quality Assurance of New born Hearing Screening Services and extending the quality measures relating to hearing aid services. Current evidence, best practice principles and clinical standards have been applied to develop Standards which will ensure the provision of high quality children's audiology services.

The work has been supported by Audiology professionals and representatives of the National Deaf Children's Society across Wales and Scotland, together with the Audiology Standing Specialist Advisory Group of the Welsh Scientific Advisory Committee. Implementation of the new Standards will continue to encourage close working between NHS professionals and external agencies to deliver the best services for the children and young people of Wales.

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

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

Introduction

Background

In 2010 the first version of Quality Standards for Paediatric Audiology (since renamed Quality Standards in Children's Audiology) were published. Since 2010/11 most of the NHS audiology services across Wales have undergone self assessment and external audit against these Standards. The South Powys service has only taken part in external audits in 2014 and 2015.

The use of the Standards in Wales has been viewed as successful with a significant advance in measured service quality across the country. However, the process also highlighted some areas within the Standards where revision may be beneficial; firstly, in order to ensure that the quality standards stay appropriate in the light of new evidence and advances in technology/practice. There is also an opportunity to clarify and improve the functionality of the standards, ensuring that audit remain robust and is efficient. Newborn Hearing Screening Wales (NBHSW) also requested consideration of incorporating its quality assurance of diagnostic assessment, and early Audiological management following screening, within any revision to the Standards.

Development of Quality Standards Version Two

A Working Group was set up and included senior audiology clinicians, paediatricians specialising in audiology, an audiovestibular physician, managers, third sector representatives from National Deaf Childrens Society (NDCS) and a representative from NBHSW. The working group also co-opted an additional member from academia 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 Children's Audiology considering the following 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. rewording of existing Criteria to avoid ambiguity and misinterpretation
3. consideration of the appropriate place of Criteria within the Standards
4. consideration and development of the Standards to incorporate Newborn Hearing Screening Wales quality assurance
5. consideration of scoring to be in line with the revised Adult Rehabilitation Quality Standards
6. consideration of incorporation of standardised evidence requirements

Consultation

The draft version two has undergone two stages of Consultation. Stage One sought views from those that had significant experience in using the original version of the Standards, including NHS Heads of Audiology Services, Paediatricians working in Audiology and external Auditors from both NHS Audiology Services and NDCS.

The second stage of the Consultation included the initial group and was extended to service users, Specialist Teachers for Hearing Impaired Children, Specialist Speech and Language Therapists, and professional bodies including ENT Wales, BAPA and BAAP. Consultation was by means of an online questionnaire.

Feedback from both consultation stages was used to develop further drafts of these revised 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 Children's Audiology
Std 1 Accessing the Service
Std 2 Assessment
Std 3 Audiology Individual Management Plan (IMP)
Std 4 Hearing Aid Management, Selection, Verification and Evaluation
Std 5 Skills and Expertise
Std 6 Information Provision and Communication with Children, Young People and Families
Std 7 Collaborative Working
Std 8 Service Improvement
Std 9 Wider Care of the Child

The scope of content of standards 1-8 is deliberately limited to items that are specific to Audiology or are particularly worthy of emphasis over more 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.

There were other areas of practice such as aetiological investigations, communication options and Multi-Agency Support Plans, which were felt to be essential to providing optimal care, but fall outside of the remit of Audiology. These areas were combined in Standard 9, the Wider Care of the Child.

Criteria which provide Quality Assurance measures for NBSHW dovetail in with the main document, but data will be extracted and reported on separately by NBHSW.

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 specify or determine 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 care for children with hearing aids
- Inclusion of NBHSW quality assurance of diagnostic assessment and early audiological management
- New scoring range from 1-5 in version one to to 0-4 where non-compliance now is identified with a 0% score
- Incorporation of a list of suggested evidence to support compliance with criteria

The Standards

Format

The Standards are made up of nine *Standard Statements* that explain what level of performance is expected. These are supported by evidence based *Rationale* which provide the reason why the Standard is considered to be important. The *Standard Statements* are expanded into a number of *Criteria* which clearly state exactly what must be achieved for the standard to be met. The *Standard Statements* are listed below. The evidence based *Rationale*, 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 children and young people with hearing problems, and their families, who require access to Audiology services are able to:

- access the correct Audiology service to meet their needs,
- conveniently access the services they require,
- 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.

Standard 2. Assessment

All children and young people receive an individually-tailored Audiological assessment, appropriate to their age and stage of development. Assessment is carried out to recognised national standards, where available.

Standard 3. Audiology Individual Management Plan (IMP)

All children and young people 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 child and/or their families,
- is updated on an ongoing basis,
- is accessible to the clinical team,
- includes recommended interventions to best meet needs of the individual,
- should follow the young person through transition to adult services.

Standard 4. Hearing Aid Management, Selection, Verification and Evaluation

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

- hearing aids are provided in a timely manner,
- hearing aids are selected, and programmes provided, taking the individual's needs into consideration,
- nationally agreed procedures and protocols for fitting and verification are followed at a local level,
- benefit from hearing aids is evaluated and steps taken if optimal performance is not achieved,
- regular hearing aid reviews take place,
- young people and families are informed about, and signposted to, environmental aids and other technologies

Following hearing aid fitting, services provide timely access for replacement earmoulds and hearing aid repairs,

Standard 5. 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 6. Information Provision and Communication with Children, Young People and Families

Services provide families with departmental contact details and ftimely information on results of assessments. Information should be available on support services for families and children/young people. Information provided should be in the family's preferred language where possible.

Standard 7. Collaborative Working

Each Children's Audiology service has in place processes and structures to ensure effective collaborative working, and communication, within a multi-disciplinary team which includes each newborn, infant, child or young person, and his/her family.

Each service has a major role in facilitating, and providing input to, the development and ongoing review of a Multi-Agency Support Plan (MASP) for each newborn, infant, child and young person who has an ongoing significant hearing loss.

Standard 8. 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 families and young people (ideally gaining feedback from children themselves) and with key stakeholders.

