SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	
Service	Hearing Services for Children
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National Context

Unmanaged and unsupported hearing disorders in childhood have a serious impact on all areas of a child's development; including speech, language and communication, education and social development. Balance problems can lead to delay in motor development, problems with social integration, difficulties with sporting activities, and anxiety etc. Children's audiology services aim to reduce the impact of any congenital or acquired hearing or balance disorder on a child's development. With multi-disciplinary and multi-agency colleagues audiology services support children and young people who have hearing disorders to fulfill their social, emotional, communicative and educational potential.

Audiology services provide assessment, diagnosis, intervention, and rehabilitation for hearing and balance disorders. Audiology is part of the healthcare sciences portfolio and staff within audiology services may come from medical, scientific, technical or support backgrounds.

The local children's audiology service/s form/s part of a wider context and care pathways for children that are commissioned by the local Clinical Commissioning Group/s, NHS England and Local Area Teams but may be provided by the same local providers, other local providers, or by alternative specialist services. It is vital that both Commissioners and Providers understand the local context of how this specification for children's audiology services work in the wider context, including newborn hearing screening, Ear, Nose and Throat services, cleft lip and palate services, bone-conduction hearing implant services, and auditory implant services.

This Service Specification is not intended to replicate, duplicate or supersede any relevant legislative provisions which may apply, e.g. of the Health and Social Care Act 2012, the Children and Families Act 2014, or the work undertaken by the Care Quality Commission. The Service Specification will be reviewed with Commissioners and Providers working pro-actively to agree variations to the Agreement to take account of any new guidance or legislation.

1.2 Prevalence/incidence

Permanent childhood hearing impairment

Permanent childhood hearing impairment is rare. Approximately 1.6 per thousand babies born will have a permanent unilateral or bilateral hearing impairment: a rare event which an average maternity unit (3-4,000 births per annum) will encounter about five times a year. A GP with an average list size will look after one deaf child in their entire career, and an average GP practice with five GPs may see only one deaf child in ten years. In a population of 500,000, there will be about ten new cases of PCHI per year, with about 50 pre school and 200 school age deaf children in the population. In some areas, where there are large numbers of children who enter the UK after the age for newborn screening, this can be expected to be two to three times the national prevalence, due to population variations (deprivation and ethnicity). An estimated further 6-800 children can develop or acquire Permanent Childhood Hearing Impairment (PCHI) by the age of ten due to meningitis, mumps, measles or head injury. By the age of ten, therefore, in each year's cohort of children in England, there will be up to 1,200 children with congenital or late onset bilateral hearing impairment and between 600 to 800 with unilateral deafness

.An average population of 500,000 people therefore can have about 150 children under the age of 18 with a hearing impairment who would benefit from a joint care plan, and 35 children under the age of five affected by PCHI. The small numbers of children with PCHI mean that highly specialist facilities and services will necessarily be concentrated in urban conurbations, serving a large population.

30-40 percent of children with permanent hearing difficulty have additional health needs or development problems, and 20 percent have more than two. There is evidence that children with hearing impairment are more likely to experience mental health problems or to be abused.

Auditory neuropathy spectrum disorder (ANSD)

Approximately one in ten of the children with permanent unilateral or bilateral hearing loss have a condition known as auditory neuropathy spectrum disorder (ANSD). This condition can cause fluctuating hearing levels and variable levels of distortion of the speech signal heard. Hearing aids or cochlear implants may be helpful for some children with ANSD. For others hearing aids further amplify the distortion heard meaning they are unhelpful. Learning to speak and learning through using spoken language may be particularly challenging for these children.

In 2015 the Consortium for Research into Deaf Education (CRIDE) reported that there were at least 41,377 children known to specialist education hearing support services in England.

Otitis media with effusion (glue ear)

The most common type of hearing problem during childhood is caused by otitis media with effusion ("glue ear"). At least 80% of children will have had one episode of glue ear by the age of 10 years. It is most common in pre-school children affecting them during early periods of language development and between the ages of one and three years. The prevalence of persistent glue ear is 10% to 30%. Glue ear is often temporary and self-limiting. However, almost 30,000 hospital admissions for grommet surgeries in children are carried out annually.

Auditory processing disorder (APD)

Auditory processing disorder (APD) is characterised by poor perception of sounds, has its origins in impaired neural function, and impacts on everyday life primarily through a reduced ability to listen, and so respond appropriately to sounds. APD will often co-exist with attention, language and learning impairments as well as autism spectrum disorder. There are 3 categories of APD:

1. Cases presenting in childhood with normal hearing (i.e. normal audiometry) and no

other known aetiology or potential risk factors. Some of these children may retain their APD into adulthood.
2. Acquired APD: Cases associated with a known post-natal event (e.g. neurological trauma, infection) that could plausibly explain the APD.
3. Secondary APD: Cases where APD occurs in the presence, or as a result, of peripheral hearing impairment. This includes transient hearing impairment after its resolution (e.g. glue ear).

Prevalence estimates of APD in the literature range between 2-10% in children.

Tinnitus

Reported prevalence of tinnitus in children varies from 12-36% and is more common in children with hearing loss compared to children with normal hearing. Most children with tinnitus do not find it distressing and self-manage, but a proportion require further support from audiology services.

Vestibular (balance) disorders

Reported prevalence of vestibular and balance disorders is up to 15% of the population with over a quarter of those having symptoms severe enough to disrupt normal activity.

However, vestibular disorders are also highly associated with hearing loss in childhood with up to 70% of children with permanent hearing loss having an impairment of their vestibular system. More than a third of severely-profoundly deaf children using cochlear implants have vestibular and balance dysfunction (usually related to the aetiology).

1.3 Local context

Local children's audiology services work within a wider context, including newborn hearing screening, school entry hearing screening, 'Ear, Nose and Throat services', bone-conduction hearing implant services, and auditory implant services.

