Classification: Official

NHS England

Paediatric Hearing Services Improvement programme – technical guidance (July 2026)

Contents

1. Introduction

1.1 Purpose of this guidance

This guidance sets out the processes, standards and expectations for delivering safe, high-quality hearing review, recall and reassessment within paediatric audiology services in England. It provides a consistent national approach so that services can mitigate risk, reduce harm and support families through every stage of the review, recall and reassessment pathway.

This guidance supplements the Paediatric Hearing Services Improvement programme – operational guidance and is supported by additional resources on the Futures Collaboration Platform. It has been developed by subject matter experts (SMEs) with experience in the process, with input from the Paediatric Hearing Services Improvement (PHSI) programme Clinical Reference Group and parents, supported by the National Deaf Children's Society (NDCS).

For the purposes of this guidance, the terms baby and child are used interchangeably, and review, recall and reassessment activity applies to babies, children and young people.

1.2 Who should read this guidance?

This guidance is for NHS England regions, integrated care boards (ICBs), providers and SMEs involved in patient review, recall and reassessment. It applies to adult audiology services that test paediatric patients and should have competent and trained staff for paediatric audiology practices.

2. Communicating with families

Effective, timely and compassionate communication with families is essential throughout the review, recall and reassessment process. Families need clear information about what has happened, what it means for their child and what will happen next. Strong communication not only supports families to engage with the process but also helps maintain trust and enables families to make informed decisions about their child's care.

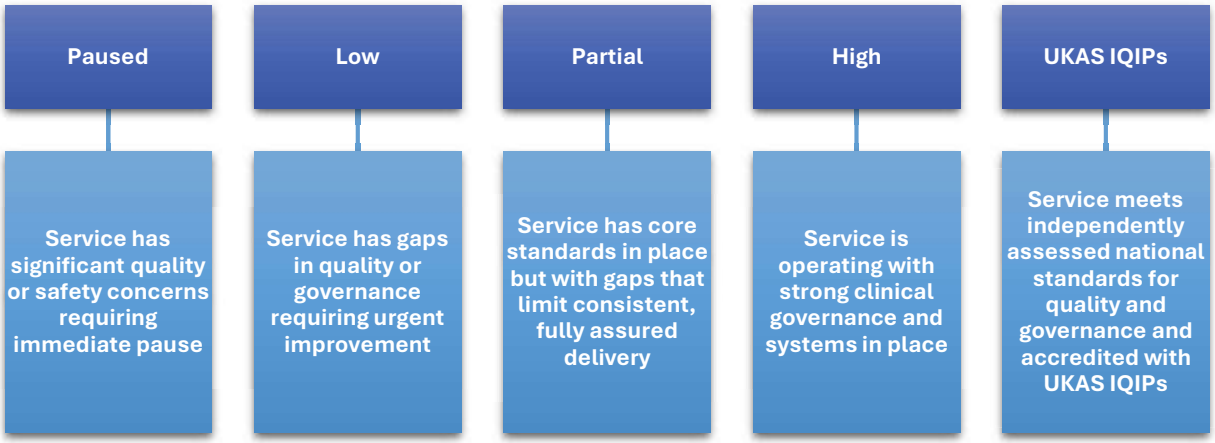
The NDCS provides support to families during the review and recall process. The NDCS has worked with families who have been through the process to develop recommendations on appropriate communication (see Appendix A).

Services must ensure that all contact, whether written, verbal or via accessible formats, is personalised, supportive and sensitive to individual needs, including language, cultural considerations and additional communication requirements. Communication with families should follow the principles developed with parents and the NDCS: explanation – action – signposting – feedback. Families consistently report valuing honesty, clarity, empathy and information that is directly relevant to their child.

3. Paediatric audiology service assurance levels

Paediatric audiology services should deliver consistently high-quality care, using continuous quality improvement to strengthen practice and develop a culture of quality improvement. Services are assessed by SMEs against 5 assurance levels. These are: United Kingdom Accreditation Service (UKAS) Improving Quality in Physiological Services (IQIPS) accredited, high, partial, low and paused.

Figure 1: Paediatric audiology service assurance levels



3.1 UKAS IQIPS accredited services

UKAS IQIPS accreditation represents the highest level of service assurance. This is an independent, externally assessed accreditation scheme delivered by UKAS, which is designated through legislation as the UK's national accreditation body.

UKAS IQIPS accreditation provides assurance that services have:

- a quality management system and clinical governance framework in place, including effective clinical leadership, oversight, safety and risk management, and systems to support continuous quality improvement
- demonstrated technical competence, including appropriate facilities, equipment and testing practice, calibration and validation alongside robust record keeping and data management arrangements
- a competent and appropriately trained workforce, with supervision, competency assessment and continuing professional development in place, and ongoing compliance with nationally recognised standards

3.2 High assurance services

High assurance services are operating with strong clinical governance and core standards, systems and controls in place, and are likely to be working towards UKAS IQIPS accreditation. The service's assurance level is agreed as high across the provider, ICB, regional and local incident management team with evidence of meeting similar standards to those within the UKAS IQIPS accreditation as set out below.

High assurance services demonstrate the following:

- established standards and operating procedures in place, aligned to national guidance and good scientific practice and embedded in day-to-day service delivery, with improvement and clinical mitigation action plans completed
- robust clinical governance arrangements, including defined clinical leadership and oversight of risk reporting
- maintained and calibrated equipment
- data and digital systems in place to support service delivery and assurance
- reliable capture, review and reporting of activity, outcomes, audiology waiting times and quality indicators [for example, Newborn Hearing Screening Programme (NHSP) and DM01]
- waiting list management arrangements in place, including active patient triage and prioritisation for children waiting to be seen, with a clear action plan in place for services holding large waiting lists, endorsed by the ICB as meeting high assurance requirements
- staff competency systems in place that are appropriate to paediatric audiology practice
- mechanisms in place to capture and review patient and family experience, with learning used to inform service improvement
- progressing towards UKAS IQIPS accreditation

3.3 Partial assurance services

Partial assurance services meet most core standards, systems and controls, with identified gaps that require further improvement before the service can be considered high assurance. The service's assurance level is agreed as partial across the provider, ICB, regional and local incident management team.

Partial assurance services demonstrate the following:

- standards and operating procedures in place, aligned to national guidance and good scientific practice, but may not be consistently applied across all areas of the service

- clinical governance arrangements in place, including identified clinical leadership and risk reporting mechanisms, though governance systems may not yet be consistently effective
- maintained and calibrated equipment
- data and digital systems in place to support service delivery and oversight
- evidence of regular data review and reporting (for example, NHSP and waiting times)
- waiting list management arrangements in place, including active patient triage and prioritisation for children waiting to be seen, with a clear action plan in place for services holding large waiting lists, endorsed by the ICB as meeting partial assurance
- staff competency systems in place with evidence of trained staff, but there may be gaps in supervision, competency assessment or resilience
- mechanisms in place to capture and review patient and family experience, though learning to inform service improvement may be variable
- progressing towards UKAS IQIPS accreditation
- smaller spoke services should work with local larger hub services if support is needed and to have clear clinical pathways and oversight arrangements

For the PHSI programme the following apply:

- improvement and clinical mitigation action plans underway
- evidence of service undertaking or having completed whole cohort review, reassessment and recall where required

3.4 Low assurance services

Low assurance services have significant gaps in core standards, systems and controls. The service's assurance level is agreed as low through provider, ICB, regional and local incident management oversight.

Low assurance services demonstrate one or more of the following:

- standards and operating procedures are absent, incomplete or not reliably applied, with identified quality and safety concerns
- clinical governance arrangements may require significant improvement
- absence of maintained and calibrated equipment
- data and digital systems may not be in place to support service delivery and oversight
- evidence of regular data review and reporting (for example, NHSP and waiting times)

- waiting list management arrangements may not be in place, with limited or absent patient triage and prioritisation. All services should immediately actively triage and prioritise patients if not already doing so
- staff competency systems may be insufficient; there may be gaps in supervision, competency assessment or resilience. Insufficient staffing resulting in operational delivery reliant on one or two individuals
- mechanisms in place to capture and review patient and family experience, though learning to inform service improvement may be variable
- smaller services should work with local larger services if support is needed

For the PHSI programme the following apply:

- improvement and clinical mitigation action plans in place or at an early stage, with provider chief executive endorsement
- services that are required to undertake review, recall and reassessment are categorised as low assurance until recall activity has been completed

3.5 Reassessment of assurance levels

Reassessment of assurance levels is led by the ICB, in agreement with the region. ICBs are responsible for maintaining oversight of services, ensuring required actions have been completed, delivery and quality and feeding outcomes back to providers. Regional teams provide guidance and support. Services can be reassessed and de-escalated on completion of a **repeat onsite review visit when moving from low or paused, or desktop review when moving from partial to high assurance**.

3.5.1 Moving from low to partial or high assurance

To move from low assurance, services must demonstrate that they meet the required definitions for partial or high assurance and auditory brainstem response (ABR) staff competency has been assessed. Staff ABR competency requirements are:

- completion of a higher education institution ABR course
- a minimum of 30 sequential ABR reviews, of which 5 were non-discharge cases, double reported by an SME, with no discrepancies
- a minimum of 3 months where ABR traces have been double reported by an SME, with no risks or concerns raised
- assessment of staff competency and documentation undertaken by an SME

3.5.2 Moving from partial to high assurance

To move from partial to high assurance, services must demonstrate that they meet the required definition for high assurance.

3.6 Paused services

Services are paused when quality and safety concerns are identified that require an immediate pause, either fully or partially, to service provision until improvements are made. Services should only be paused where there are genuine concerns around service delivery and after careful risk assessment and consideration of the impact on the local population and neighbouring services. Consideration should also be given to the potential impact on waiting times. Pausing a service should be limited to specific areas of concern, such as ABR or visual reinforcement audiology (VRA) testing. The decision to pause a service should be taken by the responsible ICB with involvement from the region, including the regional medical director. It should be based on local intelligence of safety, service quality and risk assessment, and an onsite peer review visit.

Before pausing a service, the responsible ICB should ensure a clear communications plan is in place for engaging with stakeholders, patients and families. When pausing a service, the responsible ICB should notify patients and families, those on waiting lists; local healthcare professionals including those working in primary care, such as GPs; other referring services and teams, such as speech and language therapy and teachers of the Deaf; the Care Quality Commission (CQC); UKAS.

All paused services should follow the incident management process to ensure patient safety and triage alongside active improvement. The ICB should identify local services to provide mutual aid for patients on the waiting list or undergoing review. The ICB should ensure service provision is re-established as soon as possible and patients on waiting lists are triaged accordingly.

For paused services it is possible children may have experienced a delay in management that could result in harm. This must be mitigated through clinical and operational measures such as service improvement actions, which may include mutual aid, SMEs providing support from other services for double reading of diagnostic traces, staff competency assessments and training, participation in external peer review, SME support to instigate waiting list triage and patient prioritisation, consultant clinical scientist leadership and quality improvement. Harms assessments should be undertaken in line with the guidance. A second site review visit must be carried out before a service is re-opened to ensure all the quality issues have been addressed.

3.7 Re-opening services

The ICB is responsible for the decision to re-open a service. To ensure patient safety and quality of service provision, the decision should be made in agreement with the local incident management team following a risk assessment and with endorsement from the regional medical director. Services can re-open at low assurance if the appropriate mitigations are in place, as listed above. A follow-up site review visit prior to the re-opening of services is encouraged. This will help ensure any required mitigations are in place and to re-assess staff competency.

A service should have a clear communications plan for engaging with stakeholders and families. When re-opening a service, the responsible ICB should notify service users and those on waiting lists; local healthcare professionals including those working in primary care, such as GPs; other referring services and teams, such as speech and language therapy and teachers of the Deaf; the CQC and UKAS.

Services need to follow the process for de-escalation from ABR double reporting (see Table 8). When re-opening a service, the backlog of patients should be triaged into 5 groups so focus can be given to those with the most pressing need.

3.8 ICB considerations when pausing or re-opening a service

ICBs and providers should consider the actions below when planning to pause or re-open a service:

- ensure a provider level action plan is agreed and signed off at executive level, including resource requirements, and is shared with the responsible ICB board
- secure support from a named provider senior leader, adequate local resource and audiology expertise to deliver transformation at pace
- ensure operational support is in place, including administrative support for clinic delivery and appointment management
- confirm physical capacity, available locations and equipment capacity, including room availability and the number of patients who can be tested with current equipment (pre/post usual clinics/out of hours)
- secure quality service management expertise to input into the action plan
- seek additional SME support to help with waiting list triage and patient review. To request support from the national SME register, contact england.csohearingprogramme@nhs.net – and include how many SMEs are required, the tasks they will undertake and the time and location needed
- have a structured clinical approach to additional clinics based on the number of patients needing review. This could include grouping patients by clinical assessment need and considering how to maximise available clinical sessions (even when out of hours)
- request mutual aid from neighbouring high-quality services
- bolster staff competency by shadowing neighbouring high-quality services for training
- maximise the use of trainees and junior staff to support and bolster clinical activity
- have a clear communications plan for engaging with service users and stakeholders such as GPs, CQC, UKAS, ENT specialists, speech and language therapists and teachers of the Deaf
- support the wellbeing of staff throughout the process
- ensure recording and harm review planning is in place for patients

4. Key performance indicators

Quality indicators, such as screening and waiting time quality indicators, provide objective measures of service performance and support assurance of paediatric audiology services. The indicators set out below draw on established national data sets, including the NHSP and DM01 waiting time data, to assess timeliness, access and potential risk across the pathway.

Performance against these indicators supports the overall assurance assessment by highlighting areas of good performance, emerging risk or required improvement, and should be considered alongside wider clinical, governance and operational evidence.

Compliance with these key performance indicators aligns with assurance level categorisation detailed in section 3.

