LISTEN UP 2022

Children's hearing services in England

A report by the National Deaf Children's Society

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Introduction

This report presents the findings of our national survey of NHS paediatric audiology services (children's hearing services) in England, carried out in spring 2022. This report identifies and tracks trends in paediatric audiology by referring to similar surveys we conducted from 2017 to 2021.

As well as allowing us to gather evidence to influence national policy debates, the report is a useful resource for audiology professionals to benchmark their own services and plan service developments. We hope that the report will also be useful for discussions with other stakeholders, such as Trust management and commissioners, by providing up-to-date evidence about paediatric audiology service provision.

For the 2022 survey, many questions were repeated from previous years for continuity. We compared responses from the 2022 report to those in previous years, but differences in response rates and the quality of responses mean that any differences should be interpreted cautiously.

We also added some new questions for 2022 which addressed current areas of concern. We are grateful for the advice of the Audiology Advisory Group (AAG), which provided valuable feedback which helped to refine the questions.

We sent the survey to 124 trusts that provide paediatric audiology services. As with previous surveys, we made a Freedom of Information request to ensure as many timely responses as possible. In total, 114 trusts responded fully to the survey before the deadline and were included in our analyses[1]. This gave a response rate of 92%. Not every service answered every question, for example, because the question was not relevant to their individual service, because they couldn't obtain the data, or for an unspecified reason. We have rounded figures to the nearest whole number, therefore percentages may not always add up to exactly 100%.

As always, we are very grateful to all the audiology services that responded to the survey. Although the report again reflects variation across services, it highlights that most audiology departments in England are committed to sharing evidence, even when their own time and resources may be stretched.

Year	Total respondents	% of services responding in time
2018	107	79%
2019	120	92%
2021	107	87%
2022	114	92%

Table 1: Number of responses from services for the years covered in the report

Key findings

Overall, the responses to the survey highlight that paediatric audiology services are still facing some difficult challenges as they recover from the Covid-19 pandemic. The main themes were large waiting lists,

[1] There were additional submissions after the deadline, but analysis and writing of the report had already begun. These responses, while not included in analyses, have been held on record for future potential analyses. Three NHS Trusts did not respond.

staffing issues, increasing demands on services, gaining IQIPs accreditation and other resource or funding issues.

However, responses from services provided evidence that many are working hard to tackle these challenges and maintain quality. Some are even managing to innovate and commit to service improvement in a difficult environment.

Caseload numbers

- The total number of children with permanent deafness reported to be on services' caseloads has decreased by more than 7% since 2019.
- The number of children with glue ear who were fitted with hearing aids was 31% lower than before the pandemic.
- There has continued to be a steady increase in children identified with auditory neuropathy spectrum disorder (ANSD) since our first survey in 2017.

Provision of hearing technology

- The number of services that offer hearing devices for children with **all** types of hearing loss had significantly decreased since our previous survey, from 92% in 2021 to only 75% in 2022. This decrease seems largely connected to hearing aids issued for temporary hearing loss. Twenty-three percent of services reported that they did not provide hearing aids for temporary hearing loss.
- Only 83% of services offered bone conduction hearing aids for conductive hearing loss. For some this was due to funding.
- There was an increase in services that do not offer hearing aids for ANSD, from 5% in 2021 to 9% in 2022.
- All paediatric services that provided hearing aids for children offered batteries and coloured or personalised earmoulds for free.

Differences in additional services offered

- There were significant variations in which services were offered to children with complex needs, with many referring children to specialist centres.
- The majority of paediatric audiology services (79%) **did not** offer wax removal, and most of them referred children to ear nose and throat (ENT) services, leading to long delays.
- Most services were able to offer some support or advice for children and young people with tinnitus (79%) and/or hyperacusis (77%) whether accompanied by hearing loss or not.

Access to services

- Clinics continued to use a range of options to make appointments more flexible, including extended opening times, extra appointments during school holidays and Saturday appointments, but these were sometimes limited because of staff capacity.
- Seventy-nine percent of services offered telephone or video as an option for a few appropriate appointments.
- There was a decrease in the number of appointments offered in schools, from 50% pre-pandemic to just 35% in 2022.
- Ninety-six percent of services offered email as a communication option and 54% offered text messaging. Very few services offered other options such as web forms and online diaries to book appointments.

- Ninety-seven percent of services reported that they responded to all forms of communication within 48 hours.

Waiting times

- Ninety-eight percent of services reported that they met the 28-day target for waiting times to see babies referred from the newborn hearing screen.
- However, 39% of services failed to meet the 42-day waiting list target for an initial hearing assessment for babies and children who were not referred via newborn hearing screening.
- Once a hearing loss was identified, 88% of services fit hearing aids within 28 days**,** which showed continued improvement over the past few years.
- But 80% of services reported they were struggling to review children already fitted with hearing aids at the time that was planned and agreed with the family. Children were seen on average 62.5 days later than agreed.
- Eighty-four percent of appointments were delayed for children who did not use hearing aids but required further assessment and/or monitoring. On average appointments took place 91 days over the planned review date.
- Ninety-four percent reported that children referred to ear nose and throat (ENT) services were missing the six-week initial appointment target, with an average waiting time of 141 days.
- More than half of respondents (52%) reported that their trusts were missing the 126-day target for grommets surgery. This was a rise of 23% since 2019. The average waiting time was now 178 days, with a maximum wait of 540 days.

Quality assurance

- Only 26 services (23%) reported that they were currently accredited by Improving Quality in Physiological Services (IQIPs).
- Twelve services (11%) reported that they were registered for IQIPs but not yet accredited, a decrease compared to previous years.
- Ninety-three percent of respondents performing auditory brainstem response (ABR) testing reported that some form of external peer review was undertaken.

Staffing and training

- The number of permanent staff employed in paediatric audiology services has continued to fall, from a total of 897 Full Time Equivalents (FTE) in 2019 to only 717 in 2022. This means permanent staff have fallen from an average of 7.28 FTE to just 6.46 FTE per service.
- At the time of the survey, there were 47.6 FTE posts vacant in paediatric audiology services.
- Only 19 services (17%) had trainees in post.

Collaborative working

- Ninety-five percent of services referred children to specialist education services if they had any level of sensorineural hearing loss, or permanent or persistent conductive hearing loss. Only 65% would refer children with a temporary hearing loss and 75% would refer children with a hearing loss who weren't using a hearing aid.
- However, they reported that education services were accepting significantly lower numbers of referrals. Comments suggested that qualifying criteria for specialist educational support was highly variable across the country.

- Onward referral to ENT services was available to most audiology services (96%), without the patient needing to go back to the GP. However, many audiologists were not able to refer children on to other services.
- Paediatric audiology was well represented on Children's Hearing Services Working Groups (CHSWGs) as were education services (more than 95%) and speech and language therapy (87%). Many CHSWGs also had a representative from adult audiology services (61%) and a parent representative (85%). Representation was patchier for ENT services (39%) and social services (37%).
- Very few CHSWGs had representation from their Trust's senior management team or Commissioners, and only 7% of CHSWGs had a deaf young person attending.

Technology

- Local authorities provided radio aids in 96% of responding areas, remote microphones in 68% of areas and integrated/bluetooth technology in 56% of areas. Only 38% reported that education services provided streamers, and 11% of audiology services provided these themselves.
- A small number of services reported that they planned to stop or significantly reduce the provision of hearing technology or accessories in the coming year.

