Quality Standards for Adult Hearing Rehabilitation Services The Assessment and Audit Tool V3- 1st consultation themes updates and referencing complete

These standards cover the service being referred to following initial assessment and referral from primary care. Although in some areas the initial first point of contact in PC will be with an audiologist, that part of the pathway is outside of the scope of these standards

Standard 1. Accessing the Service

STANDARD STATEMENT	RATIONALE	CRITERIA	Examples of EVIDENCE OF COMPLIANCE **This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.**
1a. Using national healthcare principles to ensure all patients and their significant other(s) who require access to Audiology services are able to: (i) access the correct Audiology service to meet their needs, (ii) conveniently access the services they require, (iii) see Audiology or healthcare professionals as first points of contact, as determined by agreed local clinical criteria,	Locally agreed pathways to Audiology services ~~is~~ allows a more effective and efficient way of meeting all patients' clinical needs where there is no robust evidence of otological pathology [1][2][3][4]. Allocation to the wrong referral pathways (or absence of alternative pathways) means additional inconvenience to the patient and inefficient use of time and resources [5][6].	**1a.1**. All adult patients have access to Audiology via locally agreed pathways where this is clinically indicated.	National standards. Where these are not in place Local Standard Operating Procedures and/or pathways for direct access of all new and existing patients directly to Audiology. Clearly defined referral criteria for both new and existing patients. Copy of AQP/ICB contract

	Correct information to an Audiology service results in more effective use of available resources [7][8][9].		
	Principles promote delivery of services close to patients for their ultimate health care benefit [10][11][12]	**1a.2.** Information about referral criteria and pathways, including any changes, is widely disseminated to all potential referrers on a regular basis.	Copies of at least annual communication with GPs which includes details of referral criteria. Integrated pathways across primary care and secondary care audiology services Examples of regular communication with patients detailing how to access Audiology directly e.g. written patient information, posters in waiting area Corroboration by staff.
		1a.3. The proximity of patients to centres delivering Audiology services is similar to other adult services in the Board/district/ICB.	Maps of Audiology service locations and other service locations such as ophthalmology, podiatry and physiotherapy.

1.b Using national healthcare principles to ensure all patients and their significant other(s) who require access to Audiology services: • wait no longer to access Audiology by one referral route than any other.[2] • wait no longer if they are an existing patient accessing the service for reassessment than a new patient accessing the service for the first time in line with government targets. • gain access to the Audiology service as quickly as other comparable diagnostic/therapy services.	Simple equity implies that no patient should wait longer for a direct referral to Audiology than they would for a referral via ENT or Audio-Vestibular Medicine (AVM)[13][14]. Simple equity implies that patients who have previously accessed an Audiology service must be able to re-access it via self-referral within a set/given timeframe[15].	**1b.1** Waiting times for direct access (via GP referral or self referral) to Audiology are no longer than waiting times for patients who are referred to Audiology via ENT or AVM.	~~D~~etails of the number of new and existing patients referred to Audiology via all routes. Waiting time data for new and existing patients at monthly points and covering last 12 months. Include patients seen by Audiology via GP referral and referral from ENT or AVM. Audit of direct access waiting times vs DM01 return for ENT

		1.b.2. The maximum waiting time from referral to commencement of treatment meets the national target.	Wait times compared to national targets. Wait times compared to AQP/ICB contract
		1b.3. Where Audiology services are delivered away from the main Audiology base, patients can access the repair service within a month at each location.	*Audit* of waiting times data for repair appointments at all local clinics.
1c Service demand and referral data for all patients are accurately monitored, reviewed and reported against available indicators and used to guide service planning	Effective allocation of resources relies upon information on actual demand and potential/projected demand for specific services. It is important that waiting times for all stages of the patient pathway from referral through to treatment (e.g. hearing device fitting) for new and existing patients are collected and monitored in an effective manner. The use of IT systems to collate demographic data and	**1c.1**. The appropriateness of new referrals in to the Service is monitored, and a system is in place to manage any inappropriate referrals. and meets the national target (where national targets exist).	**A report detailing:** • The number of direct referrals to Audiology that fulfil referral criteria • The number of patients coming to Audiology via ENT or AVM who could have come directly to Audiology. • The number of referrals to Audiology that require onward referral to ENT.

	waiting times will inform allocation of services. [13][14][15][16]. The monitoring of inappropriate referrals via all current national and local pathways assures evidence-based healthcare.	**1c.2.** The appropriateness of the referrals for existing patients for reassessment is monitored and meets national targets (where national targets exist) A system is in place to manage any inappropriate referrals.	The number of self-referrals that fulfil re-assessment re-accessing the service criteria and should follow current NICE guidance
		1c.3. Waiting times are monitored nationally and regionally based upon data collection following national agreement.	Details of the source of waiting times data. Detail national and regional monitoring process
		1c.4. Key data is identified, collected, reviewed and used in annual service review.	Annual service review with all criteria evidenced. Action plans identified to address gaps identified and reported on (to who) **A report detailing:**

			• the number and type of referrals to Audiology services, • the uptake and types of intervention in the local population compared with the predictive need for services, • demographics of locally served populations with relevance to the service • Areas where inequality of access is identified • Action plans to address any gaps that may have been identified and reported to Directorate.