Table 1: Key performance indicators

Category	Low assurance – any low	Partial assurance – any partial	High and UKAS IQIPS accredited – all measures
NHSP SO4 – number of babies referred from screen offered appointment <4 weeks	Not achieved	Acceptable threshold reached ≥97.0%	Achievable threshold reached ≥99.0%
NHSP SO5 (KPI NH1) – number of babies referred from screen who attend appointment <4 weeks	Not achieved	Acceptable threshold reached ≥90.0%	Achievable threshold reached ≥95.0%
Newborn hearing screening yield of babies identified with a permanent childhood hearing impairment (PCHI)	>2.0 x standard deviation from the mean	1.5 to 2.0 x standard deviation from the mean	<1.5 x standard deviation from the mean
Median days to hearing loss confirmed from date of outcome set for immediate referrals	>2.0 x standard deviation from the mean	1.5 to 2.0 x standard deviation from the mean	<1.5 x standard deviation from the mean
Proportion of babies immediately referred from screen with hearing status not yet determined (NYD) at latest session	>2.0 x standard deviation from the mean	1.5 to 2.0 x standard deviation from the mean	<1.5 x standard deviation from the mean

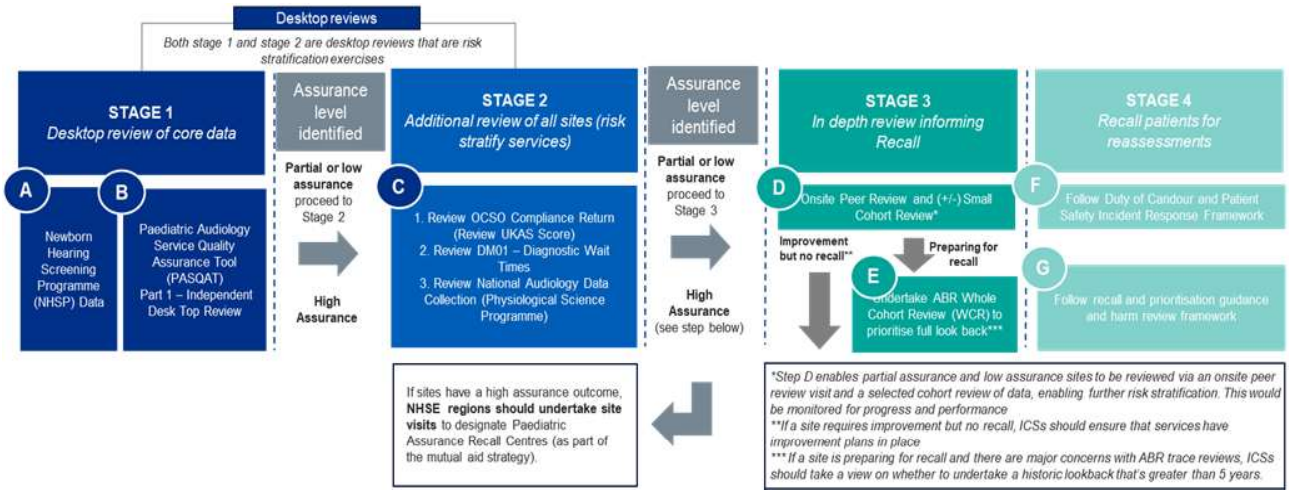
Category	Low assurance – any low	Partial assurance – any partial	High and UKAS IQIPS accredited – all measures
DM01 or ENT waiting list data (patients above x weeks)	Any patients waiting 13+ weeks	Patients waiting between 6 and 12 weeks	100% of patients waiting <6 weeks
52-week waits	Any patients waiting 52 weeks	No patients waiting 52+ weeks	No patients waiting 52+ weeks
Hearing aids fitted within 4 weeks of diagnosis	<80% fitted within 4 weeks	80% fitted within 4 weeks	100% fitted within 4 weeks
Education Health and Care Plan needs assessment contribution within 6 weeks	<80% within 6 weeks	80% within 6 weeks	95% within 6 weeks
Patient and family mechanisms for feedback provided	Not in place	In place	In place
Prioritisation and triage	Not in place	In place	In place
UKAS IQIPS accreditation (all services to be accredited by 2029)	Not in place	Discussions taking place with UKAS	Registration and/or benchmarking scheduled
Continuity of care and transition	Not in place	In place	In place
Equipment maintenance and calibration programme	Not in place	In place	In place
Data and digital systems and interoperability	Not in place	In place	In place

5. Review to determine whether recall and reassessment is required

5.1 National service assurance framework

The national service assurance framework shows the different stages of the review, recall and reassessment process.

Figure 2: National service assurance framework – stages 1 to 4



Stage 3 determines whether a full cohort review and recall of patients is necessary. During this stage, the ICB, supported by SMEs, leads onsite peer review visits.

Alongside the onsite peer review visit, an auditory brainstem response (ABR) small cohort review may be conducted. Where providers have risks flagged for ABRs, double reporting by an SME must be put in place for patients seen in the service. Otoacoustic emission (OAE) following the onsite peer review visit may be required as a mitigation for behavioural assessments. A small ABR cohort review will be required for ABR high risk sites. For visual reinforcement audiometry (VRA), a case study review will be required for high-risk sites only. In cases where there are significant concerns with the ABR service or a full cohort review is expected, the ABR small cohort review may be bypassed with the service proceeding directly to a full cohort review.

The minimum look back period is 5 years. If there are long standing historical issues within identified services, extending the look back in a phased approach should be considered to recall and reassess all children where needed but prioritise the highest risk cases.

5.2 Onsite peer review and escalation of concerns

For the onsite visit, a draft agenda, notes for reviewer template and feedback template is available on the Futures Collaboration Platform to support SMEs. The ICB will initially give verbal feedback to the service.

If SMEs note a requirement to raise queries or escalate concerns regarding services within a provider, ICB or region, they should follow the regional quality reporting system. If support is needed to identify the appropriate regional contact, please email: england.csohearingprogramme@nhs.net.

5.3 Involvement of families and system partners

Where an ICB Strategic Response Group has been established, a representative from the NDCS should be invited to attend. Please contact NDCS ndcs@ndcs.org.uk to arrange this. NDCS can support families throughout the process and should be aligned with services once recall and reassessment is identified as required. Providers and ICBs should work with NDCS to agree an appropriate information governance agreement depending on the service. The NDCS has worked with families who have been through this process to identify what they would like regarding communications (see Appendix A).

6. Auditory brainstem response (ABR) diagnostic review

The ABR diagnostic review provides a structured national approach to evaluating historical ABR testing. It determines whether further cohort review or immediate recall is required. The ICB should support providers to commission the review.

6.1 ABR small cohort review

A small cohort review offers a rapid assessment of historical clinical information relating to ABR testing. Where a small cohort review is being undertaken, existing diagnostic ABR cases being seen should be double reported in real time by staff from a high assurance or UKAS-accredited service.

The lead SME will provide the service with the list of confidential IDs of babies/children included in the review with instructions for submitting all required documentation. This includes: ABR traces, OAE traces, any internal or external peer review report, Smart4Hearing summaries, clinical notes, clinical letters, OAE discharge criteria used at time of testing and associated incident reports.

The service must inform the SME review team where diagnostic data cannot be provided or where a baby/child was referred from screening but has not been seen locally (movement into the area post ABR test). In this case, an alternative confidential ID will be supplied. All data should be provided within 4 weeks.

Where an SME raises concerns regarding the quality or interpretation of the data or the management of the findings, this should be validated by a second SME. Confirmation of an ABR testing or interpretation issue will lead to a full 5-year cohort review.

A template for the ABR small cohort review is available on Futures Collaboration Platform.

6.1.1 Identifying records

To undertake ABR small cohort review, the review team must request a list of confidential IDs for all babies referred from the NHSP national team over a 5-year period. The review cohort, selected at random from the previous 5 years and including a selection of traces for each tester within the department, should include the 5 groups in Table 2 below.

Table 2: ABR review cohorts

Cohort	Detail	Number of records from each year group
Cohort 1	Babies who have a permanent childhood hearing impairment (PCHI) flag in the Smart4Hearing system	10% of cohort (with a minimum of 2 records) Selected evenly for all testers within the site
Cohort 2	Babies set as 'not yet determined' at the time of data analysis who did not appear in cohort 1	5% of cohort (with a minimum of 2 records) of any age **and** 5% of cohort (with a minimum of 2 records) >10 weeks of age Selected evenly for all testers within the site
Cohort 3	Babies whose screening had been set to 'screening contra-indicated' where they did not appear in cohort 1 or 2	10% of cohort (with a minimum of 2 records) Selected evenly for all testers within the site
Cohort 4	Babies referred from the screen with a satisfactory reported ABR	5% of cohort (with a minimum of 2 records) unilateral referral **and** 5% of cohort (with a minimum of 2 records) bilateral referral Selected evenly for all testers within the site
Cohort 5	ABR referrals referred from other sources (identified by the site) (full cohort review only)	

The ICB Strategic Response Group (Incident Management Group) should consider extending the timeframe, number of cases reviewed or both if there is evidence of serious incident, whistleblowing, parental complaint, disputed ABR peer review findings or other local information suggesting the need for an extension.

6.1.2 Inclusion criteria

The ABR small cohort review must include all babies/children born in the determined timeframe, referred from the NHSP and who underwent an ABR test. The following babies/children must also be included:

- babies/children referred for ABR testing by other methods outside the scope of NHSP (for example, sedated ABR in theatre, referrals from paediatrics or other health professionals)
- babies/children seen within the audiology service who may have been referred from a neighbouring NHSP service

The service must make every attempt to identify babies and children who have moved out of the area and ensure that a recall and reassessment is undertaken where needed. If babies/children have been identified as having moved or are suspected to have moved out of area, the service lead or responsible individual for the recall and reassessment activity should link with the ICB nominated lead to co-ordinate locating the baby/child and signpost them to a high assurance or UKAS accredited service within the new locality, including whether this is in another ICB.

Young people in secure settings should be included in review, recall and reassessment through their GP. Some young people may be in a setting outside the local area and any children who cannot be located on local lists should be cross-checked in case they are in a secure setting. For further information, contact regional leads or england.csohearingprogramme@nhs.net.

6.1.3 Exclusion criteria

Babies/children should be excluded from the review who:

- obtained bilateral clear responses at the newborn hearing screening
- reside in the catchment area of the audiology service but had the diagnostic assessment completed elsewhere to a satisfactory standard

6.1.4 Undertaking the small cohort ABR review

To undertake the review, 2 SMEs act as external and independent assessors, with one as the assigned lead. SMEs should be currently practising or have maintained continuing professional development in ABR testing, be appropriately registered (with the Academy for Healthcare Science and/or Registration Council for Clinical Physiologists and/or the Health and Care Professions Council) and have completed appropriate training (external training course or peer review group training). The lead SME will co-ordinate and collate the responses from the reviewing team and complete an end point report, including any learning and possible risks. The cohort should be split evenly between reviewers, with at least 1 case from each category per reviewer. The reviewers should grade the ABR using the information in Table 3 and the template for the ABR small cohort review, considering the quality of the ABR testing, compliance with recommended British Society of Audiology (BSA) standards at the time of the test, use of clinical time and onward management of the baby/child.

Table 3: ABR small cohort review grading

Review grade	Descriptor	Action required	Required next steps
A	Met the standard at the time, no issues	None	None
B	Minor issues which do not affect the clinical outcome, such as unusual filter set, or rejection level has been used without any justification	10% of records should be reviewed by the 2nd SME. The SME group should agree the outcome – where a disagreement occurs, a further opinion should be sought from another SME in the region	Learning should be shared with the provider and possible risk noted
C	Any issue which affects the clinical outcome, such as incorrect reporting of response absent as clear response	All records in this category should be reviewed by the 2nd SME. The SME group should agree the outcome – where a disagreement occurs, a further opinion should be sought from another SME in the region	Full cohort review is required – see section 9
D	Unable to review record (data issues)		Full cohort review is required – see section 9

6.1.5 Reporting on a ABR small cohort review

On completion, the lead SME should provide the ICB Strategic Response Group with:

- a summary of the findings using Table 4 (complete the details of the reviewer(s), number of records in the cohort and number of records rated according to each review grade)
- key themes or findings for learning and possible risks from the review
- recommended action – either no further action or proceed to full cohort review required

If patients are identified as requiring recall and reassessment they should be recalled without delay.

Table 4: ABR small cohort and full cohort review reporting

Review cohort	Reviewer(s)	Number of records in the cohort	Number of records rated according to the review grade	
Cohort 1 Babies who have a permanent childhood hearing impairment (PCHI) flag in the Smart4Hearing system			A	
			B	
			C	
			D	
Cohort 2 Babies set as 'not yet determined' at the time of data analysis who did not appear in cohort 1			A	
			B	
			C	
			D	
Cohort 3 Babies whose screening had been set to 'screening contra-indicated' where they did not appear in cohort 1 or 2			A	
			B	
			C	
			D	
Cohort 4 Babies referred from the screen with a satisfactory reported ABR			A	
			B	
			C	
			D	
Cohort 5 ABR referrals referred from other sources (identified by the site) (full cohort review only)				

6.2 ABR full cohort review

SMEs involved in the small cohort review should lead on the full cohort review. A minimum of 2 SMEs (recommendation of 3 SMEs) should undertake full cohort review, dividing the cases for review. Once reviewed, a 10% audit check should be carried for A/B as above and all C/D cases should be reviewed by another SME.

Double reporting mitigations should continue for all ABR cases in the service until staff have undertaken and passed a higher education institution ABR course, had a minimum of 30 traces double reported by an SME with no significant issues and completed a minimum of 3 months where ABR traces have been double reported by an SME.

All data being shared should be anonymised, and the NHSP national IT system, Smart4Hearing confidential ID should be used as the case identifier.

Providers and the review team should agree a secure data sharing process. For each record, the service should submit information on: ABR traces, OAE traces, detail of what OAE equipment was used, any internal or external peer review report, Smart4Hearing summaries, clinical notes, clinical letters, OAE discharge criteria that were used at time of testing and any associated incident reports.