Data available to Clinical Commissioning Groups to inform this section will be available from:

Number of children and data on child health	National Child and Maternal Health Intelligence Network (ChiMat) http://www.chimat.org.uk/
Numbers of babies referred from newborn hearing screening annually	eSP database data – reported by newborn hearing screen programme
Numbers of babies seen by paediatric audiology service within 4 weeks of their newborn hearing screen referral	eSP database data – reported by newborn hearing screen programme
Numbers of babies with confirmed permanent childhood hearing impairment annually	eSP database data – reported by newborn hearing screen programme / audiology service
Numbers children referred post-newborn hearing screen for assessment	Paediatric audiology service
Numbers of children referred post-newborn hearing screen with confirmed permanent childhood hearing impairment annually	Paediatric audiology service & eSP database paediatric audiology section
Numbers children managed annually with temporary "glue ear"	Paediatric audiology / ENT services
Numbers children who have grommet surgery for "glue ear" annually	Paediatric audiology / ENT services
Numbers children who are fitted with	Paediatric audiology / ENT services

hearing aids (instead of grommet surgery) for “glue ear” annually	
Total caseload of children with permanent childhood hearing impairment using hearing aids	Paediatric audiology / CRIDE data reported annually by specialist education hearing support services / local authorities[1]
Number of children who receive tinnitus assessment/habilitation annually	Specialist paediatric audiology (or n/a if service not provided)
Number of children who receive vestibular assessment/habilitation annually	Specialist paediatric audiology (or n/a if service not provided)
Number of children who receive auditory processing disorder (APD) assessment/habilitation annually	Specialist paediatric audiology (or n/a if service not provided)

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2 Local defined outcomes

Children’s audiology services aim to reduce the impact of any congenital or acquired hearing or balance disorder on a child’s development. For example, early intervention and provision of amplification in babies and children identified with a hearing loss is associated with better developmental outcomes including speech, language, and literacy. With multi-disciplinary and multi-agency colleagues audiology services support children and young people to fulfill their social, emotional, communicative and educational potential. The benefit of the children’s audiology service is therefore measured by the long-term improvements made in the life chances of the children supported by the service with accompanying improvements being made in the well-being of their families. This measurement and recording of this is beyond the scope of the specification at this stage. However, indicators of a good quality service can be measured in the shorter term along with short-term outcomes based on the meeting of personal development goals identified and agreed with the child, young person and family. The broad outcomes of the service are set out below:

- Identifying children and young people with hearing disorders referred into the service via screening and other pathways as early as possible.
- Confirming the nature and degree of any hearing loss accurately and quickly in a manner that is family friendly.
- Appropriately referring children with hearing loss and auditory neuropathy spectrum disorder (ANSD) to specialist education hearing support services (Teacher of the Deaf) as soon as it is confirmed.
- Advising parents and children about options for support
- Where parents choose to use hearing aids, fitting those hearing aids, maintaining them, and reviewing progress of the child using amplification.
- Ensuring children with permanent hearing loss, auditory neuropathy spectrum

[1] http://www.ndcs.org.uk/professional_support/national_data/cride.html

disorder (ANSD) and glue ear are seen by an appropriate medical consultant with experience of and training in paediatric audiology for developmental monitoring and aetiological investigations to identify the cause of the hearing disorder.
- Referring children in a timely way to specialist services when other surgical management or implantable devices may be more appropriate for the child.
- Providing support and information to the child or young person and their family and support them through transition to adult services.
- Promote and support research and the adoption of innovation.

Applicable measures relating to these broad outcomes are set out in Schedule 4C (Quality Requirements).

These can be defined locally and will make sense done in collaboration with mandatory return specification for education and social care services. This will encourage collaboration, improve efficiency and reduce the number of measures used.

3. Scope

3.1 Aims and objectives of service

3.1.1 Aims

To commission children's audiology services which ensure that:
- children with hearing and balance disorders are identified, assessed and appropriately managed as early as possible
- families are referred to other appropriate support services across agencies as early as possible
- changing needs are accommodated
- services are delivered as locally as possible
- care provided is safe, efficient, integrated, cost effective and high quality
- national quality and good practice standards are met

3.1.2 Objectives

The key objectives of the service are to:
- Regard children and their parents as full and equal partners in the team
- Ensure that informed consent to assessments and/or further management is obtained from the child if Gillick competent and/or the parents or those with parental responsibility.
- Identify hearing difficulty early
    - through on-going monitoring of high risk cases (eg children with complex disabilities, children with conditions known to be associated with hearing loss, children on ototoxic drugs)
    - following serious infection eg bacterial meningitis or septicaemia or head injury
    - following school entry hearing screening (where the this screen is implemented)
    - Following SALT referral of children with speech and language delay when hearing difficulties are suspected
    - At any age if there is professional or parental concern
- Provide rapid, definitive assessment and differential diagnosis in high quality facilities by specialist staff, accompanied by clear accessible information about diagnosis and further management
- Refer to the hearing support service provided by the local education authority (specialist service for hearing impaired) for all babies and children diagnosed with permanent childhood hearing impairment (PCHI)
- Provide clear information on, and refer for timely aetiological investigations, possible causes of PCHI

- Provide age appropriate hearing assessment of first degree relatives even if there are no concerns about the hearing, as previously unsuspected abnormalities may be present. The Provider will develop a local written protocol for carry out parent and sibling audiograms and dealing with any losses detected.
- Manage and actively monitor children with otitis media with effusion (OME) referring to and working with ENT according to clearly documented and agreed criteria and pathways
- Contribute to the multi-agency, multi-disciplinary support and management for the child and family
- Refer using clear direct pathways to specialist or supra-specialist care as required
- Provide on-going care for children with PCHI as part of the multi-disciplinary team as close to home as possible
- Systematically monitor the progress of children especially those with PCHI to ensure that support services and any equipment provided are appropriate
- Liaise closely with other specialist children's services for the approximately 40% of children with hearing impairment who have additional health needs
- Integrate vertically into a wider hearing services network for adults to ensure a seamless transition from children's services to adult services
- Participate in the Children's Hearing Services Working Group to contribute to the shaping of services across agencies
- Provide accurate and timely information about the effectiveness, quality and any other aspects of the services for the population covered that is reasonably requested to the commissioners
- Ensure that there is a system of clinical governance for all aspects of the service with clear and robust lines of responsibility and accountability
- Contribute as necessary to statutory assessment processes (eg Education, Health and Care Plans) for known service users.