1d. Existing service users have access to effective, ongoing lifetime support.	Appropriate and timely access for existing patients needing advice and support [17][18][19][20] Appropriate and timely access for existing hearing aid patients to a repair service, replacement batteries, and onward referral as	**1d.1.** Existing service users have access to relevant rehabilitation pathways to suit their needs	Evidence of pathways on patient management system Staff discussion during audit User feedback Patient feedback via forums

	necessary is required to help maintain long term use and benefit [17][18]. Multidisciplinary local ear care / wax management pathway & procedures should be in place to support effective Audiology care[21][22][23]	**1d.2.** All patients have access to ear care with established & agreed pathways.	Standard Operating Procedures Pathways Evidence of collaborative working
		1d.3. Where Audiology delivers wax management services, it should be delivered in an appropriate care setting, in line with the nationally agreed service specification, standard operating procedures and training standards, and delivered by healthcare professionals trained in wax removal.	National agreements Standard Operating Procedures Evidence of training and competency assessments Evidence of ongoing peer reviews and outcomes measures
		1d.4. The service has a systematic approach to hearing device repairs, maintenance and battery provision. Various options are available which could include walk-in, booked appointments, drop-box, postal, remote support There is system in place to triage and prioritise. Any patient triaged as a priority will be offered an appointment within 1 working day in an available location.	• *Audit* of postal repair turnaround time. • *Audit* of waiting times for repair appointments. • Timetable showing daily open access clinic • Patient feedback

		1d.5 Audiology departments fulfil requests for replacement batteries within 2 working days of the request being received.	*Audit* of battery request turnaround time.

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

Standard 2. Information Provision and Communication

STANDARD STATEMENT	RATIONALE	CRITERIA with consultation comments	Examples of EVIDENCE OF COMPLIANCE **This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.**
2a. Timely and relevant two-way information is essential to meet the needs of all patients and their significant other(s), in formats that accommodate their communicative abilities and follow national legislation	Accessible communication before, during and after intervention benefits patients and their significant others, through reduction in anxieties/concerns and encouraging appropriate uptake of further care and self management [24][25][26][27][28][29][30][31][32][33][34 Communication needs are accommodated following legislation and reasonable adjustments are made Accessible information that is clear, up to date and in a format that is accessible to the individual facilitates understanding of the service and self-management options [24][32][35][36][37].	**2a.1.** Individual communication needs and preferences are identified at the point of referral and throughout the patients' journey, recorded and actioned in line with Accessible Information Standards.	Patient call aids in waiting areas Identifying individual communication needs and preferences
		2a.2. Accessible information should be provided in an appropriate format e.g. written, verbal, sign-language, subtitled video, easy read, braille.	Written information leaflets and letters. Patient feedback Sign language 'attending audiology information' on websites. Eg first appt, review, repair etc

	To avoid discrimination, services should meet the specific communication and information needs of hearing-impaired patients and where appropriate, their significant other(s) accessing the service [30][38][39].	**2a.3.** Accessible information prior to appointment includes encouragement to invite significant other(s). This will include information about; • Assessment procedures • types of assessment, possible • interventions (including benefits & limitations) • clinicians involved This will be for new and existing patients at the time of notification of the appointment	Written information leaflets and letters. *Audit* to check if appropriate information sent and received. Patient feedback
		2a.4. During assessment, results are recorded and discussed with the patient. The benefits & limitations of the treatment options available are discussed and agreed with the patient & their significant other.	*Audit*, cross checking the date of the appointment with record of test results and journal entries.

		A digital or hard copy is offered to patients with an appropriate explanation of the results.	
	Technology should be used to enable Audiology staff to communicate effectively with patients and to ensure that the information is given in a manner that the patient understands [32][40][41].	**2a.5.** Information should be provided in the preferred format of the patients, in accordance with their documented communication/information needs, that relate to a disability or sensory loss. Information should ideally be provided in a format that may later be referred to e.g. written format or a format that meets the needs of the patient.	For example, information about: Replacing batteries Maintaining and looking after hearing aids FAQs Hearing tactics and how to maximise the listening environment Support in the workplace
		2a.6. The service uses a range of up-to-date technology to allow for accessible 2-way communication between audiology and the service user. All staff responsible for using the technology are trained on how to use it. The application of such technology reflects the advice of local user groups and individual preference.	Technology in place. Current Standard Operating Procedures (signed by relevant staff) Evidence of staff training logs Patient survey.