The service must inform the SME review team where diagnostic data cannot be provided or where a baby/child was referred from screening but has not been seen locally (movement into the area post ABR test). In this case, an alternative confidential ID will be supplied. All data should be provided within 4 weeks.

Where an SME raises concerns regarding the quality or interpretation of the data or the management of the findings, this should be validated by a second SME. Confirmation of an ABR testing or interpretation issue will lead to a full 5-year cohort review.

The ABR full cohort review template can be used to record the review outcome.

6.2.1 Identifying records

The lead SME should request and receive a full cohort report of all referrals from NHSP for the previous 5 years as a minimum. It should include the 5 cohorts in Table 4 above. The ICB Strategic Response Group should consider extending this timeframe as detailed above.

6.2.2 Inclusion criteria

Providers will request the full cohort from the lead SME, including records of babies/children born in the determined timeframe, referred from the newborn hearing screen to audiology services for immediate diagnostic assessment and who underwent an ABR test.

Babies/children who were tested by the service who have moved out of the area are still eligible for review. Inclusion criteria include all babies/children as listed above (not a sample from the service). Babies/children meeting the inclusion criteria are subdivided into the 5 cohorts detailed in Table 4.

6.2.3 Exclusion criteria

As per small cohort review above.

6.2.4 Undertaking the full ABR cohort review

The lead SME should complete an end point report, with the cohort split evenly between the reviewers. The reviewers should consider: the quality of the ABR testing, compliance with recommended BSA standards in place at the time of the test, use of clinical time, the onward management of the baby/child, including hearing aid management, and any onward referral to cochlear implant teams. They should also take into account any further behavioural testing that may have taken place after the ABR, which may reduce the overall risk for the baby/child.

6.2.5 Prioritisation of patient recall

The ABR test should be graded as detailed in Table 5 and the children prioritised for recall according to the review findings. For records in group C, where urgent intervention is required, this should not be delayed until the end of the review. For example, if an ABR has been misinterpreted and the child has missed hearing aid amplification or referral for a cochlear implant, there should be no delay in recalling the child. Mutual aid should be arranged prior to the full cohort review.

Children in groups C and D need to be prioritised for recall. The reviewer should consider if there has been any subsequent testing that may negate the need for recall. For example, a child may have had a very poor ABR requiring recall but, due to their age, they have subsequently had ear specific testing completed and normal hearing has been obtained bilaterally. This would influence the recall categorisation. All children in groups C and D will need a harm review as there may still have been avoidable delay – even if the reviewer decides no recall is needed as treatment has been given. Where there is missing or no available information to review, the case should be considered as though testing was not completed and these children should be offered recall. Prioritisation for these cases will be led by the referral from the newborn hearing screen.

Table 5: Full cohort review recall prioritisation grading

ABR review grade	Description	Recall
A	Met the standard at the time, no issues	Not required
B	Minor issues which do not affect the clinical outcome, such as unusual filter set, or rejection level has been used without any justification	Not required but lessons to learn for the service
C	Any issue which affects the clinical outcome, such as incorrect reporting of response absent as clear response	Required
D	Unable to review record (data issues)	Required
Not applicable	ABR not completed at the site being reviewed	Not required
Priority recall group	**Urgency of recall**	
P1 priority 1	Urgent recall required Testing shows a likely bilateral sensorineural hearing loss that is currently unmanaged or undiagnosed Missing data referred from NHSP due to a screening contra-indication and no further testing	
P2 priority 2	Urgent recall required	

ABR review grade	Description	Recall
	Bilateral sensorineural hearing loss has not been ruled out Missing data bilateral referral from NHSP	
P3 priority 3	Recall required Testing shows a possible unilateral sensorineural hearing loss that is currently unmanaged or diagnosed Missing data unilateral referral from NHSP. These cases should be considered as though testing was not completed and these children should be offered recall. Prioritisation for these cases will be informed by the referral from the newborn hearing screen	
P4 priority 4	Risk and recall being considered by the ICB Strategy Response Group: Testing shows an issue that has affected the management. However, in the reviewer's opinion, it's likely that the child has normal hearing bilaterally (for example, the child has been discharged at ≤35eHL at 4kHz instead of ≤30eHL but the traces are large or do not meet clear response criteria at ≤30eHL)	
Non applicable	Used for records with missing data where a recall would not change the outcome for the child. For example, a baby with no screen risk factors whose ABR was agreed but OAEs were not available for review. Or where subsequent behavioural testing negates the need for recall. For example, a child may have had a very poor ABR, which would require recall, but due to their age they have later had ear specific testing completed and normal hearing has been obtained bilaterally.	

See Appendix A guidance for services to aid communication with families

6.2.6 Communication following the full ABR cohort review

The child's audiology clinical record should be updated to record that a review of their diagnostic ABR was carried out. A communication should be sent to parents to advise them of the outcome of the review and the next steps, as detailed in Table 6.

Table 6: Communication to parents

ABR review grade	Description	Letter to parents
A	Met the standard at the time, no issues	No issues were found
B	Minor issues which do not affect the clinical outcome such as unusual filter set, or rejection level has been used without any justification	Minor findings on the review, but these did not change the result – no further action required. However, offer parents the chance to arrange a recall for their child to be tested, if they wish
C	Any issue which affects the clinical outcome such as incorrect reporting of response absent as clear response	Following a phone call, a letter should explain what had happened and apologise for the error, describing the timeline for recall and when they can expect to be called back
D	Unable to review record (data issues)	Explain what had happened and apologise for the error, describing the timeline for recall and when they can expect to be called back
NA	Testing was not completed at the site being reviewed	The test was not performed at the site and therefore the record was not reviewed – no communication required

6.2.7 Reporting on completion of full cohort review

Using the relevant quality governance structure, the lead SME should provide the ICB Strategic Response Group with a summary report of findings. There should also be subsequent reporting to the Regional Audiology Oversight Group.

The findings summary should include: the full ABR cohort recall prioritisation template, key learnings themes or findings and possible risks, the complete ABR peer review sheet with all review comments. The ICB should take appropriate action in response to the findings.

7. Clinical testing mitigation

Mitigations can be used to minimise any immediate risk visible in the pathway. Examples of mitigations include introducing objective measurements, access to onsite or virtual support via mutual aid, education and training, replacement equipment and calibration or changes to the test environment. If any risks were identified with ABR testing, all ABR traces must be peer reviewed and double reported by an identified SME from a service with high or UKAS assurance. A de-escalation plan should be in place to enable the service to return to business as usual (see Table 8). For services where risks were identified with other areas of testing, local improvement actions should be undertaken, recorded and de-escalation agreed with the ICB Strategic Response Group. The following applies to all children.

Table 7: Clinical testing mitigation definitions

Test	Typical developmental age	Procedure to follow	Mandatory requirements
Transient evoked otoacoustic emissions (TE-OAEs) and/or auditory brainstem response (ABR)	<6 months	British Society of Audiology (BSA) recommended procedures: OAEs testing in paediatric and adult audiology ABR testing in babies ABR testing for post-newborn and adult guidelines for the early audiological assessment and management of babies referred from the NHSP cochlear microphonic testing	Those under 6 months developmental age are not suitable for behavioural tests. If an assessment is required, either TE-OAEs and/or ABR should be arranged if clinically indicated Use of sedation should be considered depending on the level of concern Peer review of all ABR testing should be considered with audit of compliance where there is any concern relating to this clinical test
Visual reinforcement audiometry (VRA)	6 months to 24–30 months	BSA recommended procedure: VRA	Only full clear head turns to be taken as a response Partial turns and/or other behavioural observations, such as changes in facial expression, eye movements, twitches or pull backs, must not be taken as a response

Test	Typical developmental age	Procedure to follow	Mandatory requirements
Performance testing	24–36 months	Please note presentation from both sides is not required as this is a 'Soundfield' test	Only full clear response, such as placing dinosaur in a box, to be taken as a response. Partial hand movements and/or other behavioural observations, such as changes in facial expression, eye movements, twitches or pull backs, must not be taken as a response
Pure tone audiometry (PTA) with inserts or headphones	24 months onwards	BSA recommended procedure: Pure tone air conduction and bone conduction threshold audiometry with and without masking	Only full clear response such as placing dinosaur in a box or clear press of button, to be taken as a response. Partial hand movements and/or other behavioural observations, such as changes in facial expression, eye movements, twitches or pull backs, must not be taken as a response.
Distraction testing	6–12 months	BSA practice guidance: assessment guidelines for the distraction test of hearing	Only to be used if unable to condition to VRA. Only full head turns to be taken as a response. Partial turns and/or other behavioural responses, such as changes to expression, eye movements, twitches or pull backs, must not be taken as a response

After behavioural testing, objective testing should be carried out:

- BSA recommended procedure: tympanometry unless clinically contra-indicated (for example, due to infection)
- transient evoked otoacoustic emissions must be attempted if tympanometry gives peaked traces. BSA recommended procedure: OAEs testing in paediatric and adult audiology
- transient evoked otoacoustic emission pass criteria:
    a. minimum S:N ratio of 6dB at two or more bands in the range 1.5–4.0kHz and
    b. total RMS ≥0dB SPL and

c. good quality with no acoustical artefact in the recording window

All children should be managed as specified by departmental guidelines. However, if the child has been tested by VRA, performance or distraction testing, they should not be discharged unless there are clear responses from TE-OAE testing in both ears. There may be some exceptions – for example, a child with autistic spectrum disorder for whom there are no hearing concerns and who might need sedation to enable this test. In these cases, parents should have open access for reassessment of the child's hearing, should they have concerns. If testing is incomplete, an immediate follow-up (next available appointment) should be arranged to complete testing, unless results obtained show a conductive loss and flat tympanograms consistent with glue ear, when a period of watchful waiting should be initiated.

7.1 ABR double reporting de-escalation

For services requiring double reporting of ABR traces, de-escalation and return to business as usual needs to be undertaken in 2 steps.

Table 8: ABR double reporting de-escalation steps

Step	Action
De-escalate individual staff member	Completion of a higher education institution ABR course A minimum of 30 sequential ABR reviews of which 5 were non-discharge cases, double reported by an SME, with no discrepancies A minimum of 3 months where ABR traces have been double reported by an SME, with no risks or concerns raised Assessment of staff competency and documentation undertaken by an SME
De-escalate whole service	All staff who carry our ABR testing have been de-escalated as above It may be that staff need to undertake ABR course one at a time due to service capacity considerations and limited numbers on university ABR courses Service may return to business as usual for ABR testing if no further risks or concerns raised The service must participate and adhere to its local standard ABR peer review and should be monitored through departmental and provider governance processes For services where risks were identified with other areas of testing, local improvement actions should be undertaken, recorded and de-escalation agreed with the ICB Strategic Response Group

8. Waiting list triage criteria

All services should have waiting list triage systems in place. Patients should be prioritised to ensure those at greatest risk are seen as a priority. The following process can be used to support waiting list triage.

Triage criteria covered in the Guidelines for surveillance and audiological referral for infants and children following newborn hearing screen refer to all other referrals received by paediatric audiology. Triage should be carried out by an experienced paediatric audiologist. It should be based on the information available to the clinician at the point of triage (usually on the clinical management system).

Clinical triage should be based on:

- chronological age of the child, prioritising the youngest age group
- clinical risk factors and co-morbidities that may increase the possibility of permanent childhood hearing impairment – for example, neonatal intensive care unit stay, prematurity, a syndrome associated with hearing loss, family history of early sudden onset sensorineural hearing loss, chemotherapy treatment, cerebral palsy (this list is not exhaustive)
- requirement for standard or urgent appointment
- indication of whether the individual requires a routine or non-routine assessment

Additionally, the need for interpreters should be highlighted to the administrative team. The patient should be referred when meeting any of the following criteria (subject to local policy):

- aged under 12 weeks corrected age and has not undergone newborn hearing screening – refer to the newborn hearing screening programme
- adult aged 18 or over (or according to local policy) – refer to adult audiology or ear, nose and throat
- referral is not audiological or does not require audiological input – return to referrer
- referral has insufficient information to clinically triage – contact the administrative team to obtain further information

Where there are concerns about responses to sound or hearing or where there are risk factors, families of newborn babies under 12 weeks of age who have not completed newborn hearing screening already should be encouraged to engage with the local NHSP to identify whether their baby requires further testing.

Children over 12 weeks of age for whom there are hearing concerns, risk factors or diagnostic follow-up after referral from the newborn hearing screen was incomplete should be referred to their local audiology services for their hearing needs to be assessed.

Children may be referred presenting with:

- hearing difficulties over a long period of time (>4 months) observed by parent/carer or professional. For example:

  - mishearing when not looking at who is speaking
  - difficulty in a group or classroom
  - asking for things to be repeated
  - fluctuating hearing loss
  - listening to music or watching TV with the volume higher than other people need
  - difficulty hearing on the phone
  - finding it hard to keep up with a conversation
  - feeling exhausted from having to concentrate while listening
- concern with reactions to sound, particularly in a younger age group
- delayed speech and language development (not dysfluency) or a failure to make any progress during speech and language intervention
- problematic tinnitus
- balance difficulties (for example, clumsiness not associated with age)
- recurrent ear infections

8.1 Appointment timescale

Referrals from the NHSP programme for screened/screening contra-indicated babies sit outside the following timelines and should be prioritised to be seen within their Newborn hearing screening programme standards: NH2 target data KPI. Where the child is medically unfit for testing and so unable to be brought to the appointment, this should be clearly documented. Referrals should be triaged into a routine appointment timescale (Priority 1–4) unless there is a clinical requirement for the patient to be seen urgently. There should be a digital process for tracking patient triage, such as using information systems and spreadsheets (see Table 9).