Standard 9. Wider Care of the Child

Each collaborative team demonstrates that within their team they have the clinical competencies necessary to support the assessments and interventions they undertake. They also provide support and guidance for the newborns, infants, children, young people, their families and other involved professionals. This includes referral for aetiological investigations and discussion around, and provision of, different communication options.

The Individual Management Plan

The Individual Management Plan (IMP) is a key area in the Quality Standards for Children's Audiology. However, it is important to recognise that the introduction of the IMP was not about asking audiology services to do something new. It was an idea firmly rooted in existing good practice. Essentially, the IMP is nothing more than a minute of the conversations that good audiologists will already be having with children, young people and their families, conversations about what they feel, want or expect; what the audiologist is able to offer; and how the audiologist and child/young person/family agree to proceed.

There is no specified form or template for the IMP. It is assumed that many services will already 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 the minutes' of that conversation. In other words they should know exactly what has been decided and why, and have a clear understanding of how and when further assessment / treatment will proceed.

Through conversation and an exchange of information at this and subsequent appointments, the audiologist and the child/young person/family 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.

Equality Act. 2010. London: HMSO.

THE SCOTTISH GOVERNMENT, 2012. *A Guide to Getting it Right for Every Child* [online]. Edinburgh: The Scottish Government. Available from: http://www.gov.scot/resource/0042/00423979.pdf

NDCS., 2013. *Audiology Service Provision in the UK* [online]. London: NDCS. Available from: http://www.ndcs.org.uk/about_us/ndcs_policies_and_position_statements/index.html

THE SCOTTISH GOVERNMENT, 2013. *Supporting Young People's Health & Wellbeing -A Summary of Scottish Government Policy.* Edinburgh: The Scottish Government.

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.

NHS WALES, 2013. *All Wales Standards for Accessible Communication and Information for People with Sensory Loss*. Wales: NHS Wales. Available from:http://gov.wales/topics/health/publications/health/guidance/standards/?lang=en

Children and Young People (Scotland) Act. 2014. Norwich: TSO.

Public Bodies (Joint Working) (Scotland) Act. 2014. Norwich: TSO.

BRADLEY, P. and WILSON, A., 2014. *Achieving prudent healthcare in NHS Wales (revised).* Cardiff: Public Health Wales.

DEPARTMENT OF HEALTH, 2004. *The NHS Knowledge and Skills Framework and the Development Review Process*. London: Department of Health Publications.

HCPC., 2014. *Standards of proficiency - Clinical scientists* [online]. London: HCPC. Available from: http://www.hcpcuk.org/assets/documents/1000050AStandards_of_Proficiency_Clinical_Scientists.pdf.

CLINICAL STANDARDS GROUP BRITISH ASSOCIATION OF AUDIOLOGICAL PHYSICIANS, 2011. *Clinical standards. Setting standards to improve care for patients with hearing and balance disorders* [online]. London: BAAP. Available from: http://www.baap.org.uk/Portals/0/Content/Documents/stories/baapcs.pdf

HARDING, J. 2013. *Report on Quality-Assuring the NBHSW Peer Review Process, 2012.* Wales: NBHSW. Available from: http://www.newbornhearingscreening.wales.nhs.uk/

SCREENING DIVISION OF PUBLIC HEALTH WALES, 2015. Newborn Hearing Screening Wales. Annual Performance Results 2013-14 [online]. Wales: Public Health Wales. Available from: http://www.newbornhearingscreening.wales.nhs.uk/

NDCS., 2011. *Quality Standards: Transition from paediatric to adult audiology services.* London: NDCS.

DEPARTMENT OF HEALTH (DH), 2007. *A Transition Guide for all Services. Key Information for Professionals about the Transition Process for Disabled Young People.* Nottingham: DCSF Publications.

The Social Services and Well-being (Wales) Act. 2014. Wales: National Assembly for Wales. Available from: http://gov.wales/legislation

Draft Additional Learning Needs and Education Tribunal (Wales) Bill, 2015. Wales: National Assembly for Wales. Available from: http://gov.wales/consultations

WELSH GOVERNMENT, 2014. *Qualified for Life*. Cardiff: Welsh Government. Available from: http://gov.wales/topics/education

DONALDSON, G. 2015. *Successful Futures: Independent Review of Curriculum and Assessment Arrangements in Wales*. Cardiff: Welsh Government. Available from: http://gov.wales/topics/education

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 Children's Audiology Services against the Quality Standards for Children's Audiology* 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 Auditor (Paediatric Audiologist) and a Paediatrician working in Audiology both from another service and a representative from NDCS.

- All Health Boards will be visited every two years for an external audit.

- 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 services delivered by different providers. However, there will be one site visit, to the only permanently manned site (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 Head of Audiology at that site will select which Service department to visit to undertake the external audit visit.

- Scores given for the NBHSW criteria at the time of the visit will be provisional. These scores will be subject to review by the NBHSW Team and may be standardised.

- 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 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 Children's Hearing Services

The Assessment and Audit Tool

version 2 July 2016

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Quality Standards for Children's Hearing Services
Version 2 July 2016
The Assessment and Audit Tool