Patient engagement

- Arrangements for transition to adult services were variable. Although 95% of paediatric services provided young people with information about adult services, only 73% of services started the transition process at 14 years, as recommended.
- For the 2021/22 financial year, on average 14% of paediatric audiology appointments were classed as 'Was Not Brought' (WNB) or 'Did Not Attend' (DNA). This is significantly higher than the national NHS DNA rate of 5.4% for **all** outpatient appointments in 2020/21 (including adult appointments)[2]. The same report estimated that there was a DNA rate of approximately 9.2% for outpatient appointments for 0 to 19 year olds.
- Services employed different strategies to encourage attendance at appointments such as text reminders (78%), phone reminders (74%) and partial booking (where the patient contacts the Trust to choose the exact time and date) (34%).

Funding and commissioning

- In 2022, most audiology services were funded by a block contract and only 5% were still funded for individual patient activity (cost-per-case). Most NHS services were moved to block contracts during the Covid-19 pandemic, and these were still in place.
- For most, there were no plans to change or review how the service would be commissioned in 2022/23.

Post-pandemic changes

- Fifty-five percent of services reported an increase in children requiring complex assessment techniques and/or multiple appointments. There were increases in referrals of children presenting with suspected autism spectrum disorder and with tinnitus and/or hyperacusis, which require additional capacity and resources.
- During the pandemic, services had introduced remote appointments (for example, telephone or video calls) and earmould scanning and some had retained these.

[2] Hospital Outpatient Activity (England) 2020-22 Publication Date: 23 Sep 2021

Section 2: Your caseload

We asked children's audiology services about their caseloads as of 31 March 2022.

Number of births covered by the service per annum

We asked services how many babies were born in the area covered by their service in 2022. This ranged from 1,400 to 26,000 as there are many different sizes and types of audiology services, from smaller community-based services to those in large city teaching hospitals.

Year	Response rate	Median births	Mean births
2019	88% (105)	5,000	6,011
2021	91% (97)	4,900	7,029
2022	89% (101)	4,700	5,401

Table 2: Number of births per year

Age range

We asked services to indicate the age range their service covered. Sixty-one percent said they covered 0 to 18 year olds and 39% offered their services beyond the age of 18.

Total number of children with permanent childhood hearing impairments

We asked services to indicate the total number of children with permanent childhood hearing impairments (PCHI) in their caseload. In 2022 this ranged from 21 to 1,124.

Year	Response rate	Total	Median	Mean
2017	58% (63)	24,309	187	386
2018	76% (91)	33,496	207	368
2019	89% (107)	42,246	250	395
2021	91% (97)	38,832	264	400
2022	88% (100)	39,226	261	392

Table 3: Overall number of children with PCHI

The total number of children with permanent deafness reported to be on services' caseloads had decreased by more than 7% since 2019. The number had been increasing steadily pre-pandemic to a maximum of 42,246 in 2019, but the number fell in 2021, and had only risen slightly in 2022. Although the average birth rate in the areas covered by services had fallen slightly in 2022, feedback suggested there were likely to be other reasons, such as decreased access to other services who refer into audiology.

Total number of children with persistent glue ear

We asked services to indicate the total number of children with persistent glue ear that needed some ongoing management. This included children with glue ear who were not expected to 'grow out' of the condition before the age of 10, such as those born with a cleft palate, Down's syndrome, cystic fibrosis or primary ciliary dyskinesia. Caseloads ranged from three to 671.

Year	Response rate	Total	Median	Mean
2022	47% (54)	5,934	55	110

Table 4: Number of children with persistent glue ear

Total number of children referred to service from newborn hearing screen

In previous years, we asked services how many children on their caseload were referred to their service from the newborn hearing screen.

Year	Response rate	Total	Median	Mean
2018	69% (83)	19,077	92	230
2019	73% (87)	15,764	121	181
2021	80% (86)	10,867	106	126

Table 5: Overall number of children on caseload referred to services from newborn hearing screen

In the 2022 survey, we asked specifically about the number of children with permanent childhood hearing impairment (PCHI) referred to their service from the newborn hearing screen between 1 April 2021 and 31 March 2022. The number of children ranged between 0 and 282.

Year	Response rate	Total	Median	Mean
2022	89% (102)	1,510	9	15

Table 6: Overall number of children with PCHI referred to services from newborn hearing screen

Total number of children assessed and referred for cochlear implants

We asked services for the number of children assessed and referred for cochlear implants between 1 April 2021 and 31 March 2022. In 2022, the number of children ranged between 1 and 136, but within most services the numbers were very small.

Year	Response rate	Total	Median	Mean
2022	71% (81)	538	<5	7

Table 7: Overall number of children referred for cochlear implants

Total number of children with temporary deafness fitted with hearing aids

We asked services to indicate the total number of children with temporary deafness who had been fitted with hearing aids. This was mostly children with temporary deafness due to glue ear, who were fitted with hearing aids as an alternative to grommet surgery, but expected to 'grow out' of the condition before the age of 10.

In 2022, the number of children ranged between 0 and 523.

Year	Response rate	Total	Median	Mean
2017	44% (48)	4,776	52	100
2018	60% (72)	8,038	66	112
2019	73% (88)	8,409	63	96
2021	73% (78)	6,126	58	79
2022	68% (77)	5,798	56	75

Table 8: Overall number of children with temporary deafness, fitted with hearing aids

Total number of children with auditory neuropathy spectrum disorder (ANSD)

We asked services to report the number of children with ANSD. In 2022, the number of children ranged between 0 and 85.

Year	Response rate	Total	Median	Mean
2017	58% (63)	488	5	8
2018	69% (83)	766	5	9
2019	83% (99)	993	6	10
2021	85% (91)	955	6	11
2022	81% (92)	982	5	11

Table 9: Overall number of children with ANSD

Section 3: What services do you provide?

This year we asked services about the assessment options for children with complex needs or those for whom it was difficult to obtain a definitive test result.

Year	Specific clinics, for example, with longer clinic times or more experienced staff	Use of non-calibrated stimuli (for example, non-calibrated but band-pass filtered music)	Sedated auditory brainstem response (ABR)	ABR under general anaesthetic	Other
2022	96% (109)	46% (52)	58% (66)	82% (94)	34% (39)

Table 10: Services provided for assessing the hearing of complex or difficult-to-test children as reported by services

Due to differences in service type and size, there was a large variety in what services offered for children with complex needs. Ninety-six percent of services reported that they offered specific clinics for this group with longer clinic times and/or more experienced staff.

Many services were introducing variations to standard testing (for example, sedated auditory brainstem response and use of stimuli that is more appealing to children with autism spectrum disorder). Approximately half of services did not offer these alternatives. Some services referred children to other centres for complex testing (for example, auditory brainstem response testing under general anaesthetic), which reflects the expertise and facilities required for this procedure.