		2a.9. At clinics, up-to-date technology is used to support communication with patients.	Technology in place, e.g message boards, loop systems. Log of staff who have received training/CPD activity on use of technology. Log of regular servicing to ensure that technology is working effectively Minutes of meetings. Patient survey.
		2a.8. Up-to-date technology (e.g. video clips, website, remote support) is used following appointments to support the self-management of technological interventions and communication needs	Examples of support Information on website Examples of links to video clips
		2a.11 Written information that is in an accessible format is available that encourages patients and their significant others to engage and communicate with the service through patient forums to facilitate planning, satisfaction auditing and information development etc.	Written information leaflets/posters. Policies. Minutes of meetings.

Standard 3. Assessment

STANDARD STATEMENT	RATIONALE	CRITERIA with consultation comments	Examples of EVIDENCE OF COMPLIANCE **This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.**
3a. All patients receive an individually-tailored Audiological assessment which is carried out to recognised national standards, where available, and includes: • measurement of hearing • assessment of activity limitations related to communication challenges	The need for, and content of, any Individual Management Plan (IMP) requires knowledge of a patient's hearing status [25][42][43]. The quality of assessment is more likely to be assured if undertaken in accordance with nationally recommended procedures [44][45].	**3a.1.** Patients are encouraged to consider the impact of their communication difficulties prior to their assessment appointment	Appointment letters/information Pre-assessment questionnaire
		3a.2. The following are established for every patient, where clinically indicated: • hearing thresholds by air and bone conduction,	Written protocols. Case *audit*. Summary of discussions about medical history, aetiology and further diagnostic assessment within journal entry that lead to

• evaluation of social and environmental communication and listening needs • evaluation of attitudes, expectation, motivation and psychological and/or biopsychosocial impact as a result of hearing status • a relevant medical history.	Measures are compromised if not gathered using equipment calibrated to national and international standards in a quiet test environment [45][46][47]. A relevant medical history is required to develop an IMP [48][49]. Hearing status is a necessary prerequisite, but is not sufficient information alone to configure an IMP [25][50][51]. Understanding the patient's activity limitations, their social and environmental communication needs, their attitudes, expectations, motivation and behaviours as a result of hearing impairment will enable an appropriate Individual Management Plan to be developed [25][52][53][54][55][56][57][58[59][60]][61][62][63]. Validated self-report questionnaires can support the assessment of activity limitations & participation restrictions related to hearing impairment [64][65][66] Validated situation-specific structured questionnaires have been shown to offer significant advantages in clinical settings over more general disability and handicap inventories [25][67][68][69][70]	• thresholds of uncomfortable loudness levels (where indicated) • additional/further diagnostic procedures as required, • a relevant medical history, • co-morbidities affecting condition or its management, • Need for aetiological investigation.	development of IMP and onward referral Examples of onward referral letters
		3a.3. There are written BAA/BSA recommended procedures or protocols being used by all staff in the department and these include air and bone conduction testing, thresholds of uncomfortable loudness levels, and tympanometry.	Written protocols.
		3a.4 Equipment is calibrated annually and documented to international standards, and daily checks are carried out and documented to international standards.	Calibration and equipment check logs/certificates. Clear protocols for calibration (daily and annually) including how and where to report faulty equipment
		3a.5. Hearing tests, with the exception of domiciliary visits, are always carried out in acoustical conditions conforming to	Calibration and equipment check logs/certificates.

		national and international standards which are tested annually.[1] A documented process is in place to assure that test facilities are fit for purpose.	Results of acoustic testing to demonstrate compliance with the above acoustic requirement must be available. Such ambient noise level measurements shall be measured at a time when conditions are representative of those existing when audiometric tests are carried out, including operation of the air-conditioning/ heating system and lighting.
		3a.6. Information relating to the following is routinely gathered and reported at each assessment; • social circumstances • biopsychosocial impacts; • communication and listening needs; • co-morbidities affecting condition or its management; • expectations and motivation	Completed questionnaires. Case *audit* showing the gathering and recording of information Random samples of cases selected by auditors.