Standard 1 Accessing the Service

Standard Statement	Rationale	Criteria	EVIDENCE OF COMPLIANCE This list contains examples that you may wish to include as evidence. You may have different forms of evidence to support your self assessment score.
1a. All newborns, infants, children and young people have access to the audiological services they require in a timely fashion, with clearly defined referral pathways to audiological services that are widely disseminated and reviewed regularly.	Correct referral information results in more efficient use of available resources [1][2][3][4]. Prompt identification of permanent hearing problems and subsequent intervention leads to improved outcomes for the child at a later date [2][5][6][7][8][9[10][11]. Parents support the principle of early identification and intervention [12][13][14][15][16][17][18]. Fluctuating hearing loss can have a disadvantageous effect on the child's	**Referral Pathways** **1a.1.** Clearly defined written referral pathways from all referral sources are in place, reviewed at least every three years, and disseminated to all potential referrers on a regular basis.	Written referral pathways, linked to referral criteria, for all referral routes for all ages of children. Pathways should include timings of appointments (urgent/routine) and request for referrers to detail any communication support requirements for the child/family. Referral forms to include communication support requirements Version numbers to be included, and documents to be updated at least every 3 years, or sooner should changes

	development [2][19][20][21]. Young people need a clear transition route from child to adult services [22][23][24][25].		occur. Written/electronic document for referrers detailing referral pathways and criteria. Evidence that pathways have been disseminated to/discussed with referrers eg. email/Agenda for GP training/presentation.
		1a.2. Where local services are unable to provide all aspects of care, clear referral routes to external providers are in place.	Written referral pathways, with details as 1a.1.
		Speed of Access **1a.3.** Routine new referrals, for hearing assessment, are offered an appointment within 6 weeks of receipt of referral.	Written policy on waiting times. Audit of waiting times, against 6 week target. Data collected a minimum of every three months for each clinic type/location.
		1a.4. Urgent[1] new referrals, for hearing assessment, are offered an	Written policy on waiting times.

[1] Urgent cases are specified as: ≤6 months of age with parental concern; meningitis; plus any others deemed urgent by the service. Medical emergencies fall outside of the scope of these Standards.

		appointment within 4 weeks of receipt of referral.	Sample/ Examples of waiting times, against 4 week target
		1a.5. Children requiring follow-up hearing assessment/hearing aid reviews are offered appointments within an identified timescale.	Audit of planned review date against actual review date, ≥80% should be seen within one month of scheduled appointment. Data collected a minimum of every three months for each clinic type/location.
		1a.6. NBHSW *Referrals from NBHSW for diagnostic assessment are offered an appointment within the nationally agreed timescales*[2]	*Local data*
		Flexibility of Appointments **1a.7.** Flexibility is available in appointment times, and where possible locations, to suit the individual needs and preferences of the parents and child or young person.	List of clinic locations. Clinic schedule from electronic records to show range appointment times/days available. Demonstration of flexibility, eg.partial booking/letters.

[2] Within 4 weeks of date of last screening episode for Well Babies, and within 8 weeks of screening episode for High Risk Babies.

		1.a.8 NBHSW *Flexibility is available in appointment times, and where possible locations, to suit the individual needs and preferences of the family*	*Patient management system schedule* *Letters* *Discussion with team*
		Transition from Child to Adult Audiology Service **1a.9.** Robust systems are in place, used and regularly reviewed, to manage the transition from child to adult audiology services.	Transition Protocol. Information sheets. Letters/or evidence of referral from children's audiology to adult/transition service.
1b. Service demand and referral data are accurately monitored, reviewed and reported to guide service planning.	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 are collected and monitored in an effective manner [1][2][3][4][16][26][27]. The number of incorrect referrals to the specialist medical route informs the effectiveness/clarity of referral criteria and compliance of referrers to those criteria. Improvements can	**Monitoring of Service Referrals** **1b.1.** The number of incorrect referrals to audiology is monitored annually, and action continuously taken to address any non-compliance with referral criteria.	Examples of incorrect referrals. Evidence from triage service. Action taken where non-compliance exists.
		Service Planning **1b.2.** Key data are identified, collected, reviewed and used in annual service review.	A Report Detailing: • the number of children referred to audiology services, *with specific reference to the numbers referred by NBHSW*

	then be made to ensure that children are correctly referred to appropriate services [1][2][3][4].		• the number of young people transferring to adult services • the number of appointments not attended and non-responders from partial booking (if used) • the number of NHS hearing aids fitted for the local paediatric population, including conductive and sensorineural losses, *with specific reference to those children referred by NBHSW* • subsequent reports monitor trends over time

Standard 2 Assessment

Standard Statement	Rationale	Criteria	EVIDENCE OF COMPLIANCE This list contains examples that you may wish to include as evidence. You may have different forms of evidence to support your self assessment score.
2a. All referred newborns, infants, children and young people receive audiological assessment appropriate to their age and stage of development. There is a spectrum of audiology appointments from routine to more complex assessments. In some cases this may involve a multidisciplinary approach. The range of audiological assessments available enables definition of degree and nature of hearing loss.	Accurate and complete assessment is required to inform decisions and discussions regarding support and management options [2][3][28][29][30][31][32]. It is important to be able to assess hearing status in children who may have other social, educational and medical difficulties; a multidisciplinary approach will assist with this [2][28][29][33]. Parental involvement and that of the child or young person where possible, in the assessment and	**Comprehensive Assessment** **2a.1.** A comprehensive range of audiological assessments is available[3], either in the local audiology department or by a pre-arranged referral pathway with an alternative service.	List of assessments available. Two cases studies demonstrating the spectrum of assessments undertaken (can be linked with 2b.1.)
		2a.2. NBHSW *A comprehensive range of audiological assessments is available.*	*Three case histories of newborns with hearing loss* *Where cases selected by NBHSW do not show the full range of assessments, local team should identify further cases to provide additional evidence*

[3] See Appendix 1

	habilitation process improves outcomes [6][7][9][28][34][35][36]. The quality of assessment is more likely to be assured if undertaken in accordance with nationally recommended procedures [29][32][37][38][39][40]. Measures are compromised if not gathered using equipment calibrated to national and international standards and in a quiet test environment [37][38][40][41][42].	**2a.3.** All audiological procedures follow national standard/guidelines where these exist.	Access to National Standards/Guidelines either electronically, or via hard copy, within Department. Local protocols for activity outside the scope of the above.
		2a.4. NBHSW *All audiological procedures follow national standard/guidelines where these exist.*	*Departmental protocols for newborn diagnostic assessment.* *Access to National Standards/Guidelines for diagnostic assessment.*
		2a.5. NBHSW *Participation in the national peer review process for NBHSW diagnostic assessments is demonstrated and is monitored locally.*	*Departmental record of sending assessment for peer review, and participating as peer reviewer, whilst adhering to defined timescales.* *Spreadsheet or patient management system entries related to peer review.*