3.2 Service description/care pathway

The Provider is to provide the children's audiology component of the local hearing services (community and secondary care levels, adult hearing services etc) within the context of a 'right care' network of children's hearing services (if this network implemented locally).

Children's audiology services should be organised and delivered so as to facilitate access to services for all children in the population served and must provide excellent clinical care and family-friendly support, whilst also ensuring best value and cost-effective use of resources.

The model of delivery will be a tiered approach. This service model enables a clear clinical distinction to be made between the complexity and level of different services that will be provided depending on whether an individual child has e.g. a permanent hearing loss and, if so, the degree, type and configuration of that loss, and also on their physical, emotional and family needs. It should also ensure that children are seen, tested and managed by professionals with the most appropriate skills and competence working within clear, integrated care pathways.

Within the model shown it is recognised that, in reality, the same staff members could provide services of varying complexity from across the different tiers.

Children's audiology will work in partnership with children, young people and their families in an integrated way across General Practice, community health services, specialist education hearing support services, and other relevant professionals and providers to deliver the service.

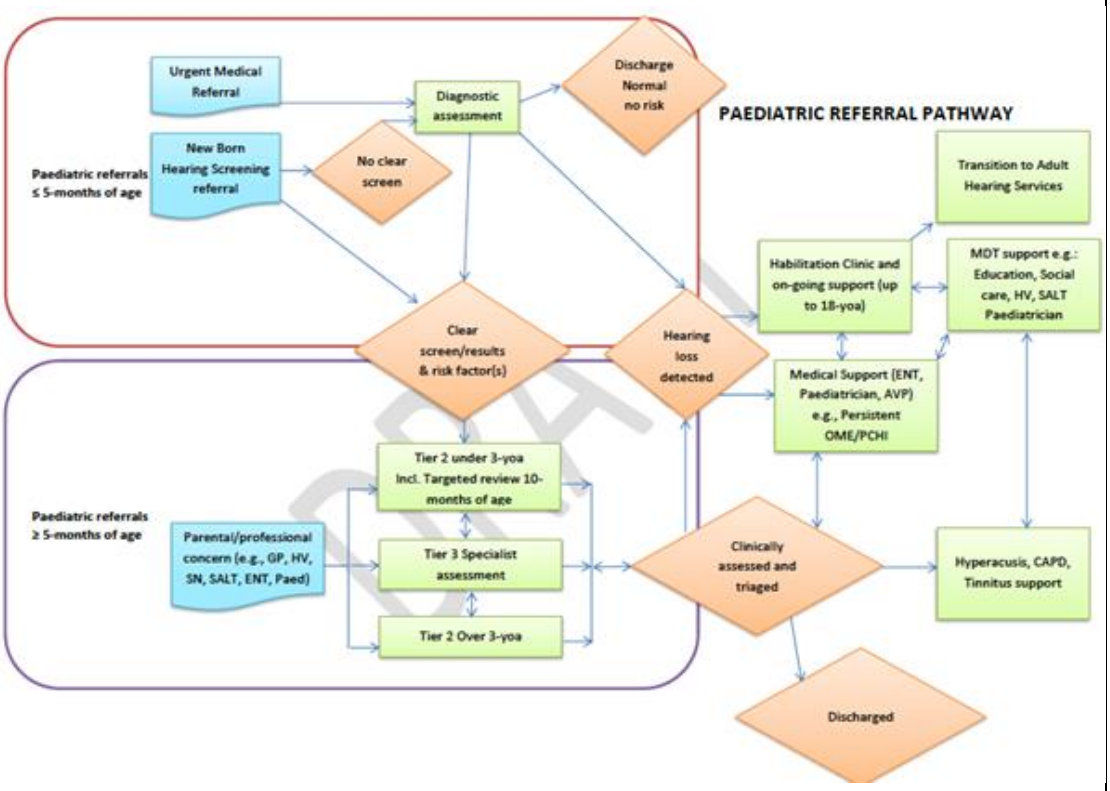
Wherever possible, all assessments required are undertaken in one visit to avoid repeat attendances, minimise inconvenience for the family, maximise workflows and reduce waiting times.

The service will be flexible, integrated and responsive, adapting to the individual needs of

children and families to meet their requirements e.g. level of risk, culture, ethnicity, language and disability.

Ilustrative Care Pathway

Figure 1 shows the expected care pathway for children with suspected hearing loss:



The Provider will ensure that there are clearly defined pathways which are widely disseminated and are monitored and reviewed to ensure compliance. Individual care pathways may be locally defined and/or based on:

- Map of Medicine has pathways for paediatric hearing aid fitting and review as well as paediatric cochlear implantation. The Ear Foundation also has a family friendly view of the clinical pathway for paediatric cochlear implants
- Public health functions to be exercised by NHS England: Service specification no. 20 NHS Newborn Hearing Screening Programme 2016-17
- Transforming Services for Children with Hearing Difficulties (DH 2008)

Accepting Referrals

The children's audiology service is a universal service for children and young people and will accept referrals up to the age of 18 years within the commissioning organisations geographical area. Timing of transition to adult hearing services aims to be flexible and decided in partnership with the young person and their family but will usually be around 16-18 years of age. The service will also work in partnership with the adult hearing service if required or the young people themselves up to the age of 25 if they have an Education, Health and Care Plan.

Referral is accepted from newborn hearing screeners, GPs, Community Paediatricians, school nurses, schools and education providers, Health Visitors, speech and language therapists, other professionals working with children, and through self-referral based on suspicion of hearing loss/speech and language delay.

Referral Route

Referrals are accepted either written or by phone.

The Provider will participate in any local or national centralised booking system in agreement with the commissioners e.g. Choose and Book.

Service response Time

All parents of babies that refer from the newborn hearing screen and wish to continue should be offered an appointment that is within 4 weeks of screen completion.

Children referred for assessment post-newborn hearing screen should be offered a full differential diagnostic assessment within 6 weeks .