Services for temporary conductive hearing loss

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

Year	Air conduction hearing aids	Bone conduction hearing aids	Grommets	Otovent	Watch and wait	Other
2018	99% (118)	86% (102)	95% (113)	68% (81)	100% (119)	11% (13)
2019	98% (118)	90% (108)	98% (118)	76% (91)	100% (120)	7% (8)
2021	99% (106)	82% (88)	90% (96)	72% (77)	100% (107)	24% (26)
2022	96% (110)	83% (95)	93% (106)	72% (82)	98% (112)	19% (22)

Table 11: Support available to children with temporary conductive hearing loss

Only 83% of services offered bone conduction hearing aids for temporary conductive hearing loss, with comments indicating that some services were unable to provide these for funding reasons.

Comments left by services selecting 'Other' included, for example, referring to ENT services. Seventy-two percent of services gave information and advice about using an Otovent, with families having to puchase the item themselves if they wished to try it.

Additional/non-standard paediatric services

In 2022 we also asked services about which non-routine clinical services they offered.

Year	Assessment/ management of listening difficulties in the absence of peripheral hearing loss/auditory processing disorder	Hyperacusis assessment/ management	Implantable devices (not cochlear implants)	Paediatric vestibular service	Tinnitus assessment/ management	Wax removal performed by audiologists
2022	39% (44)	77% (88)	28% (32)	33% (38)	79% (90)	21% (24)

Table 12: Number of additional paediatric services offered by services

A large proportion of services offered some support or advice for children and young people with tinnitus (79%) and/or hyperacusis (77%), but other non-standard services were mainly located in the larger trusts.

The majority of paediatric audiology services (79%) did **not** offer wax removal, with most referring to ENT. This is concerning as ENT waiting lists are known to be lengthy and this will inevitably lead to delays in providing hearing aids and in some cases an extra preventable element on top of an existing hearing loss.

Provision of hearing technology

We asked services if there were children for whom they did **not** provide hearing technology (multiple options could be selected).

Year	We provide instruments for all	Auditory neuropathy spectrum disorder (ANSD)	Mild hearing loss	Moderate hearing loss	Temporary conductive hearing loss	Unilateral hearing loss
2018	94% (112)	3% (3)	2% (2)	1% (1)	1% (1)	2% (2)
2019	93% (112)	2% (3)	0% (0)	0% (0)	2% (2)	1% (1)
2021	92% (98)	5% (5)	2% (2)	1% (1)	0% (0)	1% (1)
2022	75% (85)	9% (10)	3% (3)	3% (3)	23% (26)	3% (3)

Table 13: Groups not provided with hearing technology

The number of services that offered hearing technology for children with **all** types of hearing loss had significantly decreased since our 2021 survey. This was largely because 23% of services now did not provide hearing aids for temporary hearing loss. This may be because more services now refer elsewhere for managing temporary deafness and/or fitting hearing aids. However, this does not account for the entire decrease. There was also an increase in services that said they don't offer hearing aids for auditory neuropathy spectrum disorder (ANSD), from 5% in 2021 to 9% in 2022.

We asked services to explain why they did not provide hearing technology in certain cases. Most services considered hearing aids for ANSD on a case-by-case basis and some services referred children to other specialist centres to make sure they got the right support.

A handful of services said they still did not provide hearing aids for unilateral hearing loss and/or mild deafness, but did not explain why. Several services commented that fitting hearing aids for this group is based on shared decision making with parents.

Hearing aid batteries and coloured earmoulds

We asked services if they provided batteries for children's hearing aids. All paediatric services that provided hearing aids for children said they provided batteries free of charge. Most services (96%) were able to offer coloured or personalised earmoulds to children where appropriate, but this was a fall compared to previous years.

Year	Yes, always	Yes, with limitations	No, never
2018	97% (116)	3% (3)	0% (0)
2019	98% (118)	2% (2)	0% (0)
2021	99% (105)	1% (1)	0% (0)
2022	96% (109)	2% (2)	2% (2)

Table 14: Number of hospitals providing coloured earmoulds

Appointments offered

We asked about the flexibility of appointments that services offered.

Year	Deliver in schools	Extended opening times	Extra appointments during school holidays	Phone and video appointments	Saturday appointments
2018	50% (60)	76% (91)	47% (56)	0% (0)	31% (37)
2019	49% (59)	85% (102)	48% (57)	24% (29)	32% (38)
2021	35% (37)	85% (91)	39% (42)	82% (88)	32% (34)
2022	35% (40)	83% (95)	45% (51)	79% (90)	29% (33)

Table 15: Appointment types offered by services

Clinics continued to report a range of options to make appointments more accessible, including extended opening times, extra appointments during school holidays and Saturday appointments, but these were limited by staff capacity.

In 2022 we also asked if appointments were offered at community venues or if there were other appointments available. A total of 49% offered appointments at community venues.

Unsurprisingly, there has been a large increase in the number of services offering phone and video appointments since the Covid-19 pandemic. In 2018, no paediatric services reported providing remote appointments. In 2021, 82% of services were offering phone and video appointments, and this remained high at 79% in 2022.

There has been a fall in the number of services offering appointments in schools and extra appointments during school holidays, compared to pre-pandemic levels. Again, this is likely to be a consequence of the pandemic.

Communication options

We asked services about the communication options they offered and the response times for each option.

Year	Email	Online diary/ booking system	Telephone	Text message	Web form	Other
2022	96% (110)	4% (5)	98% (112)	54% (61)	11% (13)	4% (5)

Table 16: Number of communication options offered by services

Although it is encouraging that most services offer email as well as telephone communication, only 54% offered text messaging services and very few offered other options such as web forms and online diaries to book appointments.

Service response time for each communication option

Time	Email	Online diary or booking system	Telephone	Text message	Web form
0 to 12 hours	17% (19)	1% (1)	30% (34)	10% (11)	0% (0)
13 to 24 hours	28% (32)	1% (1)	24% (28)	12% (14)	4% (5)
25 to 48 hours	24% (28)	1% (1)	9% (10)	12% (14)	2% (2)
49+ hours	3% (3)	1% (1)	0% (0)	1% (1)	0% (0)

Table 17: Response times for each communication option

Ninety-seven percent of services reported that they aimed to respond to all forms of communication within 48 hours. Some services reported that that it took one to five working days to respond to online web forms and online booking, as some of these might not be forwarded immediately to the service.

Section 4: Waiting times

We asked services to report waiting times in the most recent quarter prior to survey completion (1 January to 31 March 2022).

Referral to first assessment (newborn hearing screening pathway)

The NHS waiting time target from being referred from the newborn hearing screen to attendance at an audiological assessment appointment is 28 days, according to a national standard (NHSP-S05)[3].

Year	Maximum waiting time	Mean waiting time	Number not meeting target	Response rate	Percentage missing target
2018	34	17.4	1	90% (108)	1%
2019	84	17.8	3	91% (109)	3%
2021	63	17.8	4	93% (99)	4%
2022	30	18.2	2	87% (99)	2%

Table 18: Referral to first assessment in days

The 28-day target for waiting times to see babies referred from the newborn hearing screen is reported on a mandatory basis, and 98% of services were meeting this target in 2022.

Referral to first assessment (post-newborn screening)

The NHS waiting time target for referrals to first assessment for infants and older children (for whom hearing loss is suspected after newborn screening) is 42 days.[4]

[3] gov.uk/government/publications/newborn-hearing-screening-programme-quality-standards/newborn-hearing-screening-programme-standards-2018-to-2019 (NB the standard is slightly updated from 1 April 22)

[4] For more detail on diagnostic waiting times, please see qualitywatch.org.uk/indicator/diagnostic-test-waiting-times.