		Assessment Equipment and Conditions **2a.6.** All equipment is calibrated at least annually and documented to international standards.	List of equipment with calibration dates/log. Current calibration certificates.
		2a.7. Daily checks are carried out and documented, across all sites.	Log of Stage A checks for all equipment available. Audit of Stage A checks for all equipment over 4 week period, twice in year prior to audit. 4 = ≥95%, 3 = 85-94%, 2 = 75-84%, 1 = 50-74%, 0= <50%

		2a.8. Hearing tests are always carried out in acoustical conditions conforming to national and international standards[4]	Results of acoustic testing to demonstrate compliance with the acoustic requirement available for all facilities used for hearing assessment. 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. 4 = 100%, 3 = 90-99%, 2 = 80-89%, 1 = 75-79%, 0= <75%
2b. The assessment process should inform a clearly defined management plan.	Prompt, accurate and complete audiological information informs appropriate management, and amplification, as required [2][15][28][29][32][43][44].	**Assessment Process** **2b.1.** All assessments are interpreted taking into account the developmental status of the child and any co-existing medical conditions.	Two case studies (can be the same as those used in 2a.1.)
		2b.2. NBHSW *All behavioural hearing assessments are interpreted taking into account the developmental status of the child and any co-existing medical conditions.*	*Three case histories of newborns with hearing loss* *When cases selected by NBHSW do not show the full range of assessments, local team should identify further cases*

[4] See Appendix 2

			to provide additional evidence.
		2b.3. Written local protocols exist which define appropriate management options arising from the assessment (such as decisions to refer, review or discharge).	Protocols/Care pathways Two case studies (can be the same as those used in 2a.1./2.b.1)

Standard 3 Audiology Individual Management Plan (IMP)

Standard Statement	Rationale	Criteria	EVIDENCE OF COMPLIANCE This list contains examples that you may wish to include as evidence. You may have different forms of evidence to support your self assessment score.
3a. An audiology Individual Management Plan (IMP)[5] is: Developed for each neonate, infant, child or young person Agreed with parents and/or the child or young person. Updated on an ongoing basis. Accessible to the-team members involved with the child's care.	An audiology IMP is required as each child needs to be treated as an individual case as circumstances, medical condition, audiological status and family needs will vary [28][29][31][34][39]. There is evidence that families value joint working as it avoids duplication and there is less conflict of information [13][14][15][16]. Parental involvement and that of the child or young person where possible improves outcomes [7][9] [13][14][26][28][34][36]. Regular revision allows the management plan to be responsive to the child's changing needs. It also gives the plan the flexibility to	**Developing an IMP** **3a.1.** The IMP includes an initial programme of audiological management (including provision of hearing aids where appropriate) and details of ongoing assessment as required.	Audit of 20 cases
		3a.2. NBHSW *The IMP includes an initial programme of audiological management (including provision of hearing aids where appropriate) and details of ongoing assessment as required.*	*Three IMPs for babies identified with hearing loss*
		Record of Service Provision **3a.3.** The IMP includes, where appropriate, service provision from those currently involved with the child and family.	Audit of 20 cases
		Further IMP Documentation **3a.4.**	Audit of 20 cases

[5] See Appendix 3

	incorporate additional information for the benefit of the child's management [10][28][29][31][45][46].	The IMP details any requirements families have for information, family support and practical advice.	
		3a.5. Any agreed needs are documented in the IMP and reviewed at subsequent appointments.	Audit of 20 cases
		3a.6. The IMP is circulated to parents, and members of the multi-agency team where appropriate, with the consent of the family.	Audit of 20 cases
		3a.7. The IMP follows the young person through transition and is available to the adult service.	Provision of copies of IMP for **all** Transition Cases during audit year

Standard 4 Hearing Aid Management, Selection, Verification and Evaluation

Standard Statement	Rationale	Criteria	EVIDENCE OF COMPLIANCE This list contains examples that you may wish to include as evidence. You may have different forms of evidence to support your self assessment score.
4a. All newborns, infants, children and young people using hearing aids should have access to all aspects of services they require in a timely fashion.	When families wish to go ahead with early amplification, appropriate fitting of hearing aids, coupled with good multidisciplinary and family support lead to better outcomes for the child or young person [9][10][11][14][18]. Well fitting earmoulds are essential if hearing aids are to work to specification [15][47][48][49]. Regular reviews allow monitoring of the newborn, infant, child or young person's progress, underlying hearing loss and use of hearing aid(s). Information obtained can be used to fine tune the aiding as required [10][28][29][31][43][45].	**Speed of Access** **4a.1.** All referrals for hearing aids are offered an appointment for fitting within 4 weeks of decision to aid, with the exception of mild, unilateral and temporary conductive hearing losses, where appointments can be offered within 6 weeks of decision to aid.	Audit of time between decision to aid and fitting of aid against 4/6 week target Data should cover 20 cases and include at least 5 cases of sensorineural loss
		4a.2. NBHSW *All referrals for hearing aids for babies identified via NBHSW, are offered an appointment for fitting within 4 weeks of decision to aid.*	*Audit of all babies identified via NBHSW during audit year* *Audit Care Pathway forms for babies with identified hearing loss* *NBHSW database*
		4a.3. Appointments for replacement earmoulds are within 2 working days of request, in at least one site in the area, unless delayed at young person/family request.	Audit of time from request to appointment offered against 2 day target. Data to cover range of ages, including under 2s.

