To: ICB:
- Chief Executive
- Medical directors
- Directors of nursing

cc. NHS England Regional:
- Directors
- Medical directors
- Chief nurses
- Clinical quality directors
- Healthcare scientists

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

31 August 2023

Dear Colleagues,

Quality Improvement in Paediatric Hearing Services: recommended actions for immediate implementation

The Newborn Hearing Screening Programme has reviewed the data of every newborn baby born in England (2018-2023) and identified four Trusts who had diagnosed significantly fewer babies with a permanent childhood hearing impairment (PCHI) than expected following initial hearing screening assessment.

The review of these Trusts has identified root causes that have led to poor service delivery and outcomes. These service issues include lack of clinical governance and oversight, poor reporting of data, poor interpretation of results, poor retention of diagnostic data, and lack of accreditation with UK Accreditation Services (UKAS) IQIPS (Improving Quality in Physiological Services) which provides evidence of quality management and delivery systems for CQC and other purposes.

We know that there are approximately 130 paediatric hearing services across the 42 ICBs and currently only 25 of these services are UKAS accredited. Since the initial identification of the four Trusts outlined above, more Trusts have come forward to indicate that they are actively reviewing or pausing their services and we believe there may be others in the system, where quality improvements need to be made and some babies/young children recalled for further testing.

Recognising the system wide nature of the issues identified, a National Paediatric Hearing Improvement Programme has been established by NHS England to support providers and ICBs to improve the quality of these services. The programme is undertaking work to understand the scale of the problem and the number of children who have been affected, and to develop the strategic tools and interventions to support sustainable improvements.

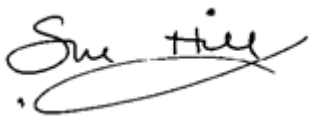
A set of system recommendations for immediate action have been developed. These have been informed by stakeholders including regional and ICB clinical and quality leads as well as the outcomes of the reviews of root cause analyses of the incidents and other pilot service assessments by UKAS.

All ICBs are now requested to work with their paediatric hearing service providers to implement the recommended actions in the document attached as a matter of urgency.

An assessment template is provided for ICBs to work with their providers to complete and gather evidence of compliance. ICSs should work with their regional teams with advice for general queries related to the process from the national team england.cso@nhs.net.
An overview report should be produced by each ICB which outlines the progress of all providers against the recommendations, their immediate risks and action plans and these should be discussed at system quality groups, committees or equivalent **by 30th October,** and shared with regional quality leads. This will inform an NHS England convened Regional Paediatric Hearing Services Improvement Group that will collate a national overview of the local plans and will identify common issues and areas of good practice. The group will work with the national team to determine the scale of the issues arising and to ensure national consistency in the approach to risk stratification and intervention.

Your engagement and support with this essential piece of work is appreciated, and we look forward to continuing to support you to improve these important services locally, so that children who need it receive safe, high quality and timely care.

Yours sincerely,



Professor Dame Sue Hill
Chief Scientific Officer for England
Senior Responsible Officer for the Paediatric Hearing Improvement Programme
NHS England

Sir David Sloman
Chief Operating Officer
NHS England