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

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

Standard 4. Individual Management Plan

STANDARD STATEMENT **Take out any her/his references**	**RATIONALE**	**CRITERIA with consultation comments**	**Examples of EVIDENCE OF COMPLIANCE** **This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.**
4a. All patients should have an individually developed plan (IMP) for the management and prioritisation of their needs. This plan:	An Individual Management Plan approach is most effective if it takes into account a range of factors in addition to the type and level of hearing loss. An effective IMP relies on consultation	**4a.1**. Within the Audiology service there is an agreed approach to IMP development.	IMP Standard Operating Procedures Service-wide guidelines on use, development and implementation of IMPs,

• is initially based on information gathered at the assessment phase, • is developed in conjunction with the patient and/or their significant other(s), • Is implemented over a series of appointments with the opportunity for revision of needs, actions and outcomes at each stage • is accessible to the patient and/or significant other and the clinical team • includes recommended interventions to best meet needs of patients. • The series of appointments is appropriate and maybe multidisciplinary	between the Audiology professional, the patient and their significant other(s). Only when all parties are committed to the joint goals is an optimal outcome achieved [25][56][58][60][62][63][71[72][73]. Planned and coordinated intervention leads to better outcomes. To be successful, IMPs need to be flexible. Flexibility within the structure of the IMP is beneficial because the content and the goals of the IMP may change over time if the patients circumstances/environment changes. [56][72][74][78]. An effective IMP will detail specific actions associated with agreed goals that take into account a listener's social, communication and listening needs, in addition to their hearing impairment and related activity limitations, e.g. living alone vs family setting vs sheltered accommodation [25][56][75][76]	**4a.2** The IMP includes agreed needs, actions and outcomes. **4a.3.** The clinical record contains details of (this is not an exclusive list): • auditory status, • expectations, • social circumstance • Relevant health status – physical, vision or cognitive issues. • psychological impacts • recommended technological intervention, • recommended non-technological intervention, • referral to other agencies and/or services • specific goals associated with assessment information (the IMP).	including reference to agreed needs, actions and outcomes. *Audit* of clinicians' compliance with service guidelines on use, development and implementation of IMPs. *Audit* of clinical records to ensure inclusion of information on each individual's hearing status, expectations, social status, options for rehab, referral to other agencies and specific goals. Results from individual clinicians' peer review demonstrating compliance with service approach to IMP use. Observation of journal entries Evidence of staff induction training Evidence of ongoing CPD

	This approach requires standardised recording of the patient journey including any interventions and their effectiveness to guide ongoing development of the IMP [42].	**4a.4.** The IMP is agreed and updated with the patient and significant other(s) when new actions and new needs are identified	Service procedures referring to development and provision of IMP. *Audit* of IMP provision Feedback from patients and/or significant others within service satisfaction questionnaire relating to their participation in development of agreed needs and the provision of a copy.
		4a.5. An up-to-date copy of the Individual Management Plan is offered to the patient in an accessible format when new actions and new needs are identified. This should include the patients pure tone audiogram where this has been carried out	

		4a.6. The clinical record includes details of: • the decision making process leading to IMP development • proposed timescales of IMP delivery.	Service procedures referring to clinical record keeping. Case study *Audit* of clinical record Results from individual clinicians' peer review (7d.2.) Decisions making tools

Standard 5. Treatment and Management

STANDARD STATEMENT	RATIONALE	CRITERIA with consultation comments	Examples of EVIDENCE OF COMPLIANCE **This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.**
5a. Where provision of hearing devices are required by the IMP the service ensures that: • Using joint decision-making patients are supported to make an informed choice • patients are offered a hearing device for each ear where clinically indicated • nationally agreed procedures and protocols for fitting and verification are followed at a local level, • performance of hearing devices is carefully matched to individual requirements and settings are recorded.	Professional bodies and national guidelines should be followed to ensure provision meets the needs of the individual [25][76][77]. Evidence suggests that hearing devices are most effective when their performance is carefully matched to the requirements of the individual [80][81][82][93] Where remote care is provided services will follow national/regional guidelines [83][84]	**5a.1.** Criteria for eligibility for hearing devices are evidence-based. Hearing devices are offered to all patients who have been identified as potentially benefiting from amplification within their IMP.	Copies of local evidence-based criteria and policies *Audit* against these criteria/policies Examples of journal entries within patient management system Copies of information/decision aids shared with patients relating to informed choice about hearing devices Patient survey
		5a.2 Standard operating procedures are in place concerning selection, fitting and verification of hearing devices. These comply with the latest professional body and/or national guidance.	Service protocols for selection, fitting and verification of hearing aids compliant with latest national guidance. *Audit* of compliance of all staff to service protocols. Results from individual clinicians' peer review

●			demonstrating compliance with service guidelines on clinical record keeping.
		5a3 Where identified and agreed in the IMP that bilateral devices will best meet the patient's need, bilateral devices are offered and patients are supported to make an informed choice [85][86]	Service eligibility criteria for bilateral hearing aid fitting. *Audit* of compliance of all staff to eligibility criteria. *Audit* of IMP to include record of eligibility, individual need and patient choice. Results from individual clinicians' peer review (7a.4.) demonstrating compliance with service guidelines on clinical record keeping. Copies of information/decision aids shared with patients relating to informed choice about unilateral or bilateral hearing aids.
		5a.4 Current UK audiological professional body best practice methods are used to verify all hearing device fittings at the earliest opportunity.	*Audit* to ensure use of verification methods to verify all hearing aid fittings.