			Audit should cover 20 cases and include 5 children under 2 years of age
		4a.4. Appointments for hearing aid repair are within 2 working days of request, in at least one site in the area, unless delayed at young person/family request.	Audit time from request to appointment offered against 2 day target. Data to cover range of ages, including under 2s. Audit should cover 20 cases and include 5 children under 2 years of age
		4a.5. Services offer the option of drop-off/postal repairs.	Information leaflet/Departmental literature.
		4a.6. Children and families are offered regular reviews, appropriate to their age and hearing loss[6].	Audit of frequency of reviews for children of different ages with a range of hearing losses. Audits should cover a range of hearing losses: 5 cases <2 years 5 cases 2-5 years 5 cases >5 years
4b.		**Selection of Hearing Aids**	

[6] See Appendix 4

The service is able to provide a variety of amplification devices, and features, suitable for the needs of the individual child.	Children need appropriate amplification to safely access sound [7][11][36][44][46][50].	**4b.1.** The type of amplification, and features employed, are selected based on the individual child's needs.	4 case studies detailing features and type of aids to include: One child under 1 year of age One primary age child One secondary age child/transition case One case, where possible, with non-conventional aid eg. Bone conduction softband/ITE
		4b.2. The Department signposts children and families to environmental/assistive listening devices.	Information available in Department. Case studies showing information given/signposted to families.
4c. Where provision of hearing aid(s) is required, the service ensures: • nationally agreed procedures and protocols are followed at a local level • performance of hearing aid(s) is carefully matched to individual requirements and settings are recorded.	Audiologists ensure that the aid is working to specification before fitting it to a child to provide optimum benefit [43][45][46][51][52]. Professional bodies' and national guidelines are followed to ensure provision meets the needs of the child [43][52]. Evidence suggests that hearing aids are most effective when their performance is carefully matched to the requirements of the child	**Verification of Hearing Aids** **4c.1.** Local protocols which comply with the latest professional bodies' and national guidance[7] are in operation concerning selection, fitting and verification of hearing aids.	Protocols
		4c.2. Verification of hearing aid performance is carried out using Real Ear Measurement (REM) or Real Ear to Coupler Difference (RECD) measurement unless clinically contraindicated for individual children[8].	Audit to ensure use of REM/RECD to verify all hearing aid fittings/reviews. 20 cases (covering initial fittings and also reviews) which should include all children under 2 years of age with initial

[7] See BAA, BSA and MCHAS Guidelines.
[8] Explained whenever IMPs are completed and recorded in patient held records.

	[28][43][45][51].		fitting during audit year
		4c.3. Where REM/RECD is performed, measurements are made according to BSA/BAA recommended procedure.	Audit to ensure compliance to BSA/BAA protocols. 20 cases which should include all children under 2 years of age with initial fitting during audit year
		4c.4. Where REM/RECD measurements are performed, responses fall within recommended target tolerances, unless clinically contraindicated for individual children.	Audit to ensure compliance to BSA/BAA protocols. 20 cases which should include all children under 2 years of age with initial fitting during audit year
		4c.5. When REM/RECD is not attempted, completed or is contraindicated, an explanation is recorded in the IMP.	Audit 20 cases which should include all children under 2 years of age with initial fitting during audit year
4d. The effectiveness of amplification is assessed, and is recorded in the IMP.	The effectiveness of hearing aid fitting is best assessed using functional measures, and	**Evaluation of Hearing Aid Fitting** **4d.1.** A range of outcome measures[9] are available to, and used by, the service.	List of outcome measures used by service.

[9] See Appendix 5

	supplemented by the use of age-appropriate questionnaires and feedback from the family and wider team [28][34][36][43][45][52][53].		
		4d.2. Outcome measures are appropriately used to evaluate hearing aid fitting, and to guide further management.	2 Case studies/IMPs covering a range of evaluation tools, and identifying the effect on further management.

Standard 5 Skills and Expertise

Standard Statement	Rationale	Criteria	EVIDENCE OF COMPLIANCE This list contains examples that you may wish to include as evidence. You may have different forms of evidence to support your self assessment score.
5a. Each audiology service demonstrates that they have the clinical competencies necessary to support the assessments and interventions they undertake.	Newborns, infants, children and young people who require ongoing health interventions must have access to high quality evidence based care, delivered by staff who have the right skills for diagnosis, assessment, treatment and ongoing care and support [6][27][29][31][32][54][55][56][57][58]. Audiology departments have a duty of care to newborns, infants, children, young people and families and must ensure that assessments and interventions are delivered by appropriately trained, qualified and registered clinicians [27][29][30][31][55][58]. Through the clinical governance framework, organisations can manage their accountability for maintaining high standards [4][27][29][31]. Children's audiology is a rapidly	**Experienced, Trained and Qualified Staff** **5a.1**. All eligible, clinical staff working in Audiology are registered with a registration body[10].	List of all staff including temporary, part time and locum Registration numbers Reasons for not registering
		5a.2. Staff in senior positions (Bands 7/8) are trained to post-graduate level, or have significant practical experience in paediatric audiology.	List of qualifications for all staff/documented experience
		5a.3. NBHSW *Audiology staff carrying out neonatal assessments should have appropriate qualifications and training/experience for newborn/early years work.*	*Audiologists should provide evidence of post graduate, or equivalent, training*
		Staff Competency **5a.4.** Competency of staff performing all clinical procedures is verified by peer review or competency checks at least every 3 years. These are formally	Local procedure/process for peer review Peer review checklist for all procedures and/or appointment types, includes information given on results at

[10] This includes Clinical Scientists, Audiologists and locum staff.