Year	Maximum waiting time (days)	Mean waiting time (days)	Number not meeting target	Response rate	Percentage missing target
2018	190	34.7	10	90% (108)	9%
2019	554	43.6	15	96% (115)	13%
2021	210	51.5	34	92% (98)	32%
2022	330	58.5	45	95% (108)	39%

Table 19: Referral to first assessment for babies and children not referred from the newborn screen (non-urgent)

There has been a significant increase in the number of services that are failing to meet the 42-day waiting list target for this group. Thirty-nine percent of services were not meeting this target. The average waiting time was 58.5 days, but there was a large range, with the maximum wait being 330 days.

Specific to 2022, we asked services to indicate if assessments were face-to-face or virtual, and to differentiate between urgent and non-urgent cases. According to a NICE standard[5], referral for urgent cases should be within four weeks.

Year	Maximum waiting time (days)	Mean waiting time (days)	Number not meeting target	Response rate	Percentage missing target
2022 – face to face	330	61.6	42	94% (107)	39%
2022 – virtual	105	32.2	4	11% (13)	31%

*Table 20: Referral to first assessment for older children (**non-urgent**), by appointment type*

Year	Maximum waiting time	Mean waiting time	Number not meeting target	Response rate	Percentage missing target
2022	84	16.9	12	89% (102)	12%

*Table 21: Referral to first assessment for older children (**urgent**)*

Time from the decision to fit hearing aids to actual fitting for PCHI

These figures include children referred via the newborn hearing screening pathway and older children referred from other routes. The NHS target for fitting hearing aids following a decision is 28 days.[6]

Year	Maximum waiting time	Mean waiting time	Number not meeting target	Response rate	Percentage missing target
2019	126	22.3	19	93% (112)	17%
2021	49	22.9	19	93% (99)	19%
2022	42	21.6	12	89% (101)	12%

Table 22: Waiting times for hearing aid fitting

Eighty-eight percent of services fit hearing aids within 28 days of a hearing loss being identified, which showed continued improvement over the past few years.

[5] NICE Clinical Guideline re meningitis: "Offer a formal audiological assessment as soon as possible, preferably before discharge, within 4 weeks of being fit to test."

[6] www.england.nhs.uk/wp-content/uploads/2016/07/P37-CYP-Service-Specification-Template.pdf

Routine follow-up hearing aid review

Routine follow-up hearing tests for children with permanent and temporary deafness do not have government targets. We asked services to tell us the number of days a child would wait to be seen beyond what was planned and agreed with the family. For example, if an appointment was set for six months' time and a child was not seen for six months and 12 days, the reported wait time would be 12 days.

Year	Maximum days over planned review date	Mean days over	Number not meeting target	Response rate	Percentage missing target
2018	135	24	57	84% (101)	56%
2019	210	30	71	96% (115)	62%
2021	365	61	72	86% (92)	78%
2022	540	62.5	85	93% (106)	80%

Table 23: Waiting times for routine follow-up hearing tests

Eighty percent of services reported that they were struggling to review children fitted with hearing aids at the time that was planned and agreed with the family. On average, children were seen 62.5 days later than agreed.

New earmoulds

Good practice is for earmoulds to be replaced within five days of the service being notified of need.[7]

Year	Maximum waiting time	Mean waiting time	Number not meeting target	Response rate	Percentage not replacing with five days
2018	14	4.2	32	91% (109)	29%
2019	14	3.8	25	96% (115)	22%
2021	21	4.0	19	97% (104)	18%
2022	20	5.0	30	91% (104)	29%

Table 24: Waiting times for earmoulds

Hearing aid repairs

We calculated waiting time as the number of working days from the time the service is notified of the need.

Year	Maximum waiting time	Mean waiting time	Number not meeting target	Response rate	Percentage not repairing within one day
2018	8	2	62	93% (111)	56%

[7] webarchive.nationalarchives.gov.uk/ukgwa/20130123195023/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088106

2019	7	2	75	98% (117)	64%
2021	14	2	71	98% (105)	68%
2022	10	2.5	81	94% (107)	76%

Table 25: Waiting times for hearing aid repairs

Most services were unable to offer a repair or replacement hearing aid within one working day of being notified, but this is likely due to reasons including clinical capacity, the capacity of families themselves to attend an appointment, and stock issues.

Routine follow-up hearing tests (for children who are not fitted with hearing aids)

We asked services to report the wait beyond the expected date.

Year	Maximum waiting time	Mean waiting time	Number not meeting target	Response rate	Percentage missing target
2022	540	90.6	87	90% (103)	84%

Table 26: Waiting times for follow-up hearing tests (not aided)

For children who need to be reviewed but are not fitted with hearing aids, 84% of appointments were delayed, with an average of 91 days over the planned review date.

Time taken to be seen initially by ear nose and throat (ENT) services after being referred by audiology

We recognise that waiting times for ENT services are outside the remit of audiology. We analysed on the basis of a six-week benchmark.

Year	Maximum waiting time	Mean waiting time	Number not meeting target	Response rate	Percentage missing target
2022	700	141.0	62	66	94%

Table 27: Waiting times for referrals to ENT

ENT waiting times are particularly concerning. Ninety-four percent of services reported that children they referred to ENT were missing the six-week initial appointment target, with an average waiting time of 141 days. One service reported a maximum 700-day wait, however most others reported waits of less than 360 days.

Grommet surgery for glue ear

We used the NHS target for grommet surgery of 126 days[8].

[8] For more detail on treatment waiting times please see qualitywatch.org.uk/indicator/treatment-waiting-times.

Year	Maximum waiting time	Mean waiting time	Number not meeting target	Response rate	Percentage missing target
2018	364	116	15	61	25%
2019	336	110	16	70	23%
2021	730	186	27	53	51%
2022	540	178.3	35	67	52%

Table 28: Waiting time for grommet surgery

More than half of respondents (52%) reported that their trusts were missing the 126 day target for grommet surgery (up from 23% in 2019). The average waiting time was 178 days with a maximum wait of 540 days. The Covid-19 pandemic has led to significant backlog and ENT waits.

Several services commented that there was now pressure on audiology to keep reviewing children with glue ear, and that they were issuing more hearing aids for temporary conductive hearing loss, while children waited for grommets.

Section 5: Quality improvement

There is no mandatory quality assurance programme for audiology services in England. However, NHS England prefers that services are assessed and accredited with the Improving Quality in Physiological Services (IQIPS) scheme. This is managed and delivered by the United Kingdom Accreditation Service (UKAS). Of the 114 paediatric audiology services that responded to our survey, only 26 (23%) reported that they were currently accredited by IQIPs.

Accreditation journey – registration if not already accredited

Registering with the accreditation provider UKAS is the first step towards accreditation.

Year	Registered (for adults and children)	Registered (children's services only)	Not registered
2018	0% (0)	0% (0)	28% (33)
2019	45% (54)	11% (13)	39% (47)
2021	44% (47)	8% (8)	43% (46)
2022	17% (19)	6% (7)	38% (43)

Table 29: Services registered with IQIPS

The numbers of services reporting that they were registered for IQIPs but not yet accredited had fallen significantly. Three services (3%) had previously been accredited but were not currently. Forty-three services (38%) were not registered at all.