Children and young people with sudden sensorineural hearing loss in one or both should be seen as a medical emergency and offered an assessment within 24 hours.

If hearing aids are required they should be fitted within 4 weeks of diagnosis.

Waiting times for assessment are monitored effectively and there are sustainable strategies for reducing waiting times if required.

Written information regarding the audiology appointment (directions, maps, car parking, duration, what happens, relevant national leaflets, desired state of the baby, facilities) is provided as part of the appointment process.

Children and young people should be seen within half an hour of their appointment time.

Did Not Attend

The Provider will put in place mechanisms to minimise DNAs and ensure that any children who DNA their appointment are reported to both the GP and the referrer. Local safeguarding procedures regarding DNA will be adhered to in full.

The Provider will post validated checklists to parents who decline appointments with explanatory letter for targeted follow-ups.

The Provider will investigate high DNA rates for diagnostic cases and implement measures to reduce these.

Discharge Process

- Will be conducted on an individual basis.
- The Provider will ensure clear discharge letters are sent to the referrer and GP and other relevant professionals stating result of assessment, diagnosis, management plan and what to do if further problems in a timely fashion.
- Onward referrals to speech and language therapy, Hearing Therapy, GP, ENT specialist and other specialist provision as necessary.
- Transition into adult services or another service are planned for and clearly documented in line with national guidance.
- Referral outcomes must be recorded in eSP according to BSA protocols.

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3.3 Population covered

The children's audiology service is a universal service for children and young people and will accept referrals up to the age of 18 years within the commissioning organization's geographical area.. The service will also work in partnership with the adult hearing service if

required or the young people themselves up to the age of 25 if they have an Education, Health and Care Plan.

The Provider must provide equitable access and ensure that services deliver consistent outcomes for patients regardless of:

- Gender
- Race
- Age
- Ethnicity
- Education
- Disability (including access and egress)
- Sexual orientation

The Provider will have procedures in place to ensure equity of access and provide support to those parents who are considered vulnerable including but not exclusive to asylum seekers, parents with substance misuse problems, parents with learning and/or physical disabilities or parents with communication difficulties.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance criteria

The children's audiology service is a universal service for children and young people and will accept referrals up to the age of 18 years within [specify area]. The service will also work in partnership with the adult hearing service if required or the young people themselves up to the age of 25 if they have an Education, Health and Care Plan.

Exclusion criteria

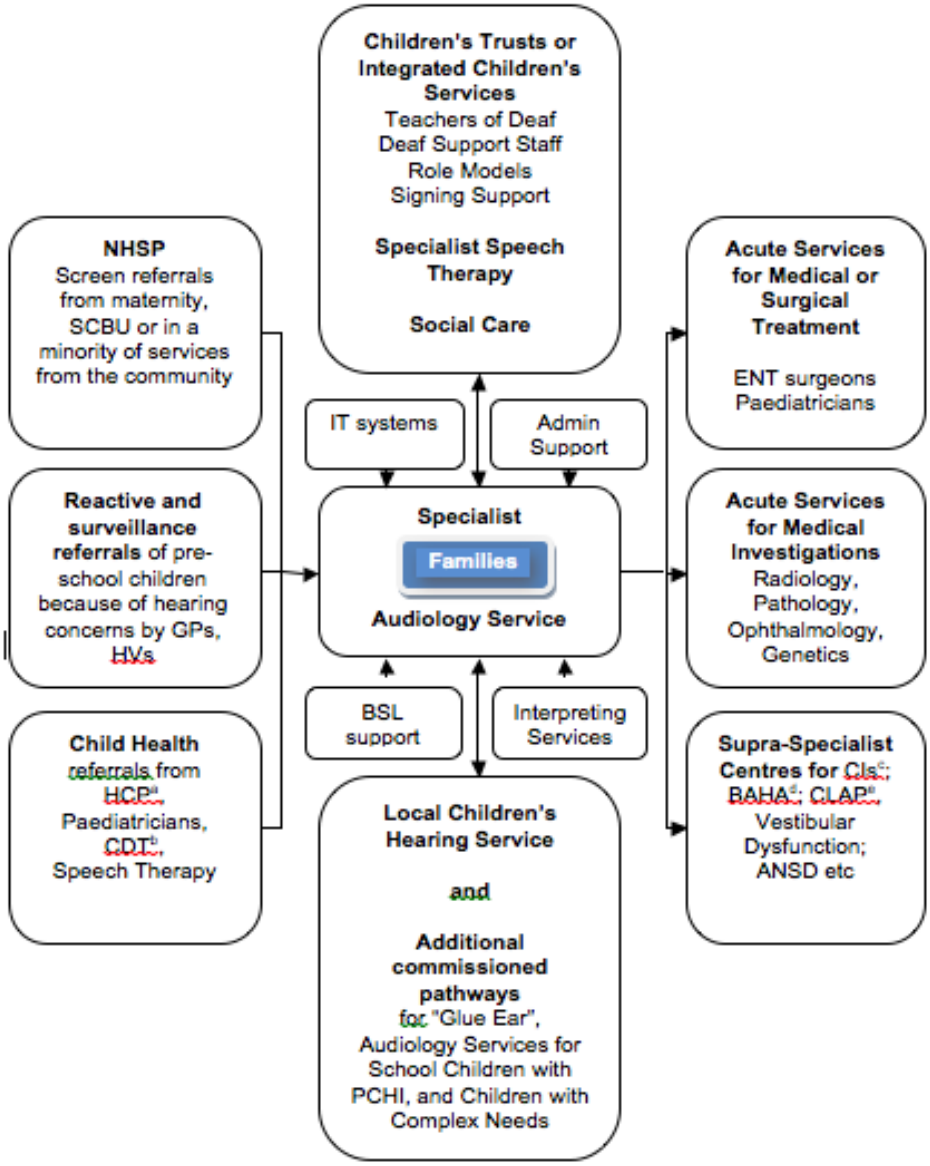
Adults over the age of 18 years of age.