	changing field and clinical competency must, therefore, be maintained through continuing professional development [27][29][31][58]. Peer review provides a useful approach to help ensure clinical competencies are maintained [59][60][61].	documented.	time of appointment List of details/dates of completed peer reviews
		5.a.5 NBHSW *Competency of staff performing neonatal assessment activity is verified by competency checks at least every 3 years. These are formally documented.*	*Log of competency checks*
		5a.6. There is a Departmental process for dealing with the outcome of peer review observations, and concerns regarding clinical practice at any other time.	Departmental policy. Local procedure/process for peer review includes dealing with findings. Action plans in place, linked to peer review observations, if necessary.
		5a.7. NBHSW *There is a Departmental process for acting on the outcomes of peer review of assessment (including the national peer review system)*	*Spreadsheet or other departmental documented process to review and act on peer review of diagnostic assessments.* *Action plans or lessons learnt from*

			peer reviewed evidence.
		5a.8. All staff **assisting** audiologists demonstrate competence in the roles performed.	Competency checks
		Continuing Professional Development **5a.9.** All clinical staff participate in relevant CPD activity in line with professional guidance.	Local systems for ensuring staff attend and record CPD Discussions with staff during external audit visit
		5a.10. All Audiologists have regular training, and annual updates on, advances in paediatric audiology, hearing aid technology and assistive listening devices.	Record of training and attendance
		5a.11. NBHSW *All Audiologists performing neonatal assessments participate in relevant CPD activity, including regular training and annual updates specific to NBHSW.*	*Relevant CPD for Audiologists undertaking neonatal diagnostic assessment documented (to include attendance at Divisional Audiology Meetings and Training Day)*
		Deaf Awareness **5a.12.** All staff employed within Audiology are deaf aware.	Staff training records (Deaf awareness training at Induction and then at least every 5 years). Evidence from complaints/satisfaction surveys with regards to deaf

			awareness, if arisen. Written policies. Staff CPD records.

Standard 6 Information Provision and Communication with Children, Young People and Families

Standard Statement	Rationale	Criteria	EVIDENCE OF COMPLIANCE This list contains examples that you may wish to include as evidence. You may have different forms of evidence to support your self assessment score.
6a. Each service has in place processes and structures to facilitate communication with children, young people and families. Use of interpreters, and other interpreting services, should be in line with Health Board policy.	Newborns, infants, children, young people and families need clear and timely information to facilitate attendance and reduce anxiety [26][35][36][62][63]. Families need to be aware of ways to contact departments and professionals working with the child or young person [29][31][35][58]. It is important that information is provided in an accessible and understandable format [15][31][35][36][62][63][64]. Effective communication enables newborns, infants, children, young people and families to participate in the development of the IMP and Multi-Agency Support Plan (MASP) Standard 8, to understand	**Written Information to Families Prior to Appointment** **6a.1.** Written information regarding the audiology appointment (directions or maps, parking facilities, appointment duration, procedures, facilities, desirable baby state) is provided as part of the appointment process.	Sample appointment letters Community and Hospital Additional sources of information eg. Website, appointment cards
		6a.2. NBHSW *NBHSW specific letter is provided as part of the appointment process*	*Current NBHSW assessment appointment letter in use*
		6a.3. Families are provided with appropriate methods to contact departments including phone numbers and either text or email.	Sample appointment letters Community and Hospital Additional sources of information eg. Website, appointment cards

	information and make informed decisions [29][31][35][36][58][64].	**Information Given After Assessment 6a.4.** Children, young people and families receive verbal explanation of the audiological assessment results, and supporting literature if required, on the same day that the assessment is carried out.	Documentation in Journal/IMP of test results/explanation Protocol including statement that verbal results are given on day Can also be included in Competency check
		6a.5. NBHSW *Families receive verbal explanation of the neonatal hearing assessment results, and supporting literature, if required, on the same day that the assessment is carried out.*	*5 IMPs for NBHSW assessments including standard 'discharge' letters* *Patient management system entries*
		6a.6. Children, young people and families are offered written information following appointments within 10 working days of the appointment[11].	Audit of letters/IMPs of time from appointment to distribution against 10 working day target 20 cases
		6a.7. NBHSW *Following completion of newborn hearing assessment, families are offered written information within 10 working days of the appointment.*	*Audit of letters/reports against 10 working day target, on completion of NBHSW assessment, to include the 5 cases in Standard 6a.5. NBHSW will advise on the sample size required for*

[11] NDCS and NBHS Wales/Scotland provide a number of documents that can be used to support information regarding outcomes of assessments undertaken.

			each audit cycle.
		6a.8. Children, young people and families are routinely given information on support services (when appropriate) to include educational sensory service as well as local and national voluntary support groups for deaf children and young people.	4 IMPs or Case Studies to demonstrate information given.
		6a.9. NBHSW *Families of babies identified with a hearing loss through NBHSW are routinely given information on support services (when appropriate) to include educational sensory service as well as local and national voluntary support groups for deaf children and young people.*	*3 letters/reports/IMPs for babies with hearing loss*
		6a.10. Children, young people and families have access to information in their preferred language via the provision of translated material where possible.	Interpreter policy Evidence of use of interpreters, where required, eg. IMPs/Journal/Invoices Evidence of access to information leaflets in other languages

		6a.11. NBHSW *Families of babies referred by NBHSW have access to information in their preferred language via the provision of translated material where possible.*	*Evidence of interpreters used for neonatal assessment, where required, e.g. invoice, letter documenting interpreter present.* *Local policy/process for identifying families requiring interpreter support and arranging this.*
		6a.12. Information is provided to young people on the transition process and future service provision.	Departmental policy Examples of information provided to young person

Standard 7 Collaborative Working

Standard Statement	Rationale	Criteria	EVIDENCE OF COMPLIANCE This list contains examples that you may wish to include as evidence. You may have different forms of evidence to support your self assessment score.
7a. Each Children's Audiology service has in place processes and structures to ensure effective collaborative working within a multi-disciplinary team which includes each newborn, infant, child or young person, and his/her family.	Working as a team leads to more effective use of time and resources [65][66]. Effective joint working avoids the need for families to repeat the same information with each new set of professionals [35][27][50]. Information sharing within the team ensures that management and care plans reflect the current needs of the child or young person and their family [2][35][27][50]. Team working increases the family's confidence in the support offered and reduces anxiety [13][14][35].	**Expertise Required in Multi-Agency Team** **7a.1.** Each audiology service works within a team of professionals with expertise in: • children's audiology • development of language and speech skills • medical aspects of audiology • child development and family support • educational support • Primary Care	List of members of collaborative team
		Access to Other Specialist Services **7a.2.** The multi-agency team, with child and parents or young person as central members, includes or has access to: • education services (in particular teacher of the deaf) • specialist speech and language	Evidence of referral to other specialist services