		5a.5 Where verification is contraindicated at the time of fitting, the reason is clearly documented and verification is completed at the earliest opportunity within the patient journey.	Service SOP that includes contraindications to verification at first fitting and guidance on management of these patients. *Audit* of above protocol.
		5a.6 A subjective evaluation of the hearing devices will be performed at fitting. This will include: Sound quality, binaural balance and loudness discomfort.	Journal entry templates Examples of journal entries *Audit* to ensure use of subjective evaluation of hearing devices
5.b. Where provision of hearing related technology is required by the IMP the service ensures that: • Using joint decision making patients are supported to make an informed choice • Patients are supported in use of their hearing device technology • patients are effectively signposted to providers of associated technologies	Hearing related assistive technology can be used alongside or in some cases instead of hearing aids to support effective communication and in meeting individual needs [79][88][89][90]	**5b.1** Information is provided to support the use of hearing technology in an accessible format Local protocols are in place to support patients in the use of hearing technology Hearing related technology options are discussed with individuals when identified within their IMP	Evidence of information provided Local procedures/policies related to assistive technologies Example journal entries on PMS identifying need for assistive technologies within the IMP
		5b.2. Patients are effectively signposted to external agencies for demonstration or provision of assistive technologies where identified within the IMP	Information about local agencies supporting/providing assistive technologies Template referral letters/forms to external agencies

			Examples for PMS showed referral for hearing related assistive technologies
5c Aural rehabilitation is fundamental to supporting patients to manage their communication needs: • by addressing goals identified in their IMP • as a sole management tool or to support the issuing of hearing aids • in a timely manner Where patients residual difficulties remain they have access to specialist audiology services	Evidence suggests aural rehabilitation improves outcomes for patients and their significant other(s) [82][91][92][93][94] This can include improvements in function, activity, participation and quality of life through: • Increased use of hearing devices [99][101][104][107] • Better speech perception in noise [87][97][98][99][102] • Lower perception of hearing handicap [92][95]	**5c.1** All patients reporting hearing problems have access to appropriate aural rehabilitation, including patients unsuitable for aiding, but reporting difficulties.	Service eligibility criteria for intervention advanced aural rehabilitation *Audit* of provision or referral against above criteria

	• Improvement in psychosocial factors [77][92][99] Promotion of self-efficacy and management will result in increased independence [57][62][73][87][94][100][103][105][106]	**5c.2** Local protocols are in operation concerning the selection and provision/referral of appropriate aural rehabilitation. These are informed by the current evidence base, and available interventions should include: • Group and/ or individual Aural Rehabilitation support for patients and their significant other(s) • information provision • patient education • communication tactics • Auditory training • Signposting to Lipreading classes	Pathways for group or individual aural rehab sessions, auditory training and lip-reading training Evidence through *audit* of appropriate provision/referral for non-instrumental interventions to aural rehab sessions, auditory training and lipreading training Results from individual clinicians' peer review (7a.4.) demonstrating appropriate identification and provision/referral for advanced aural rehabilitation Pathways demonstrating referral to specialist audiology services

		5c.3 Where group and/or individual Aural Rehabilitation sessions are in use, these should include: • Encouraged participations of significant others / communication partners • Information provision • Communication tactics • Acceptance of hearing loss • Self-management support	Programme for group or individual aural rehabilitation sessions that include information provision, clear speech training, communication tactics and counselling
		5c.4 The service ensures that staff are aware of currently available specialist rehabilitation, criteria for referral, and details of referral pathways..	Results from individual clinicians' peer review (7a.4.) demonstrating compliance with local protocols Discussions with staff during audit visit Agenda and minutes from Staff training sessions Rates of provision/referral