3.5 Interdependence with other services/providers

The service will work in partnership with:

- The NHSP as delivered locally
- General Practitioners
- Local paediatricians (community and acute)
- Specialist Physicians
- ENT
- Health visitors
- School nurses
- Speech and Language therapists
- Teachers of the Deaf
- Local NHS Community Service providers
- Independent and Third Sector providers e.g. NDCS
- Commissioning CCGs/organisations
- Local Authority Social Services and Education Departments
- Children's Hearing Services Working Group

[Insert any further local interdependencies]



a. **Healthy Child Programme**
b. **Child Development Team**
c. **Cochlear Implants**
d. **Bone Anchored Hearing Aids**
e. **Cleft Lip and Palate**
f. **Auditory Neuropathy Spectrum Disorder**

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Physiological Services Accreditation Standards (IQIPs)

https://www.ukas.com/services/accreditation-services/physiological-services-accreditation-iqips/

Audiology departments undertaking audiological assessments on babies referred from screening should participate in a scheme for external peer-review process of

ABR. Commissioners' should ensure that Audiology services participate in, and maintain accreditation to defined quality standards operating under the umbrella of the United Kingdom Accreditation Schemes (UKAS) / RCP Improving Quality in Physiological Services (IQIPS)." (p31, Section 4: Service Standards, Risks and Quality Assurance Public health functions to be exercised by NHS England: Service specification no. 20 NHS Newborn Hearing Screening Programme 2016-17).

Accessible Information Specification

https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-spec-fin.pdf)

The provider must implement and demonstrate ongoing compliance with the Accessible Information Standards.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

Current legislation, government and other agency guidance relevant to children's audiology services:

- Children and Families Act (2014)
- Special educational needs and disability code of practice: 0 – 25 years – Statutory guidance for organisations who work with and support children and young people with special educational needs and disabilities (2015)
- Health and Social Care Act (2012)
- The UN Convention on the Rights of the Child
- UN Convention on the Rights of Persons with Disability
- Equality Act (2010)
- NHS Constitution (2015)
- Report of The Children and Young People's Health Outcomes Forum (2012)
- You're Welcome quality criteria (2011)
- Better health outcomes for children and young people; Our Pledge (2012)
- National Service Framework for Children, Young People and Maternity Services (2004)
- Early help assessments (DE 2015) (such as Common Assessment Framework (CAF) (2004))
- Healthy Child Programme 0-5 and 5-19 (DH 2009)
- Safeguarding Children and Young People: roles and competencies for health care staff, intercollegiate document (2014)
- Safeguarding Vulnerable People in the NHS; accountability and assurance framework (NHS England 2015)
- Working Together to Safeguard Children (DE 2015)
- Information: To Share or Not to Share? Government response to Caldicott Review, (DH 2013)
- Commissioning a good child health service (RCPCH & RCN 2013)

Current protocols, standards, good practice guidance, NICE guidance, Quality Standards, commissioning guidance, commissioning policies and service specifications applicable to children's audiology services:

Name	Publisher	Date
Newborn Hearing Screening		
ABR testing in babies: Guidance	NHSP/BSA	2013

ABR masking calculator 2013	NHSP	2013
ASSR testing in babies	NHSP	2009
Automated ABR (AABR) testing in babies	NHSP	2002
Behavioural Observation Audiometry testing in babies	NHSP/BSA	2002
Cochlear Microphonic testing guidelines	NHSP/BSA	2011
Distraction Diagnostic Test Protocol	NHSP/BSA	2003
DPOAEs in assessment following screening	NHSP	2011
Visual Reinforcement Audiometry testing for infants	BSA	2014
Recommended procedure for tympanometry (including under 6 mo's age)	BSA	2013
Surveillance Guidelines	NHSP	2012
NHS Newborn Hearing Screening Programme: Standards 2016 to 2017	PHE	2016
Role of the doctor in the NHSP team	BAAP	2008
Service specification No.20 NHS Newborn Hearing Screening Programme	NHS England	2016/17
Community audiology		
Demonstrating the Value of Community Services – Audiology Newborn and Children	aCFT Network	2015 (Draft)
Paediatric audiology		
Lessons from accredited paediatric audiology services: Why commission and provide an IQIPS accredited service?	NDCS	2015
Recommended procedure for tympanometry	BSA	2013
Taking an Aural Impression : Children Under 5 Years	BSA	2013
Recommended procedure for ear examination	BSA	2010
Recommended procedure for taking an aural impression	BSA	2013
Pure tone air and bone conduction threshold audiometry with and without masking	BSA	2011
Determination of Uncomfortable Loudness Levels	BSA	2011
Infant Hearing Aid fitting guidelines	NHSP	2009
Early audiological assessment and management of babies referred from the newborn hearing screen	NHSP/BSA	2013
Guidelines for assessment & management of ANSD in young infants	NHSP/BSA	2013
Guidelines for the Taking of Impressions and Provision of Ear Moulds within a Children's Hearing Aid Service	MCHAS	2005
Guidelines for Professional Links between Audiology and Education Services within a Children's Hearing Aid Service	MCHAS	2005
Guidelines for testing Digital Signal Processing Hearing Aids 'In the Field' within an integrated Children's Hearing Aid Service	MCHAS	2005
Guidelines for the Fitting, Verification and Evaluation of digital signal processing hearing aids within a Children's Hearing Aid Service	MCHAS	2005
Procedures for the setting up of fm radio systems for use with hearing aids	MCHAS / Connevans	2002
Guidelines on the acoustics of sound field audiometry in clinical audiological applications	BSA	2008
Guidance on the use of real ear measurement to verify the	BSA	2008