		therapy • children's otology • children's medicine • genetics • Cochlear Implant services • vision care • social work services • voluntary agencies • educational psychology services • Child and Adolescent Mental Health Services (CAMHS)	
		Co-ordination of the Collaborative Team **7a.3.** Each collaborative team has defined written roles	List of team members with their role
		7a.4. A co-ordinator ensures that the team working with the child or young person, and the family, meet regularly	Local protocol Evidence of regular collaborative team meetings/appointments with families eg. Planner
7b. Each team has in place processes and structures to underpin effective collaborative working and communication within the team	Sharing of information between agencies in a timely manner ensures that all involved are kept informed, enabling them to provide the most	**Information Updates for Referrer and Other Relevant Professionals** **7b.1.** Results of audiological assessments are reported to the referrer and any	Examples of reports/letters/IMP

and with outside agencies and services.	appropriate support to the child, young person and family [2][29][31][50][58].	other relevant professionals	
		7b.2. NBHSW *Results of neonatal hearing assessments are reported to the referrer and other relevant professionals/family*	*NBHSW will advise on the sample size required for each audit cycle but to include the 5 cases in Standard 6a.5.*
		7b.3. Reports are distributed to relevant professionals within 10 working days of the assessment.	Audit against 10 day target for distribution 20 cases
		7b.4. NBHSW *Reports are distributed to relevant professionals within 10 working days of completion of the neonatal hearing assessment.*	*Audit against 10 day target for distribution of letters/reports to include the 5 cases in Standard 6a.5.* *NBHSW will advise on the sample size required for each audit cycle.*
		7b.5. Non attendance is reported to the referrer, parent, and appropriate professionals e.g. GP, HV, Child Health, in accordance with local guidelines/protocols.	Local protocol Audit of DNAs and to whom reports are distributed 20 cases
		7b.6. NBHSW *Non attendance for newborn hearing assessment is reported in accordance with NBHSW guidelines*	*All DNA assessments over past 12 months*

		Liaison With Other Services **7b.7.** When Audiology refers families to other agencies and services, there is ongoing sharing of information by audiology.	3 case studies
		7b.8. Feedback from other agencies is used to inform the Audiology IMP.	3 case studies
7c. Each service has a major role in facilitating, and providing input to, the development and ongoing review of a Multi-Agency Support Plan (MASP)[12][13] for each newborn, infant, child and young person who has an ongoing significant[14] hearing loss. The MASP takes into account the individual needs and views of the newborn, infant, child or young person and family and is clear, coordinated and flexible.	When a number of different services work with a family, the MASP ensures that individual components of the plan are understood in relation to one another and, more importantly, in relation to the overall aims and wishes of the family [2][29][31][50][58]. MASPs encourage: • joint holistic discussions of an individual newborn, infant, child or young person's needs	**MASP Development** **7c.1.** Audiology initiate, and offer, the first multi-agency meeting, for pre-schoolers, with the family within 3 months of confirmation of a significant hearing loss.	Audit of diagnosis to first collaborative meeting within 3 month target All cases over past year
		7c.2. Audiology provide input to the initial, and subsequent, MASPs.	Examples of MASPs
		7c.3. Audiology meet the agreed actions of a MASP.	Examples of MASPs

[12] May have different names in different areas, e.g. Team Around the Child
[13] Information about the Multi Agency Support Plan can be found in Appendix 6
[14] "Significant" hearing loss is not defined solely by the hearing level, but this must be considered alongside any other medical, developmental or social problems.

The responsibility for the MASP for school age children and young people usually lies with the Local Education Authority. Children with complex needs may require a health led MASP in conjunction with the Local Education Authority throughout their childhood.	• agreement of priorities • engagement with and involvement of the family • regular reviews of any support that is being provided, resulting in improved quality of ongoing care Regular revision allows the MASP to be responsive to the newborn, infant, child or young person's changing needs. It also gives the plan the flexibility to incorporate additional information for the benefit of the child or young person's management [10][28][29][31][58].		
		MASP for School Age Children 7c.4 Audiology Services provide information to Education for School Age Children when requested.	Copies of reports sent/information provided. 10 cases

Standard 8 Service Improvement

Standard Statement	Rationale	Criteria	EVIDENCE OF COMPLIANCE This list contains examples that you may wish to include as evidence. You may have different forms of evidence to support your self assessment score.
8a. Each service has processes in place to measure service quality. Quality measures are used to plan and implement service improvements.	Measurement of qualitative and quantitative data helps to inform ongoing service improvement [4][13][15][17][56][58][67].	**Service Satisfaction and Monitoring** **8a.1.** The Audiology service, surveys service user views, including the views of children/young people where possible, at least every two years, or sooner if significant changes are made in service provision.[15]	Report(s) of consultation/questionnaires produced and action plan implemented.
		8a.2. NBHSW *The Audiology service surveys the views of parents of children with a hearing loss every three years.*	*Survey of view of parents of children with hearing loss*
		8a.3. The Audiology service seeks the views of Stakeholders at least every five years.	Report(s) of consultation/questionnaires produced and action plan implemented.
		8a.4. Results of surveys and QRT scores,	Evidence of dissemination

[15] See Appendix 7 for example satisfaction questionnaire

		and outcomes, are made widely available	
		8a.5. Using all of the information gathered above, and the outputs of the Quality Standards visit, an ongoing programme of service improvement, is in place.	Service Improvement Plan. Direct discussions with staff during external audit visit. Timescales for implementation of service improvements, where appropriate.
8b. Each Audiology service actively participates in the local Children's Hearing Services Working Group (CHSWG)[16]	Close working with parents and young people as well as across organisations will lead to improved services for deaf newborns, infants, children, young people and their families [29][31][34][35][54][58]. Effective recruitment to CHSWGs will ensure appropriate representation for the child and family, and demonstrates a truly inclusive approach. CHSWGs can ensure that all children's and young people's hearing services remain high on the agenda of those responsible for	**8b.1.** A local CHSWG exists.	Local Terms of Reference Document Minutes of CHSWG meetings
		8b.2. The local CHSWG meets at least 6 monthly.	Minutes of CHSWG meetings
		8b.3. Audiology services participate in the local CHSWG.	Minutes of CHSWG meetings
		8b.4. Audiology ensures that the outcomes of Quality Standards and satisfaction surveys are reported to CHSWG.	Minutes of CHSWG meetings

[16] See Appendix 8

	planning and delivering services at a strategic level. They can offer advice and guidance to ensure high quality services are available.	***8b.5. NBHSW*** *NBHSW is a standing agenda item at CHSWG.*	*Minutes of CHSWG meetings*

Standard 9 The Wider Care of the Child

This standard reflects the wider team involvement of children and young people with hearing loss.
As many aspects of this standard are not under the control of Audiology Services, it will not be included in the overall Service score for Standards 1 to 8, but will be reported on separately.