Standard 6. Outcomes & Clinical Effectiveness

STANDARD STATEMENT	RATIONALE	CRITERIA with consultation comments	Examples of EVIDENCE OF COMPLIANCE **This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.**
6a. The outcome and effectiveness of the Individual Management Plan are evaluated and recorded.	The management of audiological issues, within a comprehensive management plan, involves more than a simple technical matter of fitting hearing devices. It involves the provision of a systematic approach, supported by evidence, which addresses not only the audiological issues, but also other related activity limitations and consequent reductions in quality of life (QoL) [25][71][74] Subjective outcome measures, in the form of relevant, validated questionnaires, can assess the impact of a hearing status on the patient's communication, functioning and activity limitation. This can then be used in the	**6a.1.** Every patient has access to follow up appointments and must be tailored to the needs of the individual.	Local protocol for access to follow up appointments. Evidence of protocol for vulnerable groups *Audit* of IMP and related outcome measures Direct observation within PMS during external audit Local policies and procedures relating to recording individual outcomes Outcome statements for each need for each individual

	evaluation process to measure how effective the IMP has been [64][68][70][105] IMP's help to record multiple outcomes, such as functional benefit, satisfaction and QoL. Measurement of outcome is required to shape further progression of IMP's [25][54][72][77][78] Measurement of outcome is required to obtain feedback (including a progressive evidence base) on the effectiveness and benefit associated with the service delivered to the patient group[64][65][67][69][108][109].	**6a.2.** The Service has systems in place to complete outcomes for all patients. Outcomes are directly related to the needs within the IMP and are recorded within the IMP	Case studies Audit Direct observation within PMS during external audit
		6a.3. When a follow up offer is accepted each patient will be seen within 12 weeks of the hearing aid fitting and local protocols are used to determine the most appropriate method of follow-up. .	Audit of waiting lists Journal entries Case studies Waiting list reporting
		6a.4. Follow-up appointments are comprehensive. Local protocols for follow-up that include: • Evaluation of individual outcomes directly related to individual needs within the IMP. • Identification of further actions required, e.g. onward referral to external agencies for volunteer	SOP detailing standardised follow up process Standardised journal entries Direct observation of journals in the PMS

		support, communication training etc. • Comfort and appropriate handling of any devices is observed. • Provision of advice on long-term maintenance and care. • Provision of information on long-term access to the service for battery replacement, repair and re-assessment. • Evaluation of the reports of the significant other where possible and appropriate	
		6a.5. Following fulfilment of IMP needs, ~~all~~ hearing aid patients, who are not able to self-report, are contacted every 3 years, to offer a re-assessment appointment. Patients, who have specialist care plans are contacted every 2 years as recommended in NICE guidance. n.b. ICBs may evidence agreed timescales for reassessments which differ from the above.	Evidence patients are sent an offer of an appointment in the agreed timescales Evidence of adapted waiting times for specialist groups e.g. those living with dementia and adults with learning disability who are vulnerable to early onset hearing loss.

		6a.6 The outcomes contain information on the *extent* to which the specified goals have been met and include a validated quantitative measure which is appropriate for all the interventions implemented	Evidence of staff compliance in the use of outcomes measures
		6a.7. Outcomes are used to monitor patient progress and to further develop the IMP which may result in the identification of further actions required.	Quantifiable outcome scores being used for all identified needs. *Audit* of outcome tools used to measure instrumental and non-instrumental interventions

6b. Outcomes and effectiveness of the service as a whole are evaluated and recorded to identify trends and patterns which will inform service development and planning.		**6b.1.** Outcomes are analysed at service level to identify trends and patterns within the data and are compared against different factors. Factors will include: • Numbers of patients identified with mild, moderate, severe and profound hearing loss • Trends in age of patients accessing the service • initial disability • postcode • expectations • clinic location • staff involved • use of volunteers • bilateral v monaural aids • other factors	Service level analysis and Service annual report

Standard 7. Skills and Expertise

STANDARD STATEMENT	RATIONALE	CRITERIA with consultation comments	Examples of EVIDENCE OF COMPLIANCE **This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.**
7a Leadership for each service must be able to demonstrate a clear structure with the arrangements for governance and accountability	Quality care needs robust leadership and accountability at all levels**.** Evidence shows that the quality of care and organisational performance are directly affected by the quality of leadership and the improvement cultures leaders create. [110][111] Governance is the means by which effective decision-making, risk management and the right outcomes are delivered, these outcomes include ensuring the delivery of safe and effective services in a supportive, caring and compassionate environment; in collaboration with senior management and wider heath care systems and stakeholders [110a]	7a.1 Clarity of role (leadership) Reporting arrangement Governance arrangement All staff have clarity of their role and objectives in the service, and are clearly aware of reporting lines and governance arrangements.	Clear department structure which includes: • operational structure • professional structure • line managers • Clinical supervisors • Specialist clinical leads All leadership/management staff have suitable management training to fulfil their roles and responsibilities All staff are aware of how to access senior support as appropriate in a timely manner Actions identified and outcomes recorded where gaps have identified.