Table 9: Example triage tracking process

NHS number	DOB	Name	Assessment type	Priority	Resource	Reason for referral
X	**dd/mm/yyyy**	A patient	Routine	P4	2 testers	Speech delay
X	**dd/mm/yyyy**	B patient	Non routine	P2	1 tester + 1 senior	No previous results

8.2 Examples of referrals requiring urgent priority 1 (P1) appointments (Table 5)

- Children in the ABR recall cohort P1 and P2 who fall within age groups 1–3 should be prioritised for urgent P1 appointments.
- P1 patients: children referred as an immediate, bilateral or contra-indicated, follow-up from the newborn hearing screen who were not brought, with no or inappropriate safeguarding case management and no diagnostic test completed. These children are at high risk of undiagnosed bilateral hearing loss.
- New referrals that meet P1 criteria:
    - hearing assessment in cases of confirmed or strongly suspected bacterial meningitis, sepsis or congenital cytomegalovirus (CMV)
    - hearing assessment following head injury
    - diagnosis of permanent childhood hearing impairment requiring intervention
    - patient with hearing aids who are new to area, where:
    - the patient's hearing aids are documented to be lost or broken beyond use
    - previous results suggestive of a significant hearing loss that required action, but no action was taken and where distraction only results obtained at previous appointments and referral was for confirmed or strongly suspected bacterial meningitis, sepsis or congenital cytomegalovirus (CMV), head injury, chemotherapy or for monitoring following administration of ototoxic drugs
    - diagnosis of permanent childhood hearing impairment has occurred, but no intervention has taken place
    - child whose hearing loss meets eligibility for cochlear implant where referral to cochlear implant has not been discussed/offered
    - recall case fitted with hearing aids, 1st review

  Or where the following apply:
    - assessment in children undergoing chemotherapy or for monitoring following administration of ototoxic drugs
    - tinnitus/hyperacusis whereby the patient is reported to be at risk of self-harm due to distress
    - other indication noted in the referral
    - reasons that triaging clinician determines as urgent based on their clinical judgement of the referral information

8.3 Examples of referrals requiring priority 2 (P2) appointments (Table 5)

- Children in the ABR review recall cohort P1 and P2 who fall within age groups 4 and 5 should be prioritised for P2 appointments.
- P2 patients: children referred as an immediate unilateral follow-up from the newborn hearing screen who were not brought, with no or inappropriate safeguarding case management and no diagnostic test completed. These children are at high risk of undiagnosed unilateral hearing loss.
- Children in ABR review recall cohort P3.

- New referrals that meet P2 criteria:
  - child with significant visual impairment
  - child who has not had a newborn hearing screen – this could be because the hearing screen was missed, declined or they were not born in England
  - child with a co-morbid condition associated with hearing loss, such as Down's syndrome or cleft palate, or where something in their medical history gives rise to an increased risk of hearing loss (for example, recurrent acute otitis media, strong family history of hearing loss, failed school screen + previous failed NHSP or NHSP not completed)
  - post grommet follow-up
  - failed school hearing screen
- Patients should be reviewed where:
  - no results were obtained at a previous appointment or where limited results were obtained which suggest a possible hearing loss and parental or professional concern relating to speech delay
  - raised thresholds at last appointment and would benefit from ear specific or bone conduction testing
  - significant bilateral hearing loss identified at previous appointment, defined as average of 40dB or greater in the better hearing ear
  - hearing aid reassessment where the aids are likely under amplified and no verification has taken place
  - test results obtained at previous appointment do not fit with other test results (for example, raised thresholds and normal tympanometry results or no OAE results and normal first targeted follow-up from newborn hearing screening programme)
  - previous test results suggest sensorineural hearing loss that needs to be confirmed before a management decision can be made
  - hearing reassessment of any child with a co-morbid condition associated with hearing loss where previous test results were raised or distraction only, such as Down's syndrome or cleft palate, or where something in their medical history gives rise to an increased risk of hearing loss (for example, recurrent acute otitis media, strong family history of hearing loss, failed school screen with previous failed newborn hearing screen or newborn hearing screen not completed)
  - failed school hearing screen, previous testing distraction only
  - movement into England, no newborn hearing screen, previous test was distraction only

8.4 Examples of referrals requiring priority 3 (P3) appointments (Table 5)

- Children in the ABR review recall cohort P4 should be prioritised for P3 appointments.
- New referrals that meet P3 criteria:
    - referred because of parent/professional concern, no NHSP results, distraction testing results only obtained at last test
    - hearing aid assessment referral for a child who is new to area and already aided (aids are known to be working)
    - first targeted follow-up from newborn hearing screening programme
- Patients should be reviewed where:
    - a co-morbid condition associated with hearing loss, where previous test results were satisfactory, such as Down's syndrome or cleft palate or where something in their medical history gives rise to an increased risk of hearing loss (for example, recurrent acute otitis media, strong family history of hearing loss)
    - previous test results that were mildly raised and no supporting tympanometry results had been obtained, no other parental concern or speech delay
    - distraction testing only and middle ear effusion
    - nationally recommended procedures were not adhered to (for example, testing for children with suspected/confirmed meningitis, a discharge level of 30dBeHL was used instead of 20dBeHL or only 4 kHz was tested

8.5 Examples of referrals requiring priority 4 (P4) appointments (Table 5)

- New referrals that meet P4 criteria:
    - routine hearing assessment or as part of a wider pathway for educational or medical concerns with no particular concern regarding hearing such as speech development concerns
    - targeted follow-up from NHSP but referral reason is a local protocol (for example, high gentamycin)
- Patients should be reviewed with:
    - a mild temporary hearing loss of ≤40dB in the better ear with supporting tympanometry with no other risk factors
    - an unaided hearing loss (bilateral or unilateral)
    - any other child who does not fall under Priority 1–3 above

8.6 Routine and non-routine assessment and triage

All services should have triage systems in place and clinicians should triage patient referrals based on the clinical information available. These referrals should be triaged for routine or non-routine assessment. Support from senior clinicians should be accessed if the triage decision is complex.

- Routine assessment: referral information or patient notes indicating that the patient is likely to perform age-appropriate audiological behavioural assessment.
- Non-routine assessment: referral information or previous patient notes indicating that the patient's development may significantly impact on their ability to perform age-appropriate behavioural assessment.

Examples of indications on referrals that an individual requires non-routine assessment include:

- suspected or diagnosed autistic spectrum disorder
- attention deficit hyperactivity disorder
- global developmental delay
- learning disability
- visual impairment (reduced ability to see, not fixable by wearing glasses)
- other childhood behavioural or emotional disorders
- other syndromes or complex medical needs affecting development

Care should be taken when assessing children in this group. It can be difficult to obtain reliable results from children with complex needs. Objective measures can be useful. Where a child was referred from NHSP, diagnostic follow-up was satisfactory and the child has special educational needs and disabilities, this could indicate an undiagnosed PCHI.

Table 10: Examples of clinical triage

The following can be adapted to meet the requirements of local services when hearing assessment has been the primary reason for referral.

Triage guidance	Suggested clinician(s) involved
Aged 3 months and under Aged 6 months to 5 years and triaged as routine	Senior paediatric audiologist for ABR 2 paediatric audiologists
Aged 6 months to 5 years and triaged as non-routine Aged 3–6 months Aged <5 years and significant communication difficulties (for example, non-verbal)	2 paediatric audiologists, 1 must be a senior paediatric audiologist
Aged 5–16 years and triaged as routine	1 paediatric audiologist
Aged 5–16 years and triaged as non-routine assessment	1 senior paediatric audiologist (consider 2 tester clinic)

9. Recalls, reassessments and prioritisation

Before initiating recall, patients are triaged according to section 8. The overall objective of patient recall and reassessment is to identify, limit or mitigate harm to patients. The service should also provide further information, intervention and support to patients. Regular wellbeing support should also be provided to staff involved in the incident and/or recall. A named wellbeing lead for the service should be appointed to review the team's needs and requirements as the incident progresses. Psychological support check-ins should be provided regularly. This guidance should be read in conjunction with the NHS England National Quality Board: Recall framework.

9.1 Communication before recall and reassessment

NDCS has worked with families who have been through the process to develop recommendations on communication (Appendix A).

Transparency and prompt communication with parents, carers and other key stakeholders is essential. There should be a communications plan focusing on the needs of families. A telephone helpline can help audiology administrative teams manage queries and should be established for families who may need to raise concern about their child or the service they have received, make a self-referral for their child and ensure onward care has been arranged (for example, prioritised for amplification, cochlear implants, check that their child has been referred to appropriate non-audiology services, such as speech and language therapists and qualified teachers of Deaf children and young people, access to complaints processes and other resources such as the NDCS and access to advice on Disability Living Allowance applications).

The communication resources should be used to prepare stakeholder briefings, media statements and communications to affected families. There should be appropriate communications for families where English is an additional language and written material should be available in a variety of relevant languages, as well as accessible formats.

Before any communication with parents, due diligence and liaison with child health information services and hospital tracking systems will be required to identify children who are deceased, still in the neonatal intensive care unit or have been adopted, and that their home address is correct.

9.2 Where to recall and reassess patients

Services should consider where to recall patients and if mutual aid is required to support recall. A recall process requires a skilled and competent team who have a clear understanding of their roles and responsibilities. Clinicians should be able to have conversations with families and be supported within providers by senior colleagues. The onsite review provides a level of assurance of the safety of the clinical service for ABR and behavioural assessments at the site undergoing the review. All services that are in recall are either paused or are low assurance until recalls and action plans are completed.

- Where there is **high/UKAS assurance**, the service may be designated a paediatric assurance recall centre (PARC). Mutual aid recall should take place at the service led by their staff.
- Where there is **partial assurance**, recall can only take place in the parts of the service where external assurance has been given that it's safe to continue. Mutual aid or the use of a PARC will be required to support recall, with priority given to the most urgent cases.
- Where there is **low assurance** or the service is fully or partially paused, mutual aid will be required to support recall.

9.3 Process for VRA/behavioural service recall and reassessment

Where there are concerns relating to a paediatric audiology service post ABR, such as in the behavioural service/VRA testing, it is not possible to review this work retrospectively. For these tests, where there are no diagnostic traces to review, information on the babies/children will have to be reviewed from existing records. Therefore, a full cohort recall would be required, undertaken via a pragmatic approach. As a minimum, the service should:

- identify all child referrals for paediatric audiology post ABR
- perform a targeted recall of children who were referred to audiology but did not have the newborn hearing screen because they were not brought in, declined the hearing screen or moved into the country without accessing a newborn hearing screen – these children will not have had any objective hearing measurements and should be prioritised for recall according to age or are looked after children or in secure settings

For these services, the optimal pathway to review and recall children was agreed to ensure that all children receive the support they needed.

Step 1:

- local/ICB IMT to decide time period for look back, 5 years as a minimum period
- request to NHSP to pull all data for the service for the relevant time period – 5 years as a minimum to give a list of all babies and their results from NHSP

Step 2:

- service to list all child referrals into the service (paper, EMIS, audit based) for all children within the appropriate timeframe

Step 3:

- cross-check NHSP and service lists to create a single list of children
- exclude children who passed NHSP test to reduce the list of children for recall and children who have been seen and fall into step 4 – that is, discharged and re-referred etc, those children for whom there is clearly documented evidence that they have historically met the minimum discharge criteria

Step 4:

Divide the list into 2 groups for recall or safety netting depending on the clinical risk advised by the clinical reference group.

Group 1 is the priority recall group and includes all children for whom a red flag is noted.

Immediate recall – red flag criteria

These include:

- inclusion criteria for recall
- children from NHSP as a bilateral or unilateral referral or out of area children
- discharged on distraction testing only
- discharged and re-referred
- 3+ appointments in audiology
- children who had a hearing loss identified but the true nature of the loss hasn't been established due to no bone conduction being performed
- children with onward management due to red flags (for example, Down's syndrome, SEND, under ENT, SALT, developmental pathways, safeguarding)
- not been discharged – recall for reassessment all those who have not been discharged
- any children with complex needs should be prioritised for immediate referral
- children new to the country for whom there is no NHSP information

Group 2 includes children identified to need a recall but do not have a red flag. A letter will be sent to the family and GP with an offer of recall with OAE/PTA testing. The OAE screen could be located within the community such as within a school. This will include a brief history, otoscopy, tympanometry and an OAE. Where there is no clear response on OAE, the service should notify the child's GP where this is recorded on the NHS Spine system.

Where no records are available: The child should be recalled.

Where records are available and a child was discharged using discharge criteria by service testing without issues of quality and safety concerns, a recall is not needed. However, a safety netting letter should be issued with an explanation and offering recall only if clinically indicated or where there are hearing concerns.

Letters and media statements can be used to reach as many families as possible who may have concerns. Recall should be offered on a self-referral basis. The ICB Strategic Response Group should consider setting up a local telephone helpline or working with the Regional Audiology Oversight Group on a regional helpline. This will assist with the triage of these referrals and can be tied in with mutual aid to offer recall across the system. Stakeholder communication templates are provided in the Paediatric Hearing Services Improvement programme communications toolkit and Appendix A. The templates alert primary care services, such as GPs, specialist educational providers, specialist schools and speech and language therapists that they should not be assured by previous hearing tests beyond the newborn

hearing screen. Any parental concerns should be taken seriously and the child should be referred to audiology for reassessment.

9.4 Age stratification for prioritisation

Early identification and intervention provide the best outcomes for hearing impaired children. Stratification of patients is required to ensure patients are reassessed and receive the appropriate diagnosis and optimum intervention at the earliest opportunity to gain the greatest benefit from treatment. For example, impact on long term health is greatest for babies younger than 12 weeks old, where interventions are made as early as possible. With this in mind, services should consider the following when prioritising recall: the current age of the child, their perinatal history, such as prematurity; prolonged stay in the neonatal intensive care unit, jaundice, congenital infection; and co-morbidities, such as syndromes associated with hearing loss and other health conditions, including epilepsy, cerebral palsy, chemotherapy treatment.