Services cited common reasons for not registering including:

- lack of staff capacity
- complexity and time intensity required to complete a submission
- no support or funding from trust to apply

- IQIPs not being mandatory.

Other quality assurance methods used instead of or in addition to IQIPS accreditation

Year	A local audit against national quality standards	Internal peer review (Auditory Brainstem Response)	Internal peer review (behavioural testing)	Internal peer review (hearing aid fitting)	External peer review (auditory brainstem response)	External peer review (other)	Case studies/ journal clubs	Regional network to share best practice	Reporting all PCHIs on SMART 4 Hearing
2022	43% (50)	80% (92)	51% (59)	52% (60)	91% (104)	23% (26)	61% (70)	73% (84)	84% (97)

Table 30: Other quality assurance methods used by services

Ninety-one percent of services reported that they did take part in some form of external peer review for auditory brainstem response (ABR) testing. Some of the remaining services did perform ABR testing but did not undertake external peer review.

Many services reported different methods of quality assurance, but these varied and covered only specific aspects, such as ABR and fitting of hearing aids, compared to the broad examination of services undertaken for IQIPs.

Section 6: Staffing and training

We asked about staff working in paediatric audiology services (including the Agenda for Change (AFG) band levels of staff), whether staff were permanent or temporary and how many vacancies the service was carrying. We asked for staffing numbers expressed as a fraction of a full working week. So, one full-time role and a part-time role of three days in a five-day week would be 1.6 Full Time Equivalent (FTE).

Number of permanent staff

Year	Number of FTE permanent staff across services	Number of services	Average number per service
2017	823	113	7.28
2018	829	109	7.61
2019	897	117	7.66
2021	758	104	7.29
2022	717	111	6.46

Table 31: Number of permanent staff by year

There has been a downward trend in the number of permanent staff employed in paediatric audiology services over the past five years. Services indicated that this was because they had had difficulties recruiting and retaining staff, and that some staff wanted to reduce their hours.

The graph that follows shows the number of permanent staff at each AFC band working in the paediatric audiology services responding to the 2022 survey.

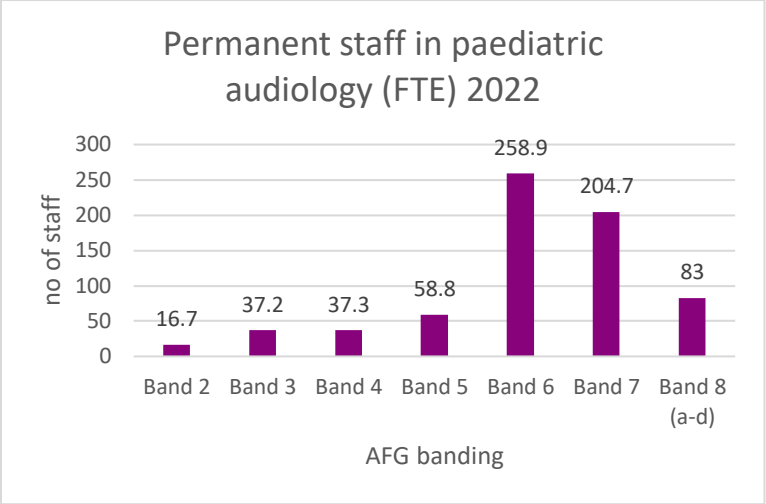

Figure 1: Permanent staff working in paediatric audiology, by AFC band

Temporary staff

Year	Number of FTE temporary staff across services	Number of services	Average number per service
2017	22.8	18	1.27
2018	48.5	25	1.94
2019	36.7	25	1.47
2021	23.4	19	1.23
2022	24.1	20	1.20

Table 32: Number of temporary staff by year

Vacant posts

Year	Number of staff across services	Number of services	Average number per service
2017	40.4	22	1.83
2018	62.8	32	1.96
2019	58.3	38	1.53
2021	39.9	26	1.53
2022	48.2	35	1.38

Table 33: Number of vacant posts by year

At the time of the survey, there were 48.2 FTE posts vacant in paediatric audiology services.

The graph below shows the numbers of vacant posts in paediatric audiology services responding by AFC band at the time of the survey.

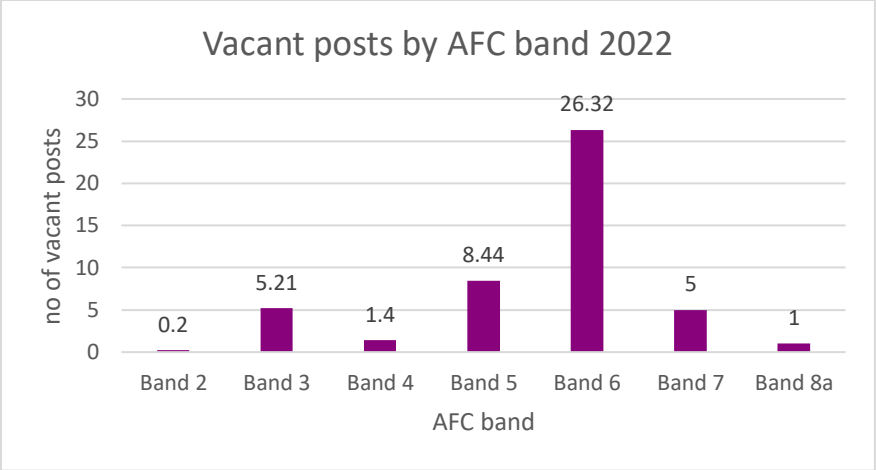

Figure 2: Vacant posts in paediatric audiology by AFC band

Trainees

In 2022 we asked services how many trainee audiologists they currently had.

Year	Number of staff across services	Number of services	Average number per service
2022	30.6	19	1.61

Table 34: Number of trainees in 2022

Sixteen of the trainees were currently on the Practitioner Training Programme (PTP) and 14.6 (FTE) on the Scientist Training Programme (STP). As shown by the earlier figures on vacant posts, this was not enough to address gaps in staffing.

Apprentices

Year	Number of staff across services	Number of services
2017	4.6	4
2018	5	4
2019	8	7
2021	8.9	9
2022	10.4	9

Table 35: Number of apprentices by year

Take up of apprenticeships was variable. There were only two Level 2 apprenticeships, two Level 4, and seven Level 6 apprenticeships reported in 2022.

Reasons for reduction

Services were asked what reasons might explain any reduction in the number or skill level of staff compared to 2021 (services could select multiple responses).

Year	Posts deleted	Post frozen	Staff hours reduced	Unable to recruit level 5 and below	Unable to recruit level 6 and above	Other
2018	4% (5)	5% (6)	14% (17)	11% (13)	10% (12)	18% (21)
2019	2% (3)	2% (2)	10% (12)	12% (14)	18% (21)	26% (31)
2021	9% (3)	6% (2)	23% (8)	9% (3)	11% (4)	66% (23)
2022	1% (1)	0% (0)	14% (16)	11% (12)	17% (19)	0% (0)

Table 36: Reasons for staff reductions

Training

We asked services if staff were able to access the continuing professional development (CPD) required to meet their personal development needs in the last year. We asked services to differentiate between mandatory training, internal training and external training, whereas in previous years we asked if staff could generally access CPD necessary for their roles.