fitting of digital signal processing hearing aids		
BAAP Clinical Standards	BAAP	2011
Role of the doctor in the NHSP team	BAAP	2008
Best Practices in Family-Centered Early Intervention for Children Who Are Deaf or Hard of Hearing: An International Consensus Statement	Journal of Deaf Studies and Deaf Education	2013
Quality Standards in the Early Years: Guidelines on working with deaf children under two years old and their families (England)	NDCS	2002
Quality Standards in the Early Years: Guidelines on working with deaf children under two years old and their families (Wales)	NDCS	2002
Transforming audiology services for children with hearing difficulties and their families	DH	2008
Improving Quality In Physiological diagnostic Service Programme (IQIPS)	DH / RCP / UKAS	2012
Quality Standards in Paediatric Audiology in Scotland	NHS Scotland	2009
Quality Standards in Paediatric Audiology in Wales	NHS Wales	2010
Quality Standards for the use of personal FM systems	NDCS / FM Working Group	2008
Quality Standards: Vision care for deaf children and young people	NDCS / Sense	2009
Position statement on audiology services	NDCS	2011
Policy on insurance and replacement of hearing equipment	NDCS	2011
Manual for prescribed specialised services	NHS England	Nov 2012
Transition	NDCS	2011
Quality Standards: Transition from paediatric to adult audiology services	NDCS	2011
Quality Standards; Transition from Paediatric to Adult Audiology Services	NHS Scotland	2013
Commissioning audiology services for young adults	NDCS	2012
Aetiological investigations		
Guidelines for aetiological investigation into mild to moderate bilateral PCHI	BAAP	2015
Guidelines for aetiological investigation into severe to profound bilateral PCHI	BAAP	2015
Aetiological Investigations into unilateral PCHI	BAAP	2015
Audit tool for aetiological investigations	BAAP	2015
Position statement on Genetics, Stem Cell Therapy and deafness	NDCS	2013
Position statement on Childhood deafness associated with marriage/relationships between first cousins	NDCS	2014
Glue ear		
18 Week Pathway - Glue Ear	DH	2008
Action On ENT - Good Practice Guide	NHS Modernisation Agency	2002
Commissioning guidance; Otiits Media with Effusion	ENTUK / RCS	2013
Service for the surgical management of otitis media with effusion in children (NICE commissioning guidance)	NICE	2008
Surgical management of OME: NICE guideline CG60	NICE	2008

Shared Decision Aid - Glue Ear	BMA Group	2012
School entry hearing screening		
Hearing assessment in general practice, schools and health clinics: guidelines for professionals who are not qualified audiologists	BSA	Consultation over - due soon (Jan 14)
Position statement on school entry hearing screening	NDCS	2010
Auditory Neuropathy Spectrum Disorder (ANSD)		
Guidelines for assessment & management of ANSD in young infants	NHSP/BSA	2013
Guidelines for Identification and Management of Infants and Young Children with ANSD	Guidelines Development Conference at NHS 2008, Como, Italy	2008
Auditory Processing Disorder		
APD Position Statement	BSA	2011
An overview of current management of auditory processing disorder (APD)	BSA	2011
Tinnitus		
Practice Guidance: Tinnitus in Children and Teenagers	BSA	2015
Specialist audiology services		
Care Standards for the Management of Patients with Microtia and Atresia	UK Care Standards for the Management of Patients with Microtia and Atresia, March 2015.pdf (645 kb) 	2015
Quality Standards: Cochlear implants for children and young people	NDCS	2010
Quality Standards in Bone Anchored Hearing Aids for children and young people	NDCS	2010
Clinical Commissioning Policy: Bone Anchored Hearing Aids (ref: NHSCB/D09/P/a)	NHS England	Apr 2013
Service Specification No. D09/S/b - Implantable Hearing England Aids for Microtia, Bone Anchored Hearing Aids and Middle Ear Implants	NHS England	Oct 2013
Clinical Commissioning Policy Statement: Active Middle Ear Implants	NHS England	Apr 2013
Clinical Commissioning Policy Statement: Auditory brainstem implant for patients with congenital abnormality of the auditory nerves or cochleae	NHS England	Dec 2015
Service Specification No. D09/S/a - Ear Surgery: Cochlear Implants	NHS England	Oct 2013
Technology Appraisal Cochlear implants for severe to	NICE	2009

profound deafness in children and adults (TAG166)		
Position statement on implantable hearing devices	NDCS	2013

The provider is contractually obliged to review evidence base on a continual basis.

Workforce

Each audiology service will demonstrate that within their team they have the clinical competencies and capacity necessary to support the assessments and interventions that they undertake.

The training and competencies required of audiology staff at each level of the tiered service model outlined in this service specification are laid down by the relevant professional body eg British association of Audiological Physicians (BAAP) and the British Academy of Audiology (BAA). Assessments should be carried out by/ under the supervision of senior staff that have the expertise to explain and discuss results with families. It is not acceptable for families to wait for days for information or results.

Each service should have access to a suitably skilled and trained paediatrician to work with children with complex needs and to provide aetiological advice and investigation.

The provider will ensure that there is appropriate leadership and clinical oversight in particular there needs to be a clearly identified lead for aetiological investigations and on the medical aspects of the service.

Professional and Clinical Standards

Audiological assessment and support is undertaken by experienced staff capable of performing and interpreting such tests.

All professional staff working in paediatric audiologies holds the necessary qualifications and are registered with the appropriate professional registration body.

Staff in senior positions are trained to post graduate level supplemented by suitably assessed practical experience in paediatric audiology.

The clinical team must meet the requirements of Continuous Professional Development for on-going registration including participation in peer review and audit. Competency for all clinical procedures is verified formally by peer review observation at least every 2 years for all clinical staff undertaking such procedures.

All assistant staff are able to demonstrate additional competency training in paediatric audiology along with Continuing Professional Development in the areas in which they are currently working.

All staff have basic training in child protection and deaf awareness. All staff who come into contact with children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have a concern about child protection.

Staff should be DBS checked in line with national policy.

Where the competencies required for an individual care plan are not held within the service clear referral pathways must be in place for external referral.

The Provider must demonstrate experience and competence in all fields relevant to the activity to be undertaken.

It is expected that the Provider will establish a positive working relationship with other providers in the hearing services network and engage with a managed local clinical network appropriate for the delivery of the necessary services and engage in peer review activities. It

is expected that they will organise and maintain records of this activity.

All aspects of care will comply with minimum national standards as laid down in statute, by the Royal Colleges, UKCC and other relevant professional and authoritative bodies, and comply with national and local guidelines on care pathways

The CCGs expects the service to work effectively as a team and to liaise and participate with other providers and groups/individuals who relate to the delivery of hearing services.