The meta-analysis into risk factors for infant hearing loss provides 14 risk factors for consideration. Other factors to consider during prioritisation include equitable access to audiology services for children with special educational needs and disabilities in mainstream and residential schools who may require modified testing techniques which will consider their behavioural age; key populations requiring special consideration including families; children where English is an additional language; children who entered the UK post-birth; children who have multiple co-morbidities; children living in communities that require a targeted approach to engaging in healthcare services.

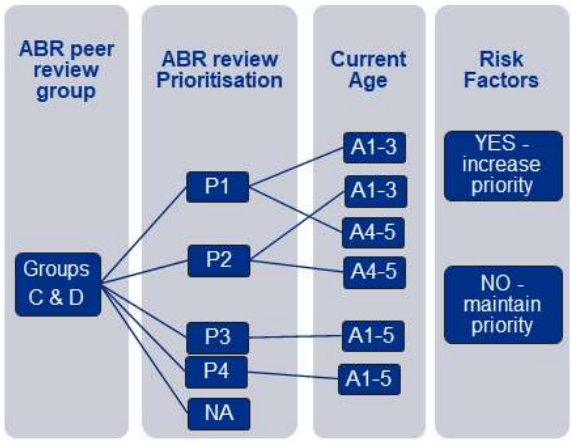
The recall lead should obtain as much information as possible from the audiology record and other local health record systems. They should use the completed ABR full cohort review prioritisation spreadsheet to add in the date of birth of the child to calculate their current age and add additional information to help with prioritisation. Prioritisation on age should be assigned according to Table 11.

Table 11: Age stratification prioritisation

Priority group	Urgency of recall	Testing required (based on developmental age)
A1a	≤16 weeks	ABR
A1b	16 weeks to 6 months	Sedated ABR where severe concern from review or parents Where no concern, parental choice should be heard, risk assess the clinical need and consider waiting until child is old enough to assess behaviourally

Priority group	Urgency of recall	Testing required (based on developmental age)
A2	6–18 months	Behavioural testing with OAE or with inserts as soon as possible. Where behavioural testing is unsuccessful, a risk assessment should be completed considering parental choice and concern and sedation for ABR
A3	19 months to 3.5 years	Same testing as priority group A2
A4	3.5–5 years	Ear specific behavioural testing or pure tone audiometry (PTA)
A5	>5 years	PTA

Figure 3: ABR recall prioritisation model

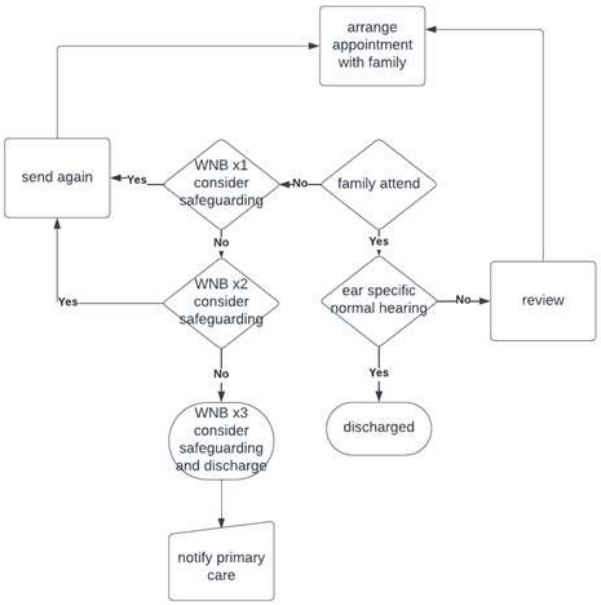


9.5 Offering recall and reassessment

Every effort should be made to engage with families when offering recall. This may include encouraging attendance with help from other health services, such as health visitors and school nursing teams. The service should consider safeguarding and the needs of adults or children with special educational needs and disabilities. They should also account for people who have English as an additional language, ensuring inequalities are addressed and not created. Services should have an agreed process for situations where families do not respond to recall, where a child was not brought (WNB) or where children are looked after or in secure settings. This process should include multiple attempts to engage families and repeated offers of appointment.

The status of all recalled patients should be closely monitored. The ICB Strategic Response Group and Regional Audiology Oversight Group will provide oversight and assurance. Regular data reporting will be required. Figure 4 is an example chain for offering recall.

Figure 4: Process for offering recall and reassessment



Local safeguarding policies should be adhered to. Child health information services and hospital tracking systems should be used to identify where children have moved out of the area. Communication with their new local audiology service should take place to ensure these children are offered local recalls. Reporting the outcome of any recall testing external to the provider should be approved via reporting governance structures.

Regular data returns are required to gather review, recall and reassessment status nationally. NHS England will issue reporting returns to ICBs for completion.

Each missed appointment should be reported to the appropriate health visiting team, school health team, child health team and primary care team so that attendance can be supported and encouraged where required. Where babies/children were not brought, cases should be tracked and reported through relevant structures. Only when all avenues have been exhausted should the record be marked lost to follow-up.

9.6 Clinical decision making

When re-testing children who form part of a recall cohort, it is essential to obtain ear specific information before any decision is made to discharge them from the service.

Where required, onward referral to follow-up services should be made according to routine referral practices. It is recommended that where subjective tests are used, objective measurements are also carried out to corroborate the results obtained. However, it is also recognised that objective measurements are not always possible. In these cases, verbal and written communication with parents needs to be clear and an individual management plan should include information about:

- when and why these tests have not been used
- continued monitoring required by the parents
- referral mechanisms should the parents have concerns in the future

The end point of recall is considered to be when a child has had a diagnostic assessment and is discharged, a treatment plan can be commenced or the patient is referred to other services such as ENT. At this point harms assessment should be instigated.

9.7 Primary care referrals

Appropriate referral supports patient and families and service provision. Where there are concerns about responses to sound or hearing or where there are risk factors, families of newborn babies under 12 weeks of age should be encouraged to engage with the NHSP) to identify whether their baby requires further testing. Children over 12 weeks of age should be referred to their local audiology services for their hearing needs to be assessed. Audiology services can be identified via local provider directories and websites. Children of any age who move into the area and have been identified to have permanent or temporary hearing loss should also be referred to the local audiology service to allow their audiology follow-up care to continue.

Testing outside the paediatric audiology service is not recommended. Parent/carer concern should always be taken seriously even where the child has been assessed as having normal hearing in the past. Conservative referral to audiology is needed to avoid overwhelming the audiology service. Details of the reason for referral should be clearly described to enable appropriate triage. The referral should also include:

- age of the child
- previous newborn hearing screen or hearing test results
- severity of the parent/carer concern (how worried the parent/carer is)
- onset of symptoms
- duration of complaint
- any behavioural complexities or delay the child may have (to allow triage into appropriate clinic setting)

Children should be referred to specialist paediatric services where there are concerns around:

- special educational needs
- behavioural problems (particularly lack of concentration and attention), being withdrawn or irritability
- poor educational progress

The following presentations should be referred directly to ENT:

- sudden onset (over 3 days or less) unilateral or bilateral hearing loss which has occurred within the past 30 days and cannot be explained by external or middle ear causes
- unilateral hearing loss associated with focal neurology
- hearing loss associated with head or neck injury
- hearing loss associated with severe infection (for example, necrotising otitis externa)
- suspected head and neck malignancy – refer using a 2-week cancer pathway

- rapidly progressive hearing loss (over a period of 4–90 days) which cannot be explained by external or middle ear causes
- pulsatile tinnitus

10. Harms assessments

This guidance aligns with the NHS England patient safety incident response framework (PSIRF). The PSIRF supports the development of a patient safety incident response system that prioritises compassionate engagement and involvement of both staff and families affected by patient safety incidents. It provides full details of how to manage a patient safety incident response and a complete patient safety learning response toolkit. It's recommended that all incident teams follow the established framework detailed in the PSIRF toolkit.

The Policy guidance on recording patient safety events and levels of harm provides guidance on grading levels of harm. This states that "degree of harm recording relates to the actual impact on a patient from the particular incident being reported … patient safety incident harm definitions should always be applied based on the best information about the actual impact of the incident at the time of recording. The harm grading can be reviewed and updated as more information becomes available, but should not be used to speculate about, for example, more severe "potential harm" if that does not appear to have been caused."

10.1 Roles and responsibilities

An SME works to assess each recall case and assigns a recommended harm level. This is validated with the region and ICBs, independent of the provider, with the provider informed of the recommended harms level assignment. Providers can then follow the PSIRF framework and should undertake Duty of Candour with families where moderate or severe harm has been identified.

10.2 When a harm assessment is required

For sites that have been paused and recall sites, a harm review by an SME/region will be required for all cases where the management/treatment plan had to be changed following recall and reassessment.

10.3 Harm assessment process

Services that need to undertake harm assessments should contact the regional named lead for harm assessment to discuss the process. Contact england.csohearingprogramme@nhs.net for a link to the relevant lead. Information for regional harms leads is available on Futures Collaboration Platform. The local harms process should ensure services work with the regional SMEs who have expertise in harms assessment. They can support providers and ICBs to follow guidance to complete the harm assessments using the template and categorisation aligned to multidisciplinary team and incident review processes in providers. A National Harms Review Group has been established to ensure consistency.

10.4 Harm reviews

Harm reviews should take place after the recall is complete for all cases identified as C or D even if families declined or WNB. If, after a recall, no harm can be identified, it is a no-harm incident. The recalling to check if harm has been caused does not constitute harm.

Harm reviews should be conducted by a minimum of 1 SME external to the provider, a senior leader in the audiology service and the nominated ICB lead. It can also be useful to have representation from the provider patient safety team. Staff members involved should be offered the opportunity to attend the harm review, but this should not be enforced. Learning from harm reviews should be shared with staff in a sensitive way to identify areas for development.

The harm review should consider the testing completed following the initial referral and the outcome/clinical decision, findings from subsequent testing and physical impact on the child. Establishing psychological harm on the child will be complex, especially given the child may be unable to express the psychological effect of delays in or inappropriate care. Therefore, when recording psychological harm, you are not required to make a formal diagnosis; your answer should be an assessment based on the information you have at the point of recording, considering child and parental views where possible to do so, and can be changed if further information becomes available.

Due to the nature of audiology testing, it may take more than 1 appointment to ascertain true hearing levels and the level of harm may be undetermined. Harm categories should be agreed by the majority and where there are disagreements the case should be discussed with the ICB patient safety team. For paused services it is possible children may have experienced a delay that could result in harm. Harm assessments should be completed and cases that have experienced harm as a result of delay should be recorded and reported.

10.5 Audiology examples of harm

These examples have been developed by SMEs who have undertaken this process. This is an indicative list of how levels of harm from the Learning from Patient Safety Events policy can be applied to paediatric audiology. It is not exhaustive and psychological harm is not included. It is important to consider harm assessments over time as further information comes to light.

Table 12: Audiology examples of harm

Level of harm	Description
Unable to determine	**Family does not engage with recall, unable to conclude level of harm.**
No physical harm	**Testing indicates no further management is required.** ABR review has been completed, and the patient has been recalled, with no or mild issues noted with the test performance. This does not affect the outcome of the test.

Level of harm	Description
	ABR review indicated concern with the quality of testing. The child: • has been seen subsequently for ear specific testing and has normal hearing bilaterally • has been identified with permanent childhood hearing impairment and is being managed appropriately • had permanent childhood hearing impairment ruled out and the remains on active monitoring A child who has had an ABR that is not completed to the recommended standard, which results in them returning to the service for further testing.
Low physical harm	**No impact on the child's speech, language and educational outcomes.**
Moderate physical harm **(Duty of Candour applies)**	**Impact on the speech and language audibility without long term impact on development of hearing, language or speech or educational outcomes.** The intervention selected, fitting and/or verification of hearing aids has been inappropriate because of poor threshold data. A child who has experienced delay to the fitting of hearing aids but this is no longer than 6 months and the child will require additional treatment to catch up. A child who is appropriately identified as having a hearing loss but then does not receive appropriate effective management for this and the child will require additional treatment to catch up. A child is misdiagnosed as having a hearing loss when they do not. The child receives hearing aids for this 'hearing loss'. A child where a referable condition is missed – for example, auditory neuropathy spectrum disorder is misdiagnosed as a profound hearing loss and the recommended aetiological follow-up is delayed.
Severe physical harm **(Duty of Candour applies)**	**The child's speech, language or educational outcomes have been impacted by lack of amplification or delay that will either not resolve with treatment or will endure beyond 6 months.** A child who is discharged with normal hearing but on review has a permanent hearing loss. A child with a bilateral severe or profound sensorineural hearing loss that is late diagnosed (either was present at birth and miscategorised as normal or there is a significant delay to their identification) and is fitted with cochlear implants after the age of 2.

Level of harm	Description
	A child who is appropriately identified as having a hearing loss but then does not receive appropriate effective management for this. A child who is incorrectly diagnosed and discharged as having normal hearing but on review has a unilateral sensorineural hearing loss that would not be helped by a hearing aid.

11. Mutual aid clinics

11.1 Purpose of mutual aid clinics

Mutual aid clinics help accelerate the review, recall and reassessment of babies/children. Providers within a system or network may temporarily share resources such as staff, equipment or clinic estates to support services that are behind schedule or under pressure. ICBs are expected to co-ordinate and facilitate mutual aid arrangements to ensure that all children identified as requiring recall are seen and treated in the correct pathway.

Mutual aid should be prioritised over short-term performance metrics (for example, the 6-week diagnostic wait target), especially when it comes to ensuring children receive timely and accurate recall and reassessments to mitigate harm. Prioritisation and triage systems should be in place and operational across providers, ICBs and/or regions.

11.2 Setting up mutual aid clinics

A mutual aid contract should be established across sites. This should set out who will be seen to support referral management including referrals from GPs outside the mutual aid envelope and agreed pathways for follow-up; safeguarding, did not attend (DNA)/was not brought (WNB) processes and late cancellations. It should also specify funding arrangements including for WNB and late cancellations. A mutual aid request form is available on Futures Collaboration Platform.