A total of 95% of services said they accessed internal CPD training and 99% said they accessed all mandatory training. Eighty-eight percent of services accessed external courses and other CPD.

Seven percent of services said they were not able to access external CPD because there was not sufficient cover for clinical duties and 7% said it was due to financial constraints. Thirty-seven percent of services said all staff were able to access external CPD.

Year	Yes	No cover	Financial constraints prevent this	CPD training not covered	No (other reasons)
2018	81% (96)	8% (10)	12% (14)	7% (8)	5% (6)
2019	85% (102)	6% (7)	12% (15)	5% (6)	9% (11)
2021	93% (99)	0% (0)	4% (4)	0% (0)	11% (12)
2022	99% (113)[9]	7% (8)	7% (8)	N/A[10]	11% (13)

Table 37: Training opportunities for staff

Grading for roles within paediatrics

We asked services to indicate what roles members of the paediatric team, working at different grades, perform (services could select multiple options).

[9] This figure applies to mandatory training being met. The question in 2022 was slightly different to previous years.
[10] Not provided as an option in the 2022 survey.

AFC band	**Lead** newborn diagnostic assessment and/or immediate follow up	**Lead** routine assessments	**Assist** routine assessments	**Lead** routine assessments	Provide routine **testing only (**e.g. no history-taking) for **ENT** clinics	**Lead** assessment of children with complex needs	**Assist** assessment of children with complex needs	**Lead** pre-school and/or complex needs hearing aid clinics	**Lead** school age hearing aid clinics	**Lead** additional/ advanced clinics, for example for tinnitus, hyperacusis or auditory processing disorder
		<4 years	**<4 years**	**school age**						
2	0	0	11	0	0	0	7	0	0	0
3	0	0	33	0	2	0	22	0	0	0
4	0	0	25	3	16	0	16	0	0	0
5	0	8	50	34	66	2	38	0	15	2
6	38	95	82	104	88	54	93	61	92	38
7	95	99	67	97	71	104	75	100	96	74
8a	53	54	39	54	40	56	45	54	47	37
8b	17	20	15	19	14	20	17	18	17	15
8c	3	5	4	5	3	5	4	5	5	2
8d	3	2	1	2	1	3	1	3	2	2
Doctor	2	11	4	8	1	16	5	6	4	11

Table 38: Roles performed by staff at different grades (numbers reported by role and grade)

This demonstrates the skills mix required in different clinic types and will be useful for paediatric services to benchmark themselves against.

Staff qualifications

We asked services to report how many staff they had working in their paediatric service, based on their qualifications and training (services could select multiple options). Table 39 shows the average number of staff with each qualification at each AFC band.

AFC band	BTEC in Healthcare Science	Foundation degree	BSc or equivalent	STP or equivalent MSc + HTS (or CAC)	Standalone HTS paediatric modules	Relevant MSc (no HTS/CAC)	Management/ leadership qualification	Relevant PhD, HSST or other doctoral level
3	1.0	1.0	1.0	0.0	1.0	0.0	1.0	0.0
4	1.3	2.2	1.0	0.0	0.0	0.0	0.0	0.0
5	1.0	0.0	2.1	1.0	1.0	1.0	0.0	0.0
6	1.8	1.0	2.9	1.3	1.5	1.9	1.6	0.0
7	1.8	2.3	2.1	2.5	1.3	1.6	1.6	1.3
8a	0.9	0.0	2.0	1.1	1.1	1.8	1.6	1.2
8b	1.0	0.0	1.0	1.0	0.0	1.0	1.0	1.0
8c	1.0	0.0	1.0	0.9	0.0	1.0	0.9	1.0
8d	0.0	0.0	0.0	1.0	0.0	0.0	1.0	1.0
9	0.0	0.0	0.0	0.0	0.0	0	0.0	0.0

Doctor e.g. AVP or paed	0.0	0.0	2.5	0.0	0.0	2.6	1.0	1.5

Table 39: Average number of staff by band and qualification

Section 7: Collaboration

Referrals

This year we asked services about referrals to the local specialist education service for deaf children in their area (services could select multiple options).

Year	Children with a severe or profound hearing loss	Children with a moderate sensorineural hearing loss	Children with a mild sensorineural hearing loss	Children with permanent or long-term conductive hearing loss	Children with temporary or fluctuating conductive hearing loss	Children with a hearing loss who do not wear hearing aids	Unilateral hearing loss	Auditory neuropathy spectrum disorder
2022	95% (108)	95% (108)	95% (108)	95% (108)	65% (74)	75% (85)	94% (107)	88% (100)

Table 40: Groups of children that services refer

Ninety-five percent of services referred children with any level of sensorineural hearing loss or permanent or persistent conductive hearing loss to specialist education services. Only 65% would refer children with a temporary hearing loss and 75% would refer children with a hearing loss who were not using a hearing aid.

We then asked if all referrals from audiology are **accepted** for the same groups.

Year	Children with a severe or profound hearing loss	Children with a moderate sensorineural hearing loss	Children with a mild sensorineural hearing loss	Children with permanent or long-term conductive hearing loss	Children with temporary or fluctuating conductive hearing loss	Children with a hearing loss who do not wear hearing aids	Unilateral hearing loss	Auditory neuropathy spectrum disorder (ANSD)
2022	70% (80)	69% (79)	58% (66)	61% (69)	33% (38)	33% (38)	53% (60)	59% (67)

Table 41: Proportion of services accepting all referrals from audiology for the different groups of children

The numbers of referrals that were **accepted** by education services were reported to be significantly lower than the number referred by audiology. Responses from services suggested that qualifying criteria for specialist educational support varies across the country, and some services did not know if all referrals were accepted.

We asked if services were able to routinely refer directly to non-audiology or external professionals.

External professionals	Yes	Referrals not accepted from audiology, for example, referrals via GP or consultant only	Service not available	Don't know
Speech and language therapy	69% (79)	22% (25)	1% (1)	3% (3)
Ear nose and throat (ENT) services	96% (110)	3% (3)	0% (0)	0% (0)
Family support/MAST/Social services	62% (71)	13% (15)	2% (2)	14% (16)
Safeguarding	96% (110)	1% (1)	0% (0)	0% (0)
Clinical psychology/child and adolescent mental health services (CAMHS)	45% (51)	35% (40)	4% (4)	13% (15)
Deaf child and adolescent mental health services (Deaf CAMHS)	45% (51)	18% (21)	10% (11)	21% (24)
Paediatrician or developmental assessment service	61% (70)	30% (34)	1% (1)	3% (3)

Table 42: Referrals to non-audiology/external professionals

Onward referral to ENT services was available to most audiology services (96%) without the patient needing to go back to the GP. However onward referral to other services varied, with some services requiring a GP referral, and some services entirely unavailable in some areas.

Children's Hearing Services Working Groups (CHSWGs)

In previous surveys, we asked services whether they had a parent rep on their CHSWG:

Year	Yes	No	Don't have one	Don't know
2018	86% (102)	8% (9)	4% (5)	3% (3)
2019	82% (99)	12% (15)	2% (3)	2% (3)
2021	84% (90)	12% (13)	4% (4)	1% (1)

Table 43: Parent Representatives in Children's Hearing Services Working Groups from 2018 to 2021

In 2022 we also asked services if the CHSWG in their area included a representative from other groups.