Training and Development

All staff engaged in the provision of these services will need training (accredited as appropriate) to the suitable level for the tasks required.

All service clinicians and support staff will attend any mandatory approved training sessions as required.

All doctors involved in providing aetiological investigations must attend a relevant training course, such as UCL Institute of Child Health's Aetiological Investigations for hearing loss in children course.

The lead audiologist and lead paediatricians should undertake the one day NHSP eSP training course in order to be familiar with the interrogation of eSP.

Audiology staff involved in the testing and habilitation of children should undertake HCCC training to improve clinical practice.

The Provider will be responsible for any costs incurred in relation to general professional training by the Provider or his/her directly employed staff providing services under this specification. This includes the cost of providing cover during training absences.

All staff involved in delivery of the service will undertake annual appraisal.

Facilities
Care should be provided in an appropriate location and in an environment that is safe and well-suited to the age and stage of development of the child or young person.

Working with commissioners, providers should ensure that facilities conform to standards outlined in the Department of Health Building Note (1994). Audiological testing must be performed in soundproofed accommodation built to ISO 8253-1 (1998) and ISO 8253-2 (1998) standards for acoustic test methods and suitable for children."

Behavioural testing of young children (Visual reinforcement audiometry - VRA) must take place in facilities that meet the guidance contained in Visual Reinforcement Audiometry for Infants (BSA Recommended Procedure 2014)

Equipment

The Provider will be responsible for all set up costs and maintenance, repair and replacement of equipment. Providers must ensure all test equipment is checked daily and calibrated in accordance with national guidance.

Decontamination and Infection Control

The Service Provider/s will be responsible for ensuring that all aspects of the service are compliant with the policies as listed below (or as updated from time to time);

- NICE "Infection Control – Prevention of health-associated infection in primary and

community care" 2003
- BMA "Healthcare associated infections, a guide for healthcare professionals" 2006

And appropriate organization-wide policies that will be produced and that are in line with National guidance.

Service clinicians and assistants will be required to attend approved infection control training and educational sessions annually. The Provider will need to demonstrate audited compliance with this requirement.

Communication and Record Keeping
The Provider shall ensure the maintenance of full, accurate, legible and contemporaneous records utilising IT systems for all patients attending for assessment and/or management in line with national guidance.

Any systems need to be able to meet national reporting requirements including relevant commissioning datasets submitted to the Secondary Uses Services (SUS).

This data requirement by each CCG is:

For each attendance by the patient
Patient NHS number
Unique booking reference number
Patient Pathway Identifier
Referral to treatment status
Referral to treatment period start
Referral to treatment end date
Date of Birth
Sex
Post Code
Ethnicity
Registered GP / Practice Code
Diagnostic Code (ICD 10)
Procedure code (OPCS 4.4)
Date referral received
Source of referral
Date of attendance
First attendance
Date of procedure
Cost of attendance
Outcome or comments

The Provider will ensure that the referrer is kept informed of non-attendance, attendance and treatment.

The Provider will also ensure that all data reporting requirements of the national NHSP screening service are met.

The Provider should ensure that relevant legislation concerning confidentiality; data protection and freedom of information legislation are complied with, along with compliance with Caldicott principles.

Families will be fully informed, both verbally and in writing, of the management options and the management proposed.

The Provider/s will ensure that written information when supplied through the pathway is presented in a format suitable for the patient's needs e.g. large print, languages.

The service provided by the Provider shall comply fully with the NHS Branding guidelines. All communications with the patient and other health care organisations or

professionals associated with a patient treated or seen through this agreement will clearly indicate that the treatment has been carried out under the NHS.

Patients
The Provider agrees to comply with the NHS complaints procedure if dealing with patient complaints.

The Provider will ensure that Serious Incidents and adverse incidents are analysed and reported to the CCG using the CCG Incident Form and the National Patient Safety Agency as appropriate. The process should include the following as a minimum:

- A mechanism to identify events.
- Regular Significant Events meetings. Multidisciplinary, chaired and notes to be taken.
- Follow up of decisions to include description of event, learning outcome and action plan.

The Provider will also have systems in place to record patient safety incidents in line with national and CCG guidance and learning can be demonstrated.

All cases of late identified children with PCHI should be reviewed as a department, to ensure that any changes necessary can be implemented.

The Provider will make arrangements to carry out annual service user satisfaction surveys in relation to the Service and will co-operate with such surveys that may be carried out by the Commissioner. In discharging its obligations under this clause the Provider shall have regard to any Department of Health guidance relating to patient satisfaction surveys.

The Provider will collect and report on any national or locally agreed Patient Reported Outcome Measures.

Quality Standards and Governance
In addition to delivering services in accordance with good practice guidance and standards identified previously, the provider will have operational systems that support the following principles:

- Clear lines of responsibility and accountability
- A programme of quality improvement activities
- Clear policies aimed at managing risk and procedures to identify and remedy poor professional performance

The Provider shall review current clinical structure to ensure that regular MDT meetings (including Audiology and Education colleagues) are held to discuss services across all aspects of the paediatric pathway. Meetings should cover clinical governance, patient safety, reflective practice and case based discussions. Meetings should occur at the facility and be attended by >60% of clinical staff (to encourage engagement at all levels of responsibility)

The Provider should establish or join an existing network to provide critical mass of patients in order to facilitate joint audit, peer review and case discussions etc.

Active risk management strategies should be in process according to organization wide protocols.

Audit
The Provider/s will ensure regular audit of the audiology provision (including medical aspects of the pathway) to ensure robust procedures (e.g. audiological assessment of all screen referrals) and confirm audiological practice (e.g. audit against relevant quality standards).

Population Healthcare with the Department of Health initially, and then NHS England and Public Health England after the reorganisation of 2014, convened meetings with service

providers, commissioners and patient representatives and developed an example annual report that could be used locally.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4C)

5.2 Applicable CQUIN goals (See Schedule 4D)

6. Location of Provider Premises

The Provider's Premises are located at:

The Provider shall provide services in the hospital and in the community as appropriate. The aim is to provide services as close to home as possible but it is recognised that some assessment equipment may only be available in certain settings and that certain settings may not be suitable for audiological testing.