11.3 Running mutual aid and rapid screening clinics

11.3.1 Clinic set-up and co-ordination

Screening clinics can be set up as defined clinics to rapidly review patients without suspected complex clinical issues with 15-minute appointments.

These can be run alongside routine clinics or scheduled for weekends or specific dedicated days, to enable a higher volume of patients to be seen each day. A shared tracker should be used across sites to ensure patients are not lost between organisations. Dedicated administrative support should be allocated.

If audiologists are seeing families at a site away from their home services, responsibilities should be mapped out in advance, including who is responsible for equipment (including breakages) or faults identified in calibration checks, use and purchase of consumables (otoscope/tymp tips). It is also essential to ensure safety protocols (for example, fire and life support scenarios).

11.3.2 Clinic processes

These include:

- a specific mutual aid clinic template should be set up to separate mutual aid patients and staffing, to allow for easier tracking, costing and charging against the contract
- be clear about who receives individual management plans (IMPs)/reports and ensure copies go to the home site for future reference. The mutual aid site will not be as familiar with local health visitor addresses, safeguarding and social work teams or teachers of the Deaf. Provide this information with the pathways to avoid delays in identifying contacts
- the first early (08.30 and 09.00) and the last late (16.00 and 16.30) appointment times often have a higher WNB/DNA/cancellation rate due to the increased distance to travel to the site, so schedule local patients in these slots where possible
- ensure full referrals (not just names/NHS numbers) are provided to enable appropriate triage and confirm addresses, avoiding unnecessary appointments. Patients may have moved residence from the time they were put on the waiting list and checking the NHS Spine system list helps clarify the location

11.3.3 Communication with families

Communication from the home site about why patients are being asked to travel to a mutual aid service is essential. Services found that where families have not been sufficiently aware this has led to difficult communication and loss of appointments time. A communications toolkit is available to support services with families, developed with the NDCS. Families have helped develop detailed communications guidance for services and the recall process (Appendix A).

Mutual aid sites should call families to confirm attendance. Services with multiple WNB/late cancellations can maximise the clinic capacity by phone triage. For Deaf parents, alternative contact methods should be used as set out in the communications guidance.

A documented process should be in place for families who no longer want their appointment and this should be tracked to prevent families being sent multiple appointments that they then cancel or fail to attend because they do not want the appointment. Distinguish between families who appropriately decline (for example, no longer have hearing concerns) and those who decline despite clinical need. For these families, admin teams can follow-up first and, if they still do not want to attend, a clinician can contact the families by phone call to explain further. The pathway process and documentation should be recorded for both scenarios.

11.3.4 Safeguarding and follow-up

Responsibilities for who undertakes safeguarding in the instance of multiple cancellations or WNB must be clearly defined. Pathways for review need to be tracked and mapped out, recognising that many patients require more than one appointment. Mutual aid sites will not be as familiar with local safeguarding processes or contacts; safeguarding guidance is available.

Contracts should be based on the number of activity units rather than the number of patients. Often children need a review, especially if they have travelled to the appointment as you may not achieve discharge criteria or full diagnosis. There is a risk with mutual aid planning that the home provider thinks 'x' number of patients will be seen and this is not the case if you factor in reviews and cancellations.

11.3.5 Tracking and oversight

For triage, some patients will require longer than 30-minute appointments, 45 to 60 minutes instead, so scheduling should reflect this and care should be taken when grouping the number of patients to 30-minute time slots. Use a shared tracker for all patients to ensure no-one is lost to follow-up. Assign dedicated staff at both the home and mutual aid sites to manage the tracker and communications and ensure this work is not absorbed into routine day-to-day activities.

11.4 Mutual aid for paused services

All ICBs must have a co-ordinated approach to the provision of mutual aid, delivered through provider collaboratives or networks. It is important to get mutual aid established, particularly for urgent assessments, new fittings and urgent repairs. Patients must be prioritised into P1–P4 groups. Services should support families with travel to the new site and put in place a clear mechanism for managing results and reports, including who will hold initial conversations with families. Some patients may prefer to remain with the mutual aid site and SMEs travelling from the mutual aid site to the provider will require appropriate support.

12. Tracking and reporting

Tracking and reporting review, recall and reassessment and subsequent harm reviews is essential. Reporting timeframes should be established to enable reporting via relevant governance structures. Review, recall and reassessment data will be collected through a centralised form. NHS England will issue reporting returns to ICBs for completion. ICBs are requested to include updates to service improvement and service assurance levels in the reporting returns.

Reporting will cover all stages of the Paediatric Hearing Services Improvement programme – operational guidance and reporting requirements relating to CQC Regulation 20: Duty of candour.

For services in stage 3, reporting will include:

- has there been an onsite peer review visit/small cohort review/how many patients were in the small cohort review
- if a whole cohort review is required, the number of patients identified requiring record review/the number of completed record reviews

For services in stage 4, reporting will include:

- the number of patients requiring recall/the number of patients reassessed
- the number of patients identified with levels of harm following reassessment
- where families do not engage with recall for a child, the service should work with NCDS to try and support engagement and reduce cases where the patient was not bought
- where recall is not possible, patients should be reported as unable to recall

12.1 Recording cases of harm – harm categorisation

Use the categories below to record the number of cases where harm was identified. For each harm level, record: (a) the number of cases and (b) of those cases, how many resulted in delay and/or incorrect management.

A. ABR/VRA-related harm (post-NHSP referral)

A1. Severe harm

A1a) Number of cases of severe harm due to diagnostic inaccuracy following NHSP referral (ABR, VRA or both).

A1b) Of these cases, how many resulted in a delay to hearing aid assessment/fitting, a delay to referral to other services and/or an incorrect management plan?

A2. Moderate harm

A2a) Number of cases of moderate harm due to diagnostic inaccuracy following NHSP referral (ABR, VRA or both).

A2b) Of these cases, how many resulted in a delay to hearing aid assessment/fitting, a delay to referral to other services and/or an incorrect management plan?

A3. Low harm

A3a) Number of cases of low harm due to diagnostic inaccuracy following NHSP referral (ABR, VRA or both).

A3b) Of these cases, how many resulted in a delay to hearing aid assessment/fitting, a delay to referral to other services and/or an incorrect management plan?

A4. No harm

A4a) Number of cases of no harm following review of ABR/VRA cases referred from NHSP (ABR, VRA or both).

A4b) Of these cases, how many resulted in a delay to hearing aid assessment/fitting, a delay to referral to other services and/or an incorrect management plan?

B. PTA-related harm (post-NHSP referral)

Excluding cases that passed the newborn hearing screen.

B1. Severe harm

B1a) Number of cases of severe harm due to diagnostic inaccuracy of PTA.
B1b) Of these cases, how many resulted in inappropriate hearing aid fitting, a delay to hearing aid assessment/fitting, a delay to referral to other services and/or an incorrect management plan?

B2. Moderate harm

B2a) Number of cases of moderate harm due to diagnostic inaccuracy of PTA.
B2b) Of these cases, how many resulted in inappropriate hearing aid fitting, a delay to hearing aid assessment/fitting, a delay to referral to other services and/or an incorrect management plan?

B3. Low harm

B3a) Number of cases of low harm due to diagnostic inaccuracy of PTA.
B3b) Of these cases, how many resulted in inappropriate hearing aid fitting, a delay to hearing aid assessment/fitting, a delay to referral to other services and/or an incorrect management plan?

B4. No harm

B4a) Number of cases of no harm following review of PTA cases.
B4b) Of these cases, how many resulted in inappropriate hearing aid fitting, a delay to hearing aid assessment/fitting, a delay to referral to other services and/or an incorrect management plan?

C. Harm arising from other parts of the care pathway

For example: inappropriate triage; longer waiting times than clinically advised; delayed decisions resulting in delayed diagnosis; diagnosis outside the clinically appropriate timeframe for intervention; incorrect discharge/diagnosis identified later; hearing aid fitting/amplification; psychological harm; or a required test not undertaken.

C1a) Number of cases of severe harm arising from other parts of the care pathway.
C2a) Number of cases of moderate harm arising from other parts of the care pathway.
C3a) Number of cases of low harm arising from other parts of the care pathway.
C4a) Number of cases where no harm arose from other parts of the care pathway.

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Appendix A – Guidance for services to aid communication with families

NHS England has worked with the National Deaf Children's Society (NDCS) and parents with lived experience of the review and recall process to develop this guidance. It has been designed to support the delivery of a high-quality review and recall process for children identified through the historical trace review as requiring reassessment of their hearing, providing practical information for local services to contact and engage effectively with families. It includes adaptable template letters, conversation scripts and information about additional support that can be offered to families.

It aims to improve the experience for families who are to go through or have been through the recall process. It is important that families understand what has happened (explanation) and the need for further assessment (action), have access to information and support (signposting) and feel empowered to engage with services and share any concerns (feedback).

National Deaf Children's Society support

The NDCS can offer tailored support for both services and families accessed via early intervention specialists (EIS) who work with audiology services to provide families with emotional support and signposting through the review and recall process to:

- support families emotionally and practically throughout the review and recall process, even before the recall appointment takes place
- support families with information about deafness
- support with advice around reducing those that do not attend (DNA) or have not been brought (WNB) to appointments
- provide impartial advice on communication, technology and local services
- collaborate with professionals for a co-ordinated support approach
- advocate for families' rights and access to support
- help families prepare for key transitions, like starting nursery or school
- support the work of local professionals including teachers of the Deaf

The NDCS can work with providers through third-party referral forms, honorary contracts or memorandum of understanding/data sharing agreements. To discuss EIS support, contact adviceandguidance@ndcs.org.uk. Support can be arranged at any stage, ideally during the recall planning phase, and is available for families currently going through recall or who have already been through the process. The NDCS can also support services by creating resources or reviewing communications, including:

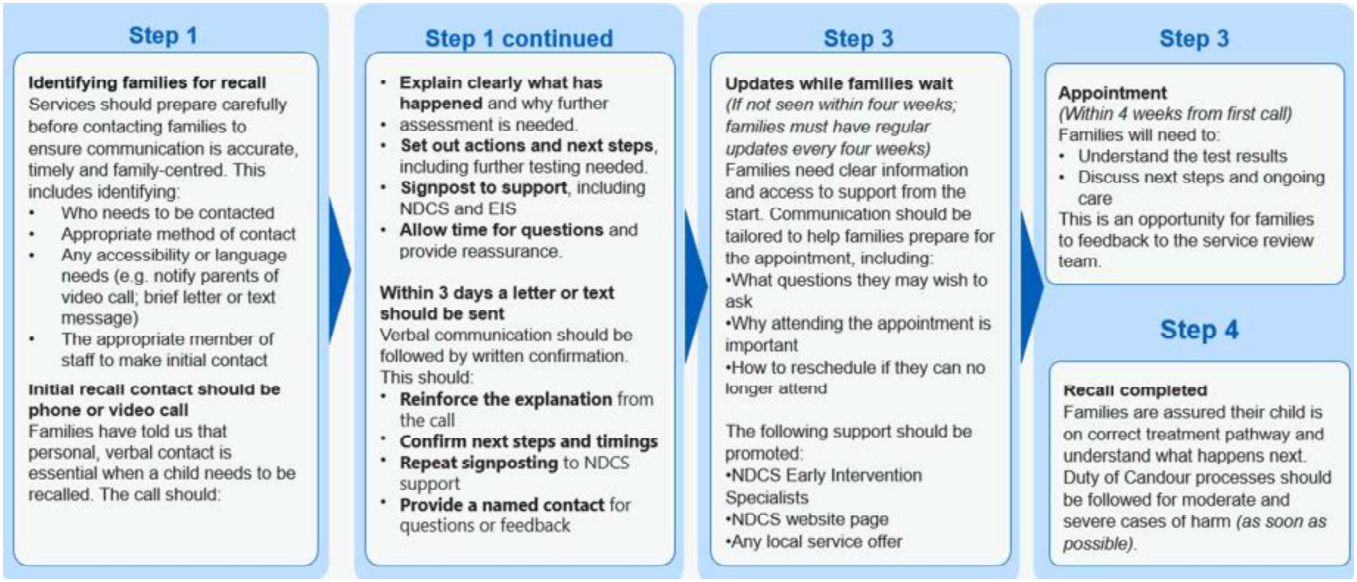
- Deaf awareness training
- informed choice discussions
- signposting to information about deafness

The NDCS provides website information about review and recall, with links to appropriate resources for families. The NDCS welcomes professional feedback on this website content and is open to working with services to develop new resources as needed. Please discuss this further with your EIS.

Communication timeline for families, developed with families

Families would like to know when services are paused or require recall in case there is action they can take independently to support their child. They appreciate open and honest information and have reported previous communications have not conveyed the serious requirement for a recall for their child. They have helped develop the communications and approach below to support other families through recall. Families should receive regular updates (every 4 weeks) if waiting for recall or on waiting lists. Families have requested reminders are issued by text 3 days before and on the day of appointment.

Figure A1: Communication timeline



Appropriate staff and contact methods

Services should ensure wider health professionals (for example, GPs, speech and language therapists, health visitors and school screening services) and services for Deaf children are aware of the review and recall programme in their local area. They should explain the incident and ensure they are aware some families are being recalled. Families have talked about missed opportunities for their child's hearing loss to be identified when engaging with other health professionals. Ensure other services know what advice to give to families; this may include encouraging attendance at audiology appointments or signposting to further information. Other services should also be aware of the local referral process.