Representative	Yes	No	Don't know
Parent representative(s)	85% (97)	10% (11)	2% (2)
Deaf young person	7% (8)	73% (83)	10% (11)
Adult audiology service or transition team	61% (69)	30% (34)	3% (3)
Speech and language therapy	87% (99)	7% (8)	3% (3)
Specialist education service	95% (108)	1% (1)	1% (1)
Ear nose and throat services (ENT)	39% (45)	45% (51)	5% (6)
Social services	37% (42)	45% (50)	11% (12)
Trust senior management team	14% (16)	70% (80)	6% (7)
Commissioner	21% (24)	61% (70)	8% (9)

Table 44: Representatives in Children's Hearing Services Working Groups

Five services (4%) answered that they did not have a CHSWG, but most said there was a local deaf children's group. As well as paediatric audiology, education services were well represented on CHSWGs

(more than 95%) as were speech and language therapy (87%). Many had a representative from adult audiology services (61%) and the majority (85%) also had a parent representative. Representation was patchier for ENT (39%) and social services (37%).

Very few CHSWGs had representation from their Trust's senior management team or Commissioners and only 7% of CHSWGs had a deaf young person who attended.

A total of 40 services (35%) selected 'other'. The comments indicated that the following groups are sometimes represented in CHSWG groups (number of comments in brackets):

- National Deaf Children's Society member of staff/representative (22)
- Cochlear implant team representative (4)
- Paediatric consultant, paediatrician or community paediatrician (10)
- Deaf child and adolescent mental health services (Deaf CAMHS) (3)
- A member of a deaf children's society or representative of a deaf group that isn't the National Deaf Children's Society (8)
- National Hearing Screening Programme (NHSP) team representative (11)
- Audiologist implant team representative (4)

Section 8: Assistive technology

Organisations providing technology

We asked services which organisation provided assistive listening devices.

Organisation	Year	Radio aids	Streamers	Remote microphones	Bluetooth/integrated receiver technology[11]
Local authority	**2018**	96% (114)	45% (53)	67% (80)	-
	2019	94% (113)	37% (44)	65% (78)	-
	2021	93% (100)	37% (40)	67% (72)	-
	2022	96% (110)	38% (43)	68% (77)	56% (64)
Your service	**2018**	0% (0)	14% (17)	11% (13)	-
	2019	1% (1)	17% (20)	12% (14)	-
	2021	1% (1)	10% (11)	12% (12)	-
	2022	1% (1)	11% (12)	8% (9)	28% (32)
Jointly	**2018**	4% (5)	3% (4)	3% (3)	-
	2019	8% (9)	4% (5)	4% (5)	-
	2021	6% (6)	7% (7)	9% (10)	-
	2022	1% (1)	6% (7)	8% (9)	9% (10)
Not provided	**2018**	0% (0)	0% (0)	0% (0)	-
	2019	0% (0)	39% (47)	16% (19)	-
	2021	0% (0)	38% (41)	13% (14)	-
	2022	0% (0)	25% (29)	11% (12)	4% (5)

Table 45: Organisations that provide assistive listening devices by year

[11] Option only provided in 2022 survey.

Services could also indicate if they did not know if the local authority provided the different types of technology: radio aids (0%), streamers (15%), remote microphones (7%), or Bluetooth/integrated receiver technology (2%).

Plans to stop provision of equipment

We asked services if there were any plans to stop or significantly reduce the provision of hearing equipment or accessories for hearing technology in the coming year.

Year	Yes	No
2018	1% (1)	97% (115)
2019	2% (2)	95% (114)
2021	1% (1)	99% (105)
2022	0% (0)	96% (109)

Table 46: Number of services planning to stop provision of equipment

Section 9: Patient engagement

Transition

In previous surveys, we asked services how they prepared young people for transition to adult services (multiple options could be selected).

Year	Provide information	Offer appointment with adult service	Transition event or clinic for young people	Joint appointments	Visit local schools	Other	None of the above
2018	92% (109)	56% (67)	-	46% (55)	6% (7)	42% (50)	1% (1)
2019	92% (110)	61% (73)	-	55% (66)	8% (9)	41% (49)	2% (2)
2021	95% (102)	60% (64)	21% (22)	47% (50)	1% (1)	41% (44)	2% (2)

Table 47: Transition planning options to adult services from 2018 to 2021

In 2022 we asked this question slightly differently.

Preparation type	Proportion of services
Start talking about the transition process from age 14	73% (83)
Complete a trust transition assessment or process	60% (68)
Provide information on the adult service for young people	95% (108)
Hold joint appointments with both paediatric and adult audiologist present (virtual or face-to-face)	43% (49)
Offer an appointment with the adult service before being discharged from the children's service	44% (50)
Offer young person the opportunity to come into the clinic without their parent or carer if appropriate	73% (83)
Hold transition event or clinic for young people	21% (24)
Visit local schools to offer sessions to share information with young people about subjects such as deafness, independence and transition.	9% (10)
None of the above	2% (2)

Other	28% (32)

Table 48: Transition planning options to adult services in 2022

Disappointingly, some services commented that transition planning was not necessary because they were a joint adult and children's service. This indicated a lack of understanding about the transition process and the need to prepare young adults so that they are able to manage their own care and understand their healthcare needs.

Missed appointments

We asked services how many appointments were classed as 'Was Not Brought' (WNB) or 'Did Not Attend' (DNA) in the 2021/22 financial year.

Year	Average number of appointments offered in 2021/22 (all appointment types for children)	Average number of appointments classed as WNB or DNA in 2021/22	Average percentage WNB or DNA if known
2022	5,538.4	774.5	14%[12]

Table 49: Appointments classed as WNB or DNA in 2022

- Appointments offered: Range: 315 to 83,954 Median: 3549
- Appointments classed as WNB or DNA: Range: 40 to 14,182 Median: 442
- Percentage WNB/DNA: Range: 4 to 40% Median: 13%

Year	Response rate	Mean score	Median score	Number over 9% rate	Percentage over 9% rate
2018	105	13%	13%	80	76%
2019	110	12%	12%	82	75%
2021	97	12%	11%	61	63%

Table 50: Missed appointments from 2018 to 2021

Strategies for missed appointments

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

Strategy	Yes	No
Partial booking	34% (39)	34% (39)
Text reminders	78% (89)	10% (11)
Phone reminders	74% (84)	13% (15)
Other	31% (35)	5% (6)
None	1% (1)	4% (4)

Table 51: Strategies for missed appointments in 2022

[12] We calculated the average percentage based on the number of appointments provided by services in relation to all the appointments offered. However, some services did not provide values in this format so their responses could not be included in this calculation.

Section 10: Funding and commissioning

We asked services how their funding was provided (they could select multiple options). Where services ran a joint adult and paediatric service, we also asked if budgets were shared.

Funding

Funding type	2021	2022
Block contract for all children's audiology services	19% (20)	26% (30)
Block contract for both children's and adult's audiology services	57% (61)	54% (61)
Block contract within ear nose and throat (ENT) services	1% (1)	4% (5)
Block contract within wider children's services	18% (19)	11% (12)
As an individual tariff per child	0% (0)	5% (6)

Table 52: Provision of funding for services

Joint budget type	2021	2022
Our service is joint and budgets are not shared	7% (7)	9% (10)
Our service is joint and budgets are shared	73% (77)	67% (76)
Our service is paediatric only	21% (22)	23% (26)

Table 53: Budget sharing

Section 11: Pandemic recovery

We asked services if there were any areas where there had been an increase in demand following the pandemic.