Standard Statement	Rationale	Criteria	EVIDENCE OF COMPLIANCE This list contains examples that you may wish to include as evidence. You may have different forms of evidence to support your self assessment score.
9a. All newborns, infants, children and young people are offered referral for appropriate aetiological investigations as part of their ongoing management.	The outcome of aetiological investigations, as part of the ongoing management, may lead to a better understanding and management of not only the hearing loss but also the whole child. It may also provide an opportunity to identify co-existing medical conditions and prevent further deterioration of these and the hearing loss in some cases [2][21][29].	**Aetiological Investigations** **9a.1.** Local referral pathways from Audiology are in place regarding aetiological investigations for children with hearing loss.	Local pathways
		9a.2. Local guidelines, which reflect national guidelines, are in place regarding aetiological investigations for hearing loss.	Local guidelines
		9a.3. Aetiological investigations are offered, and carried out, in line with local and national guidelines.	5-10 case studies

9b. Each collaborative team demonstrates that within their team they have the clinical competencies necessary to support the assessments and interventions they undertake and to provide support and guidance for the newborns, infants, children, young people, their families and other involved professionals.	Newborns, infants, children and young people who require ongoing management and support must have access to high quality evidence based care, delivered by staff who have the right skills for the service they are providing [27][29][31][54][56][58]. Health, education and social services have a duty of care to children, young people and families and must ensure that assessment, interventions and support are delivered by appropriately trained, qualified and registered individuals [27][29][31][56][58]. Families are informed about different communication options and are supported in their chosen mode of communication [29][31][50][58]. Through the clinical governance framework, organisations can manage their accountability for maintaining high standards [4][27][29][31]. Paediatric audiology is a rapidly changing field and clinical competency must, therefore, be maintained through continuing professional development	**Skills and Expertise** **9b.1**. All staff working within the collaborative team have appropriate qualifications, training and expertise for their role.	List of members of collaborative team Medics have specific experience/relevant training in medical aspects related to newborns and early years
		9b.2. NBHSW *All medical staff working within the collaborative team have appropriate qualifications, training, expertise and competence for newborn/early years work.*	*Medics should provide evidence of post graduate training, or equivalent competencies in medical paediatric audiology specific to newborn assessment*
		9b.3. The team informs the family about all communication options and supports the family to achieve an informed choice.	Examples of cases showing discussion of communication options and support provided where required.

	[27][29][31][58].		
9c. All members of the collaborative team have a role in facilitating, and providing input to, the development and ongoing review of a Multi-Agency Support Plan (MASP)[17] for each newborn, infant, child and young person who has an ongoing significant[18] hearing loss. The MASP takes into account the individual needs and views of the newborn, infant, child or young person and family and is clear, coordinated and flexible. The responsibility for the MASP for pre-school children lies with the Health Service. The responsibility for the MASP for school age children and young people is agreed locally. Children with complex needs may require a health led MASP in	When a number of different services work with a family, the MASP ensures that individual components of the plan are understood in relation to one another and, more importantly, in relation to the overall aims and wishes of the family [2][29][31][50][58]. MASPs encourage: • joint holistic discussions of an individual child or young person's needs • agreement of priorities • engagement with and involvement of the family • regular reviews of any support that is being provided, resulting in improved quality of ongoing care Regular revision allows the MASP to be responsive to the newborn, infant,	**Multi-Agency Support Plan (MASP)[19]** **MASP Development** **9c.1.** The MASP is informed by the information gathered throughout the multi-agency assessment phase.	Copies of 5 MASPs
		9c.2. There are agreed processes in place to enable the MASP to be in place within 3 months of confirmation of a significant hearing loss.	Protocols/pathways
		The MASP Team – Collective Responsibilities **9c.3.** A MASP meeting is offered at least 6 monthly for pre-school children.	Audit of meetings offered for all pre-school children attending over past year
		9c.4. There are recognised and agreed pathways for multi-agency review of school-age children.	Pathways Examples of local practice

[17] See Appendix 6 for further information regarding Multi-Agency Support Plans
[18] "Significant" hearing loss is not defined solely by the hearing level, but this must be considered alongside any other medical, developmental or social problems
[19] May be known by different names in different areas, e.g. Team Around the Child

conjunction with the Local Education Authority throughout their childhood.	child or young person's changing needs. It also gives the plan the flexibility to incorporate additional information for the benefit of the child or young person's management [10][28][29][31][58].	**The MASP Team – Individual Responsibilities** **9c.5.** Each agency undertakes the more detailed assessments and information gathering necessary to complete the clinical, educational and social input to the MASP. During this process information is shared with all members of the MASP team.	Copies of 5 MASPs
		Content of MASP **9c.6.** The MASP includes details of service provision from those currently involved with the child / young person and family.	Copies of 5 MASPs
		9c.7. The MASP details any identified needs (desired outcomes) for the child /young person and family including agreed actions with responsible individuals and timescales recorded.	Copies of 5 MASPs
		9c.8. The MASP will be reviewed and updated regularly	Copies of 5 MASPs

		9c.9. The MASP is circulated to all members of the collaborative team including the family.	Copies of 5 MASPs

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