Table A1: Appropriate staff and contact methods

Situation	Contact methods	Communication from
Case reviewed and moderate or greater harm identified Action required	Duty of candour phone/video call or face-to-face appointment and letter follow-up for children with Deaf parents/carers, services should use alternative methods of communication to phone calls – such as face-to-face or virtual appointments with British Sign Language specialists to ensure access. Appointments could be arranged via text message or letter.	Senior clinician
Case reviewed and low harm identified Action required	Phone/video call or face-to-face appointment and letter follow-up for children with Deaf parents/carers, services should use alternative methods of communication to phone calls – such as face-to-face or virtual appointments with British Sign Language specialists to ensure access. Appointments could be arranged via text message or letter.	Clinician/admin team
Case reviewed and no harm/undetermined harm identified No action required	No Duty of Candour activity required. Families have requested they are informed where their child's case is being reviewed and of the outcome.	Provider
Case not reviewed. Wider concerns about service have resulted in other children being recalled. Action required	No Duty of Candour activity required. Families have requested they are informed when the service is being paused or undertaking recall.	Provider

Families have shared that they need transparency and honesty and that some of these discussions may be difficult. Staff members will be dealing with parents who are worried and possibly angry. Staff members should have up-to-date training in conflict resolution and skills in sharing bad news, be signposted to provider health and wellbeing services and be supported by a senior clinician as required.

Families have shared that they have experienced a huge emotional burden, including feelings of guilt and anxiety, and they need information that not only informs but also reassures and empowers. Families may feel guilty for missing signs of deafness and have stressed the importance of supportive communication from professionals and resources that validate their experiences and feelings. Some parents also reported feeling let down and losing faith in the system. Services should consider what support networks, including peer support, and

counselling offers are available locally and ensure this information is shared as part of any support package for families. Families have expressed it has been helpful to meet other local families who have been through recall. The NDCS can support services with this.

> *"Parents should be supported in their feelings and anger at what has happened; they should not be made to feel a burden or a nuisance because they advocate for their child." – Family member*

Principles of communication with families

NDCS work with families has identified key principles for communication or engagement with families during the recall process: **explanation – action – signposting – feedback**.

Explanation

Families have told us they want honesty and transparent communication about what happened, including the seriousness and scale of the issue. When asked about what was most helpful about the support provided by the review team, one family responded:

> *"Their openness and honesty and the confidence they gave us during the appointment."*

When asked what could have been better, one family responded:

> *"Clarity about what had happened, candour about what happened and being honest and truthful. We were blindsided by what appeared at first to be a routine appointment and it was upsetting and distressing for our family to be so underprepared for this."*

Explanations should be family-centred – parents value child/family centred communication.

> *"Always on time, spoke to both parents and child, especially as he got older to explain what was happening and what the results of any tests meant."*

> *"The nurse at every appointment was excellent and made my child feel at ease. She explained all of the steps and why things were happening."*

Action

Families need to know what action needs to be taken and to understand the urgency of taking action.

> *"We were upset that we did not get clear enough information to make it a priority to attend and so we waited for the next batches of appointments and scheduled for her father to take her which if we had known we both would have gone. The letter should've been clear, it felt like a box ticking thing."*

Signposting

Families need access to information and support in different ways to suit their needs. There is a particular need for families who may be waiting a significant period of time before their recall

appointment takes place. Parents value knowing what will happen next and having a named point of contact and access to information and regular information.

> *"Having someone as a point of contact now works; it has made it easier with communication." – Family member*

Feedback

Families need to be empowered to feedback to services about what did and did not work well. This should be incorporated into service delivery.

A range of options need to be offered for families to give feedback. For example, scanning a QR code to complete a survey on their phone or using a tablet/paper to complete a survey at reception. See NDCS website for further information.

These principles should be considered at every stage of contact with families, from the initial contact, responding to queries and through to any identification of deafness.

Initial contact with families

Once a provider has reviewed cases and identified which patients require reassessment, families should be contacted with the outcome as soon as possible.

Following best practice, when a child needs reassessing, families should be contacted by telephone first. The call should explain what has happened and outline the next steps. After recall, where moderate or greater harm has been identified, another phone call should occur within 10 days and be followed by a written letter within 3 days. For Deaf parents or carers, services should use accessible alternatives such as text messages, video calls with British Sign Language (BSL) interpreters or face-to-face appointments with BSL specialists.

Families want personalised information and the opportunity to ask questions about their child's specific case. They value continuity and the opportunity to speak with someone knowledgeable about their child's case. Communication on harm should be led by a senior clinician, supported by other service members, and remain consistent throughout the process.

> *"The initial call taker had no idea about the recall and was just calling people up; they asked if my child had any issues, I was concerned about, but they weren't a clinician and gave no indication of any urgency or that this was anything other than a paper exercise or double check."*

Consider the most accessible way to convey information for each family. This may include translated materials in different languages using culturally respectful and inclusive language, easy read versions or an early intervention specialist (EIS). The key principle is to communicate in a way that is respectful, inclusive and responsive to individual needs, ensuring families feel fully informed and supported. Families value continuity of care, timely appointments with transparent timescales and clarity about their point of contact and who is involved in their care.

"Generally, the appointments were fine, however our child attended several with audiology and was then referred to ENT as the audiologist didn't think the issue was glue ear after all - however ENT went straight back to glue ear, without seeming to reference previous notes/medical history, meaning that we have started again."

In some cases, where no actions from families are required, letters can be the initial contact for information only. Phone/video calls or face-to-face meetings should always be followed by a letter. The following scripts can be personalised by services to fit their contexts.

A) Phone, video call or face-to-face meeting scripts – preparing to recall

When to use this guidance. Use this guidance when an audit has found that a child may have issues with their hearing assessment. This requires phone calls to families and asking children to return for repeat testing.

Who should make the call. The person making this call must be an experienced clinician in a leadership role (usually Band 7 or above), such as a lead paediatric audiologist, clinical scientist, head of service. They must have current training in both conflict resolution and sharing difficult news, as families will understandably be worried and may be upset.

Preparing for the call. Before calling, the clinician must:

- review the case thoroughly: understand the child's clinical background, test results and exactly why they need to return
- get the facts straight: know what went wrong, how the problem was discovered and what this might mean for the child
- check all information: make sure you have the most current and accurate details
- prepare to answer questions: be ready to explain the situation clearly and know where to direct families for additional support
- review available support: services should consider what support networks and counselling offers are available locally and ensure this information is shared as part of any support package for families

What families need to know. During every call, make sure families understand:

- they can ask as many questions as they need to
- what will happen next and when
- when they'll receive their appointment letter
- what support is available to them

Administrative support. Admin teams can help with practical arrangements like booking appointments, but clinical conversations about harm must be led by senior clinicians.

Introduction to the call. Approach the conversation with empathy, clarity and transparency. Verify who you are speaking to. *"Is this the parent of Sam Smith?"* Introduce yourself and the purpose of the phone call. You could say: *"My name is [name] and I am the head of service for audiology at [hospital name]. We saw Sam for a hearing test when he was a baby and I wanted to talk to you about his results."*

Explanation. Explain what has happened clearly.

- You could say: *“As part of a review of children seen in our service, we have identified the hearing test your child had may not have been interpreted correctly."*
- Apologise sincerely. NHS guidance emphasises that saying sorry is not an admission of liability. A genuine apology helps build trust and shows empathy. *"I want to start by saying how truly sorry we are that this has happened. We understand how worrying this must be for you."*
- Be clear on what is known and what requires further investigation. For example, *“Although you were told your baby’s hearing was normal, a review of the results has identified a need for further testing. The sounds used during testing were not quiet enough and therefore we cannot rule out a hearing loss. However, we do know your child showed responses at louder levels.”* You could relate any responses obtained to sounds the parent might understand, such as a dog barking.
- Use plain language and avoid any medical jargon. For example, *“The tympanometry results were peaked”* could be *“The results showed your child did not have glue ear at the time of testing.”*
- Give the parent or family member space for any questions.

Potential impact. Parents are likely to be concerned about what this means for their child.

- Be clear about what this means for their child’s development. You could say: *“We are not sure if Sam’s hearing aids are set optimally due to the uncertainty around his hearing levels. We want to establish his exact hearing levels as soon as possible so we can adjust his hearing aids appropriately.”*
- If the impact is uncertain, it’s important to acknowledge that. You could say: *"At this stage, we’re not certain whether the results affected your child’s care, but we are treating this seriously and will ensure any necessary follow-up is arranged quickly."*
- Emphasise why it is important to attend for follow-up.

Next steps. Be clear about what is happening next. You could say: *"We’ve arranged for a repeat hearing test to be done as soon as possible, and we can share some information with you on how to best prepare for the appointment."*

Offer support and answer questions

- You could say: *"I know this is a lot to take in. Do you have any questions right now or is there anything I can clarify for you?"*
- You could say: *"If you think of any questions later, please don’t hesitate to contact me directly* [and give details how]*.”*
- Signpost to the NDCS and our offer of an early intervention advice and guidance officer.
- The NDCS has some information that it can be helpful to signpost families to. For example:
    - Understanding your child's hearing tests
    - Comic for children: Going to the hearing clinic

- the family may have questions about what they can do while they are waiting for an appointment. Supporting families while they wait provides guidance around this

Documentation. Record the details of the call in line with your service's policy. Include what was said, the family's response and any agreed actions. Ensure it also includes any additional information that families may require (for example, access to communication support or schemes to reimburse travel to appointments). This can also be used to personalise the letter that goes out to families.

B) Letter templates

Phone calls (or alternative method for those children with Deaf parents/carers) should be followed by a written letter within 3 days

What do families need to know?

- Explanation: personalised text to confirm why the family was contacted and a summary of the phone discussion.
- Action: clear next steps for the family, including how they can best support their child in the interim and the anticipated timeline for future contact with the family.
- Signposting for further support and information about deafness to the NDCS, including signs of deafness or any red flags the family should look out for. Where an EIS is available, include their direct contact details.
- Feedback: who do they contact if they have any concerns or questions? Ideally this should be a named person rather than a generic contact.
- Space for parents to note any questions or concerns or any observations that may be useful for the clinician when they attend. It can be useful to create prompts, so parents feel empowered to approach professionals.

B1) Letter template: if parents have contacted the provider to enquire if their child is involved in a review

<insert date>

Dear Parent or Guardian,

Re: <insert child's details>

I am writing to confirm that our paediatric hearing service at [insert provider] is under national review to make sure that all national guidelines and standards are being followed. **If your child has been part of this review, you will be contacted to either arrange a reassessment if it's required or to let you know that your child's hearing does not require reassessment.**

If you have any concerns about your child and would like to speak to a member of our staff, please do not hesitate to contact us on [insert telephone number and available dates and times]. Or you can email: [insert email]. Alternatively, you can contact [insert name of person sending the letter] directly on [insert phone number] or by email [insert email].

You can use the space below to note any questions:

- I am concerned about my child's hearing. What should I do?
- My child has a speech delay. Do they need their hearing reassessed?
- _____

Where can I find out more information?

The service's website is: [insert website]

Information about the different types of hearing tests for children can be found on the NHS website: Hearing tests - NHS

For more information about childhood deafness, you can contact the National Deaf Children's Society: Website: www.ndcs.org.uk. Phone: 0800 800 8880 (free). Text: 0786 00 22 888 (texts are charged at your standard rate). Helpline hours: Monday to Thursday 9am to 5pm, Friday 9am to 12.30pm. Live chat and SignVideo are also available via its website.

Yours sincerely,

[insert name and job title]

B2) Letter template: for parents of a child who needs their hearing reassessed

<insert date>

Dear Parent or Guardian,

Re: <insert child's details>

I am writing to you following the conversation you had with [insert name and job title] today about your child needing a further hearing assessment. I'd like to say again that we are very sorry that this has happened.

[Briefly summarise content of phone call in a few sentences. For example, *we discussed that the hearing test your child had at birth had not been interpreted correctly. This means that we do not know if your child has a hearing loss.]*

It is important to identify hearing loss in children as early as possible, so that they can get the right support to develop the language and communication skills that are critical to their future.

It is very important that your child has another hearing test at the earliest opportunity. Please make sure that you and your child attend. If, for any reason, you think it will be difficult to attend, please contact the team to discuss.

I will arrange for the team at [insert hospital name] to call you to arrange an appointment. However, if you want to contact the team yourself then please telephone [insert contact number] to get through to the children's booking team.

OR

As discussed, I have booked an appointment for your child to be retested on [insert date], at [insert time].

The test takes about [insert number of minutes] so please allow plenty of time. This will take place at:

[insert name and full address] [Include map / link to where the appointment is]

Please do not hesitate to contact us on [insert telephone number and available dates and times] if you have any questions and would like to speak to a member of our staff. Or you can email: [insert email]. Alternatively, you can contact [insert name of person sending the letter] directly on [insert phone number] or by email [insert email].

You can use the space below to note any questions:

- Can you tell me more about the type of hearing test that was done before and what went wrong?
- My child has a speech delay; how can I support them with their communication while I wait for the appointment?
- _____

Where can I find out more information?

The service's website is: [insert website]

Information about the different types of hearing tests for children can be found on the NHS website: Hearing tests - NHS

For more information about childhood deafness, you can contact the National Deaf Children's Society: Website: www.ndcs.org.uk. Phone: 0800 800 8880 (free). Text: 0786 00 22 888 (texts are charged at your standard rate). Helpline hours: Monday to Thursday 9am to 5pm, Friday 9am to 12.30pm. Live chat and SignVideo are also available via its website.

Yours sincerely,

[insert name and job title]

B3) Letter template: for parents of a child who needs their hearing reassessed and has moved out of area (no prior contact has taken place)

<insert date>

Dear Parent or Guardian,

Re: <insert child's details>

As part of a national programme to review the safety and quality of audiology services in England, we recently reviewed some of our previous patients seen during [time period]. The review found that some of the hearing tests were not interpreted correctly. While we haven't identified any specific concerns with your child's hearing test, we're inviting families for a repeat check to provide peace of mind and ensure their child has received the best possible care.

However, our records indicate that your family has moved outside our catchment area.

It is important to identify hearing loss in children as early as possible, so that they can get the right support to develop the language and communication skills that are critical to their future.