7b. 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.	Regulatory Bodies' 'Standards of Proficiency' statements detail requirements for registered practitioners to remain registered. These are produced for the safe and effective practice of the professions they regulate and are deemed to be the minimum standards which are necessary to protect members of the public [114][114a][115] To help ensure a safe and effective service, all people working with Audiology patients should work within their agreed Scopes of Practice and have the skills required for their contribution towards patient care [112][113][114] Registration bodies and employers require demonstration of regular CPD activity. Facilities to access CPD close to the point of work and in association with colleagues is advantageous [113][114][117]. Peer review provides a useful approach to help ensure clinical	**7b.1** All eligible, clinical staff working in Audiology are registered with a registration body. [1]	List of all staff including temporary, part time and locum Registration numbers Reasons for not registering
		7b.2. Nationally-agreed Scopes of Practice are adhered to (e.g. BAA scopes of practice).	*Audit* of appointments Crystal report of people v tasks Discussions with staff during external audit visit Just check job descriptions

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

	competencies are maintained [118][119]. To ensure safe and effective outcomes for patients it is important that there are safeguards in place governing the employment and deployment of volunteers [120][121][122][123]		
		7b.3. All staff working in Audiology have deaf awareness and communication training. New starters should receive training routinely as part of the induction process. Training is updated every 3 years and provided by an external source.	Training records Auditors speak to staff

7c. Volunteers significantly enhance the services provided by paid staff, thereby greatly improving the experience of patients and their families. .	To ensure safe and effective outcomes for patients it is important that there are safeguards in place governing the employment and deployment of volunteers [120][121][123][124].	**7c.1** All volunteers are registered with a third sector/NHS organisation or managed within local/regional volunteering policy.	List of volunteers and associated organisations HB/Trust volunteering policies Evidence of adherence to HB/Trust volunteering policies Evidence of completed recruitment process including DBS
		7c.2 Local Scopes of Practice and competency-based training are implemented for all volunteers	Volunteer scopes of practice Evidence of competency assessments and completed training logs Examples of volunteer referral form and feedback from volunteers following patients contact Volunteer training materials

		7c.3. Patients have access to support from trained volunteers for hearing aid maintenance and advice: • Evidence of availability of volunteer support. • Data relating to the number of patients referred to and receiving volunteer support. • Postcode analysis of patients using the volunteer service. • Activity types	Report summarising evidence for the criteria as listed.
		7d.1 All clinical staff and volunteers participate in CPD activity.	Local systems for ensuring staff attend and record CPD Discussions with staff during external audit visit
		7d.2 Clinical supervision and direct peer reviews are ongoing and all types of clinical activities are included over a 3 year period for all registered clinical staff and one year for non-registered clinical staff.	Local procedure/process for peer review Peer review checklist for all procedures and/or appointment types List of details/dates of completed peer reviews

		7d.3 There is a department process for dealing with the outputs of the peer review observations. This will include sharing of good practice to the wider team and management of areas of concern. There is evidence of progress against actions plans	Local procedure/process for peer review includes dealing with findings Evaluation of peer review observations Action plans linked to peer review observations Documented evidence of progress against action plans

Standard 8. Collaborative Working

STANDARD STATEMENT	RATIONALE	CRITERIA with consultation comments	Examples of EVIDENCE OF COMPLIANCE **This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.**
8a. Each Audiology service has in place processes and structures to ensure effective collaborative working. Collaborations appropriate to patient and service needs should be identified and established and may be with internal and external agencies and services.	Understanding the collaborations required to deliver an effective, joined up service will improve service user experience and outcomes [123][124][126][127][128][129][130][131]. Having awareness of and appropriate links and referral mechanisms to specialist Audiological services, other health services, Social Services, peer and voluntary sector support is more likely to result in the hearing, communication and additional health needs of patients being met [30][132][133][134][135][136][137]	**8a.1**. Audiology services identify a comprehensive list of external organisations it needs to work with in order to provide a joined up service for service users. These would typically include: • Social Services • Third sectors • Primary Care • ENT Service • Sensory teams • Fire Service • Dementia Services • Learning Disability Services	List of external organisations and reasons for collaborations.

	Planning and coordinating services in collaboration with stakeholders (including service users and their significant others) is more likely to result in services that better address the needs of the patients [137][138][139][140][141].	**8a.2.** Written protocols/processes are in place to support referral to other services/agencies:	Copies of referral pathways including methods of assessing outcomes and protocols for the collaborative partners used Evidence through referral rates to collaborative partners Evidence of links to external organisations providing a range of holistic support to patients.
	In order for agreed interventions to be effective, referral to another agency/service for interventions should be prompt so as to be based upon an up-to-date appraisal of need [79][139].	**8a.3.** Where referral to another agency/service is indicated, referral is made from Audiology within 7 days of appointment.	*Audit* of time from patient appointment to referral being sent.
		8a.4. Mechanisms for assessing and improving the effectiveness of external relationships and the resultant impact on patients arising from onward referrals/signposting	Patient feedback/outcome reporting Evidence of actions and patient outcomes following outward referral recorded within the patient record.