Area of change	Demand decreased	Demand remained stable	Demand increased
Routine pre-school assessments	6% (7)	45% (51)	41% (47)
Routine school-aged assessments	8% (9)	47% (54)	35% (40)
Children requiring complex assessment techniques or multiple appointments	5% (6)	32% (37)	55% (63)
Children requiring sedated auditory brainstem response (ABR) or ABR under general anaesthetic	6% (7)	53% (60)	28% (32)
Children with listening difficulties in the presence of normal hearing	4% (5)	57% (65)	25% (29)

Table 54: Increases in demand related to the pandemic

Comments indicated that services were experiencing an increase in referrals of children that require more complex assessment and management, such as more children presenting with possible autism spectrum disorder, and with tinnitus and hyperacusis.

Some examples of these are:

- “Referrals to us due to speech concerns have increased.”
- “Meningitis referrals (awareness by medical professionals).”
- “Children with glue ear being fitted with hearing aids temporarily, while awaiting ENT input.”
- “Children with sensitivities to loud sounds.”
- “Routine school aged assessments: unable to comment (separate audiology service).”
- “Children requiring complex assessment techniques or multiple appointments: (hugely increased!)”
- “Children requiring sedated auditory brainstem response (ABR)/ABR under general anaesthetic (as a consequence of increased numbers of children not successfully tested with routine assessment techniques).”
- “Specific types of hearing aid clinic (e.g. infant or BAHA clinics) have increased.”
- “There seem to be high numbers of children with possible autism spectrum disorder.”
- “Children with loudness intolerance.”
- “Hearing aid fittings for glue ear.”

We also asked each service if they had introduced any new ways of working or changes in response to the pandemic that they anticipated would be retained. Services made the following comments:

- remote appointments – telephone or video (10)
- scanned moulds (3).

Section 12: Further evidence from services

The final section of the survey was optional. We asked services to tell us about any good practice or innovative solutions in their service, and also any challenges to their service now, or potential future threats.

Good practice

Some services told us about many examples of good practice that they were rightly proud of:

- “Improved processes for hearing aid patients and families to access the service using SharePoint.”
- “Engagement with Trust lead for Auditory Spectrum Disorder (ASD) to improve environment and experience of accessing audiology for children with ASD.”
- “Super sedation for auditory brainstem response tests which can be administered up to age six and beyond.”
- “Virtual review clinics with paediatric ear nose and throat (ENT) services.”
- “We complete peer review of assessments for our aided children with a neighbouring audiology department.”
- “We hold a weekly joint clinic with our local education audiologist.”
- “Home visits for neonates for diagnostic auditory brainstem response and ongoing impression taking where appropriate.”
- “Fast track referral process for pre-school ENT referrals.”
- “Invited children with hearing aids (accompanied by their hearing support teachers) to join Children’s Hearing Services Working Group (CHSWG) online and feedback about their experiences.”
- “Scanning earmoulds for older children and posting directly to home address to avoid frequent hospital visits during pandemic.”

- “Joint audiology clinic (aetiology investigation clinic) has introduced early request by audiologists for feed and wrap MRI scanning, and referral to Ophthalmology and cytomegalovirus (CMV) swabbing to avoid delay.”
- “Initial investigations, namely for congenital cytomegalovirus and feed and wrap MRI, are initiated by audiology.”
- “We have a pathway for newborn babies with malformed external ears to access plastics for possible ear splinting.”
- “Children’s Hearing Services Working Group remains a strong platform for change, and can influence decisions that will benefit our families, i.e. we have an ENT consultant at the meeting and we have been able to develop a fast track appointment system for our families to access ENT, for wax removal/follow ups which have been delayed.”
- “Jointly commissioned educational audiologist post between education and health for children under two years of age because this age group is not traditionally covered by (our) education services.”
- “The service is engaged in a root and branch quality improvement programme. Service development is linked to cyclical review and RAG rating of Draft British Academy of Audiology Quality Standards in Paediatric Audiology benchmarking domains and standards.”

Challenges or threats

Many services told us about the challenges they were facing. The main themes they reported were workforce shortages, increased demands for services, barriers to accreditation and resources and funding. The comments below are a selection which illustrate these concerns:

Workforce challenges

- “Significant staffing pressures October 2021 to February 2022 with vacancies and high levels of sickness.”
- “We do not have enough human and non-human resources to keep to service needs.”
- “The service continually struggles with the amount of maternity leave it has. This together with some staff coming up for retirement may provide challenges to the service over the next year or so.”
- “Recent retirement of Paediatric Audiologist Clinical Lead, as yet post unfilled, meaning backlogs acquired as a result of the pandemic cannot be cleared. The current vacancy will exacerbate existing waiting lists.”
- “Recruitment is a problem.”
- “Training of paediatric audiologists creates pressure.”
- “Recruitment remains an issue for our service the same as for many other NHS services.”
- “Chronic national shortages of qualified and experienced paediatric audiologists.”
- “The difficulty recruiting in audiology has implications for the sustainability of the service.”
- “Difficulty recruiting paediatric audiologists.”
- “Our head of service left almost 12 months ago and we have been unable to recruit a replacement yet, which has had a major impact on the service, particularly in negotiating the new contracts.”

Increased demand and pressures

- “Pressure on audiology to keep reviewing children with glue ear whilst they wait for grommets.”
- “Capacity issues due to service demand due to the number of school referrals received post Covid and children returning to normal schooling.”
- “Increase in referrals due to the school screening service not continuing.”

- “A general increase in workload; there is a lot more paperwork involved, more than we ever had before and with increased demand in services this is making the day to day work a lot busier.”
- “Wait to be seen by ENT does affect our workload too.”
- “The increased demand for hearing tests for children undergoing autism assessment are taking resources away from deaf children.”
- “Rises in numbers of complex/challenging-to-test kids being referred.”

Accreditation

- “There needs to be different ways of measuring the quality of a service other than UKAS accreditation which for many services is impossible to achieve due to time.”
- “Focus on other priorities, for example, it has been our priority to recover from Covid-19 as quickly as possible and minimise waits for families, and we have been concentrating on this rather than accreditation.”

Resource and funding challenges

- “Budget is held within adult audiology where budget holder is only accountable for adult care (not for paediatric service provision), there is no motivation for budget holder to release funds to improve paediatric services.”
- “We have a auditory brainstem response business case for new kit which is not being financially supported.”
- “Not enough estate (space and testing booths) and capacity to support the current service demands.”
- “Suitable testing venues. Loss of one permanent venue during pandemic, no equivalent replacement yet secured.”
- “Critical accommodation shortfall.”
- “One of the challenges that I see is lack of funding for the newer technology.”
- “It is also very difficult to secure funding for advanced training modules that I want my team to attend, and I cannot see any improvement this year.”
- “Lack of clinical space to increase capacity.”
- “Ongoing IT issues and equipment replacement issues.”

We are very grateful to audiology services for sharing these insights. This evidence will be instrumental in helping us to influence national policy affecting the areas of concern in audiology.

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