[delete as appropriate]

- **We have contacted your local audiology service and they will be in touch to arrange an appointment with you within [time period]. If you do not hear from them, please contact...**
- **We kindly ask you to contact your GP for a referral to your local audiology service. A copy of this letter has been sent to them/you can take a copy of this letter with you.**
- **You can self-refer to your local audiology service via its website...**
- **We can offer a further assessment at our service if this is convenient.**

We understand that this may be an unexpected communication and want to support you through the process.

Please do not hesitate to contact us on [insert telephone number and available dates and times] if you have any questions and would like to speak to a member of our staff. Or you can email: [insert email]. Alternatively, you can contact [insert name of person sending the letter] directly on [insert phone number] or by email [insert email].

You can use the space below to note any questions:

- I am concerned about my child's hearing. What should I do?
- My child has a speech delay. Do they need their hearing reassessed?
- _____

Where can I find out more information?

The service's website is: [insert website]

Information about the different types of hearing tests for children can be found on the NHS website: Hearing tests - NHS

For more information about childhood deafness, you can contact the National Deaf Children's Society: Website: www.ndcs.org.uk. Phone: 0800 800 8880 (free). Text: 0786 00 22 888 (texts are charged at your standard rate). Helpline hours: Monday to Thursday 9am to 5pm, Friday 9am to 12.30pm. Live chat and SignVideo are also available via its website.

Yours sincerely,

[insert name and job title]

B4) Letter template: informing parents of a paused service

This template is for services that are paused while addressing particular aspects of service delivery, such as waiting list management, training and improvement of facilities.

Families will naturally have a lot of questions and it can be challenging for them when they have to chase information, particularly if it is difficult to contact the audiology department. Transparency with families is important to reduce anxiety.

<insert date>

Dear Parent or Guardian,

Re: <insert child's details>

We want to let you know about an important change to your child's audiology service.

As part of a national programme to review the safety and quality of audiology services in England, we have decided to temporarily pause the service. This is because the review identified [give example]:

- we need to update the facilities to ensure the test rooms are suitable for performing hearing tests
- staff may require further training around performing hearing tests for young children

This pause will give us the time to carefully review how we deliver care and make sure the service meets the needs of all children and families.

We have made arrangements to minimise any interruptions to your child's care. This includes [give example]:

- working with neighbouring audiology services so children requiring urgent assessments and hearing aid support can be seen at alternative sites
- checking our waiting lists to prioritise children with urgent needs

We will keep you updated as our review progresses and we aim to resume services as soon as it is safe and appropriate to do so. We understand that this may be an unexpected communication and want to support you through the process.

If you have any questions or concerns and would like to speak to a member of our staff, please do not hesitate to contact us on [insert telephone number and available dates and times]. Or you can email: [insert email]. Alternatively, you can contact [insert name of person sending the letter] directly on [insert phone number] or by email [insert email].

You can use the space below to note any questions:

- I am concerned about my child's hearing. What should I do?
- What do I do if my child's hearing aid has a fault?
- _____

Where can I find out more information?

The service's website is: [insert website]

Information about the different types of hearing tests for children can be found on the NHS website: Hearing tests - NHS

For more information about childhood deafness, you can contact the National Deaf Children's Society: Website: www.ndcs.org.uk. Phone: 0800 800 8880 (free). Text: 0786 00 22 888 (texts are charged at your standard rate). Helpline hours: Monday to Thursday 9am to 5pm, Friday 9am to 12.30pm. Live chat and SignVideo are also available via its website.

Yours sincerely,

[insert name and job title]

B5) Letter template: for parents of a child who does not require a reassessment

<insert date>

Dear Parent or Guardian,

Re: <insert child's details>

I am writing to you about a review of hearing test results which involved reviewing your child's records. We have undertaken a review because some tests were not completed to the standards that we expect.

Our review has shown that your child was tested accurately and no hearing loss was identified. You do not need to take any further action unless you have a concern.

Please do not hesitate to contact us on [insert telephone number and available dates and times] if you have any questions and would like to speak to a member of our staff. Or you can email: [insert email]. Alternatively, you can contact [insert name of person sending the letter] directly on [insert phone number] or by email [insert email].

You can use the space below to note any questions:

- I am concerned about my child's hearing. What should I do?
- My child has a speech delay. Do they need their hearing reassessed?
- _____

Where can I find out more information?

The service's website is: [insert website]

Information about the different types of hearing tests for children can be found on the NHS website: Hearing tests - NHS

For more information about childhood deafness, you can contact the National Deaf Children's Society: Website: www.ndcs.org.uk. Phone: 0800 800 8880 (free). Text: 0786 00 22 888 (texts are charged at your standard rate). Helpline hours: Monday to Thursday 9am to 5pm, Friday 9am to 12.30pm. Live chat and SignVideo are also available via its website.

Yours sincerely,

[insert name and job title]

B6) Letter template: for parents of a child who was not brought to their appointment and needs to have their hearing reassessed

<insert date>

Dear Parent or Guardian,

Re: <insert child's details>

We are writing to inform you that your child was not brought to their scheduled appointment with Audiology on [date].

We understand that there may be many reasons why an appointment is missed. However, the appointment was made because [reiterate personalised reason for recall clearly]. It is important that we identify any hearing loss in children as early as possible, so that they can get the right support to develop the language and communication skills that are critical to their future.

[delete as appropriate]

- We have arranged a further appointment on [date/time]. **Please contact us if this is inconvenient.**
- **Please contact us to arrange a further appointment at a convenient time.**

Please be aware that repeated missed appointments may be discussed with other professionals involved in your child's care, in line with our safeguarding responsibilities.

Please do not hesitate to contact us on [insert telephone number and available dates and times] if you have any questions and would like to speak to a member of our staff. Or you can email: [insert email]. Alternatively, you can contact [insert name of person sending the letter] directly on [insert phone number] or by email [insert email].

You can use the space below to note any questions:

- I am concerned about my child's hearing. What should I do?
- My child has a speech delay. Do they need their hearing reassessed?
- _____

Where can I find out more information?

The service's website is: [insert website]

Information about the different types of hearing tests for children can be found on the NHS website: Hearing tests - NHS

For more information about childhood deafness, you can contact the National Deaf Children's Society: Website: www.ndcs.org.uk. Phone: 0800 800 8880 (free). Text: 0786 00 22 888 (texts are charged at your standard rate). Helpline hours: Monday to Thursday 9am to 5pm, Friday 9am to 12.30pm. Live chat and SignVideo are also available via its website.

Yours sincerely,

[insert name and job title]

B7) Letter template: for informing local services of review and recall

<insert date>

Dear Colleagues,

As part of a national programme to review the safety and quality of audiology services in England, we recently reviewed some of our previous patients seen during [time period].

As a result, we're recalling some families for a repeat hearing assessment to ensure their child has been tested accurately and has received the best possible care.

It is important to identify hearing loss in children as early as possible, so that they can get the right support to develop the language and communication skills that are critical to their future.

Families may ask you questions about the review and recall process. Please ensure:

- you continue to refer families raising concerns about their child's hearing to our service, even if they have had a hearing assessment before
- that families are encouraged to attend any repeat audiology appointments
- families are signposted to the National Deaf Children's Society for more information

Families can contact us on [insert telephone number and available dates and times] should they have any questions and would like to speak to a member of our staff. Or they can email: [insert email].

Where can I find out more information?

The service's website is: [insert website]

Information about the Paediatric Hearing Services Improvement programme can be found at: https://www.england.nhs.uk/long-read/paediatric-hearing-services-improvement-programme-operational-guidance/

For more information about childhood deafness, you can contact the National Deaf Children's Society: Website: www.ndcs.org.uk. Phone: 0800 800 8880 (free). Text: 0786 00 22 888 (texts are charged at your standard rate). Helpline hours: Monday to Thursday 9am to 5pm, Friday 9am to 12.30pm. Live chat and SignVideo are also available via its website.

Yours sincerely,

[insert name and job title]

Supporting families while they wait

For many families involved in the recall process, there may be a significant wait between initially being notified that their child requires further assessment and the appointment taking place. For families, this can be period of uncertainty, with many unsure of how they can best support their child in the meantime. Families should receive regular updates (every 4 weeks) on their waiting time and tailored support to help them manage any concerns. Families may be offered support from an EIS if available. They can be signposted to the NDCS for information. It may also be useful to:

- give families advice on how to best prepare their child for the audiology appointment. Families may have waited a while for the appointment and services may have limited appointment availability, so it is important to work with families to ensure that the appointment is as successful as possible by:
    - checking with the family whether their child has any additional needs that need to be accommodated
    - ensuring the family are aware they can reschedule the appointment if it is inconvenient
    - signposting to any support that may be available for travel to the appointment
    - signposting to books and videos about having a hearing test. Some services may have their own videos. Consider whether your service could produce a video or social story for children. The NDCS has examples on their website Deaf-friendly medical appointments and a comic called Going to the hearing clinic
    - giving families an understanding of what to expect can help them prepare their child at home (for example, playing doctors to prepare their child for examination or using headphones/earphones). Advice around desensitisation can be particularly helpful for children with additional needs
- give families advice on how to best support their child's communication while they wait for the audiology appointment. While services are likely to see children most at risk of hearing loss first, there may still be children on the waiting list with undiagnosed hearing loss. Supporting families with communication helps them feel empowered and may reduce the impact of delayed diagnosis:
    - general advice on Deaf awareness can benefit all children, not just those with hearing loss
    - access to sign language and sign systems can support a child's communication, even if they are not Deaf
    - NDCS information supporting language and communication and developmental play chart
- give families advice on what information may be helpful for the appointment. Are there any observations they should be making about their child's hearing? Is there any history they can prepare? Families are not always sure what questions they need to ask professionals, so it can be useful to provide them with prompts

- empower families to know when to escalate concerns. Provide them with advice and guidance on the signs and symptoms of hearing loss and ensure they know who to contact if they have significant concerns about their child's hearing. NDCS signs of deafness and hearing loss

The recall appointment

For many families, the recall appointment is likely to be straightforward. Most families will not receive a new diagnosis, but they are likely to still require some reassurance, so a clear explanation of the test results is crucial: *"Today's results show your child's hearing is within the typical range. We assessed the hearing by checking your child's responses to different sounds, using a game. Do you have any questions about the test?"*

The NDCS has information for families on understanding the different types of hearing test. It is important families feel empowered to ask questions about the results and the process. Some families may need reassurance of the accuracy of the test procedure and information about what has changed in the service since their child was last seen. For some families, clinicians may have to inform the family that their child is Deaf. This will need to be individualised for each family but should follow the same principles.

Acknowledge how the family may be feeling: *"Thank you for coming today. I know this may be a difficult process, but we are here to support you."*

Explain the results: *"Today's results show your child has a moderate hearing loss in both ears. This means they may struggle to hear softer sounds or speech, especially in noisy environments. Do you have any questions?"*

If parents have expressed concerns, validate those concerns: *"You mentioned that your child has difficulty with their /s/ and /f/ sounds. This is likely related to their hearing loss. We are sorry that there has been a delay in identifying the hearing loss and we want your child to have all the support they need going forward."*

Check in with the family: *"How are you feeling?"*

Action: *"There are several options available to support your child's communication and development. These include hearing aids to help your child access sounds, support from specialist teachers and referrals to other professionals. While you don't need to make any immediate decisions, today we'll work with you to create a plan for next steps that suits your family's needs. Would you like to find out more about your options?"*

Signposting: *"There is support available for you and your family. We can refer you to the National Deaf Children's Society for support from one of their early intervention specialists. They can provide you with emotional and practical support and more information about deafness and connect you with local services."*

Feedback: *"We welcome any feedback on the process and today's appointment. If you would like to feedback now, we can bring you an iPad to fill out a survey or you can contact our Patient Advice and Liaison Service."*

Encouraging attendance

Professionals may benefit from the NDCS safeguarding deaf children in healthcare webpage, which discusses things to consider when families do not attend appointments and how to encourage attendance. For example:

- keep messaging clear and family-friendly:
  - avoid jargon and explain clearly what the appointment is for (for example, replace "audiology review" with "an appointment for your child's hearing test").
- include why it's important (for example: "*Hearing loss can affect a child's development, so it is important to find out as early as possible*").
- ensure any actions to be taken by the family are clear in your correspondence with them

Reminders

- Your service may already have systems in place for appointment reminders. Use multi-channel reminders where possible (text, email and phone reminders), ideally 2–3 days before and again on the day of the appointment.
- Your EIS can support you with reminding families to attend appointments. For those families known to have higher non-attendance risk, a personalised phone call or text message can be more effective than automated reminders.
- Where possible, confirm attendance via a text reply system or over the phone.
- Work with other professionals to encourage attendance (for example, health visitors).
- Provide transport and parking information in reminders.

Accessibility

- Offer appointment letters and reminders in multiple languages or easy read formats.
- Offer evening, weekend or community-based clinics where possible. Some families are more likely to attend local familiar settings.
- Ensure appointments are flexible and can be easily changed. Allow rescheduling via text or an online portal if possible.
- Include information about the duration, location and what to expect during the appointment to reduce anxiety and confusion.
- Signpost to hospital transport services, community volunteer schemes or travel grants, where applicable.

Personalised follow-up

- After one missed appointment, phone or text to explore any barriers to attendance.
- Use a supportive tone: "*We just wanted to check everything is okay. Would another day work better?*"

- Explore the barriers raised (transport, timing, anxiety) and adjust future appointments accordingly.
- Aim for continuity of care with the same clinician or small team to review a child. Familiar faces increase trust and engagement.
- Identify vulnerable families (for example, looked after children, families with additional needs) and liaise with safeguarding leads or family support workers/teams to assist with attendance.

Parent feedback and engagement

- Ask families who do attend what makes it easier or more difficult for them to attend.
- Use feedback to make small service improvements (for example, clearer signage, shorter waits).
- Raise awareness of your service (for example, sharing leaflets or short videos explaining how hearing impacts speech, school and social development). The NDCS has a wide range of resources that can be shared with families.