		Local process in place for vulnerable patients to ensure onward referral has been actioned Where further Audiology intervention is requested, this is actioned as appropriate.	Evidence patients are given information to ensure they have relevant contact details to follow up on referrals made on their behalf. Evidence patients are given external organisation information to enable self-management and referral follow up.
		8a.4. Referrals to collaborative partners are analysed at service level to identify areas requiring improvement and acted upon.	Reports related to service level evaluation of outward referrals. Action plans linked to the above reports
		8a.5. Audiology works strategically with external organisations. Where mandatory groups exist, membership and shared group objectives for these collaborations should be clearly stated. There may be a number of separate collaborations relevant to different aspects of the service being provided	A statement of purpose and Clear aims and objectives are identified in group memberships

		8a.6. Information provided to patients, including information on websites and noticeboards, is developed in collaboration with service users and local corporate communications teams, and is reviewed annually.	Minutes of meetings to review information. Plain English (or similar) on all information
		8a.7. Action plans to meet shared group objectives should be developed, implemented and monitored	Examples of action plans developed to deliver group objectives. Evidence of progress against action plans
		8a.8 Service users are included within membership of Audiology working groups	Service users and volunteers listed as part of the membership

Standard 9. Service Development

STANDARD STATEMENT	RATIONALE	CRITERIA with consultation comments	Examples of EVIDENCE OF COMPLIANCE **This list contains examples that you may wish to include as evidence. This is not an exhaustive list and you may have different forms of evidence to support your self assessment score.**
9a. Each service has processes in place to measure service quality. Quality measures are used to plan and implement service developments	Measurement of qualitative and quantitative data helps to inform ongoing service improvement and/or developments [141][142][143][144][152][153]	**9a.1** The Audiology service has a framework in place to ensure ongoing collection of qualitative and quantitative data relating to service performance and service user experience and the annual reporting of this data	Service review framework that outlines the what, when, where and how this data will be collected and reported

		9a.2. Patients and significant others are encouraged to complete surveys on a continuous basis to determine satisfaction with different elements of the service received which should include: • Service users have access to PSS in a variety of formats to suit their needs throughout their patient journey • All patient populations with protected characteristics • All locations • Include All clinicians • Include all types of appointments including repairs.	Evidence of representational coverage including gender, ethnicity, age and all locations of service delivery), in line with local policies Evidence of promotion routes and formats. Face to face discussions with staff Annual self-assessment and/or external audit scores.
		9a.3 Results of satisfaction surveys and service quality rating tool scores remain on public display in Audiology waiting rooms and websites and are discussed with patients on ~~an~~ at least an annual basis.	Direct observation during external audit visit Minutes of events in 9b.1. include discussion of service satisfaction questionnaires and adults quality standards audit results.

			This will be evidenced in the annual service review
		9a.4. Actions are identified from patient satisfaction surveys outcomes are shared with internal and external stakeholders. Plans to address poor patient satisfaction survey scores are recorded.	Actions identified from results of patient satisfaction surveys are published
9b. Each service has processes in place to keep up to date with and employ key innovations relevant to Audiology.	Use of up-to-date technology and models of service delivery is integral to effective service delivery and ongoing development [108][111][148][149][150][151].	**9b.1.** The Audiology service has a systematic approach to the coordination, identification and appraisal of Audiological innovations.	Local procedure/policies for appraisal of innovations Examples of use of the approach (identification to implementation) Local procedure/policies for appraisal of innovations Examples of use of the approach (identification to implementation)

9c. All relevant information is used to review and implement a comprehensive service development plan. This will reflect the outcomes of all the standards, summarise where actions are needed, key performance indicators, patient satisfaction surveys etc		**9c.1.** Using all of the information gathered above and information gathered within 1c5, 6b1, 9a4, and the results of the Quality Standards visit, an ongoing programme of service improvement is in place and has been actioned.	Service improvement Plan including reference to all elements within Std 9 and criteria 1c5 & 6b.1. Direct discussions with staff during external audit visit Timescales for implementation of service improvements Key Performance indicators for service improvements ONS website to pull demographic data to support report.

The quality standards audit tool should be implemented with the consideration of the key point below.

Overarching statement

For those individuals who do not suit routine pathways there is evidence their needs are met throughout the Standards

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