The service opening hours will be by agreement but as a minimum should cover 40 hours a week over 4/5 days with one of these days extending cover into the evening or on a Saturday morning. For example Mon – Fri 8.00am – 6.00pm, with answer phone service for non-urgent messages available 24hrs / 7 days a week

However, the opening hours, function and processes of the unit should be sufficiently flexible to accommodate future changes in service volume and specialty groupings which may occur due to changes in case mix and/or potential increase in numbers, as per the standard contract terms.

7. Individual Service User Placement

Evidence Sources for Service Specification:

Transforming Services for Children with Hearing Difficulty and their Families: A Good Practice Guide, DH 2008

Data from NHSP England presented at British Society of Audiology's Paediatric Audiology Interest Group, G. Sutton May 2010

CRIDE report on 2015 survey on educational provision for deaf children in England http://www.ndcs.org.uk/professional_support/national_data/uk_education_.html

Section 1.1 - Surgical management of otitis media with effusion in children, Clinical Guideline, National Institute of Health and Clinical Excellence, 2008

Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children (Review), Lous. J., Burton. M.J., Ovesen. T., Rovers. M., Williamson. I. The Cochrane Collaboration, 2009

Hospital Episode Statistics; Ear Surgery 2013-14

Position Statement; Auditory Processing Disorder (APD) (2011 British Society of Audiology's Auditory Processing Disorder Special Interest Group) http://www.thebsa.org.uk/bsa-groups/group-apdi/

Ferguson, M. Diagnosing Auditory Processing Disorders. Vol 17 No 6 ENT News Jan/Feb 2009 https://www.ihr.mrc.ac.uk/Legacies/apd/docs/MAF_Article.pdf

Tinnitus in Children; Practice Guideline, British Society of Audiology 2015

Niemensivu R, Pykkoo I, Weiner-Vacher SR, Kentala E. (2006) Vertigo and balance problems in children - an epidemiological study in Finland. Int J Pediatr Otorhinolaryngol 2006;70:259-65.

O'Reilly RC, Morlet T, Nicholas BD, Josephson G, Horlbeck D, Lundy L, Mercado A. Prevalence of vestibular and balance disorders in children. Otol Neurotol. 2010;31(9):1441-4.

McCaslin DL, Jacobson GP, Gruenwald JM. The predominant forms of vertigo in children and their associated findings on balance function testing. Otolaryngol Clin North Am. 2011;44(2):291-307, vii.

Niemensivu R, Pykkoo I, Weiner-Vacher SR, Kentala E. (2006) Vertigo and balance problems in children - an epidemiological study in Finland. Int J Pediatr Otorhinolaryngol 2006;70:259-65.

Shambaugh, G. Statistical studies of children in public school for the deaf. Arch Otolaryngol. 1930;12:190–245.

Arnvig, J. Vestibular response in deafness and severe hard of hearing. Acta Otolaryngol. 1955;45:283–288.

Cushing SL, Papsin BC, Rutka JA, James AL, Gordon KA. Evidence of vestibular and balance dysfunction in children with profound sensorineural hearing loss using cochlear implants. Laryngoscope. 2008;118(10):1814-23.

http://www.ndcs.org.uk/professional_support/national_data/cride.html

Sandberg, L., Terkildsen, K. Caloric tests in deaf children. Arch Otolaryngol. 1965;81:352–354.

Outcomes of Children with Hearing Loss Study http://ochlstudy.org/

Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) http://outcomes.nal.gov.au/papers.html

Edited from A population system of care for children and young people with hearing loss, V11 260515 http://www.healthcarepublichealth.net/children--with-hearing-loss.php

Standard 4 (KPI2 / NH2) NHS Newborn Hearing Screening Programme: Standards 2016 to 2017 (PHE)

6 week diagnostic target within 18-week pathway

Getting the right start: National Service Framework for Children, Standard for Hospital Services, 2003

ISO 8253-1 and BS EN ISO 8253-2 Standards for Acoustic Audiometric Test Methods (updated in 1998) and Department of Health (1994) Building Note 12, Supp 3 ENT and Audiology Clinics/Hearing Aid Centres, NHS Estates

Children and Families Act, SEND Code of Practice, 2015

Quality Standards Transition from paediatric to adult audiology services: Guidelines for professionals working with deaf children and young people, NDCS 2011

SCHEDULE 3 – PAYMENT

A. Local Prices

Enter text below which, for each separately priced Service:

- *identifies the Service;*
- *describes any agreement to depart from an applicable national currency (in respect of which the appropriate summary template (available at: http://www.monitor.gov.uk/locallydeterminedprices) should be copied or attached)*
- *describes any currencies (including national currencies) to be used to measure activity*
- *describes the basis on which payment is to be made (that is, whether dependent on activity, quality or outcomes (and if so how), a block payment, or made on any other basis)*
- *sets out any agreed regime for adjustment of prices for the second and any subsequent Contract Year(s).*

Insert template in respect of any departure from an applicable national currency; insert text and/or attach spreadsheets or documents locally – or state Not Applicable

SCHEDULE 3 – PAYMENT

B. Local Variations

For each Local Variation which has been agreed for this Contract, copy or attach the completed publication template required by Monitor (available at: http://www.monitor.gov.uk/locallydeterminedprices) – or state Not Applicable. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.

Insert template; insert any additional text and/or attach spreadsheets or documents locally – or state Not Applicable

SCHEDULE 3 – PAYMENT

C. Local Modifications

For each Local Modification Agreement (as defined in the National Tariff) which applies to this Contract, copy or attach the completed submission template required by Monitor (available at: http://www.monitor.gov.uk/locallydeterminedprices). For each Local Modification application granted by Monitor, copy or attach the decision notice published by Monitor. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.

Insert template; insert any additional text and/or attach spreadsheets or documents locally – or state Not Applicable

SCHEDULE 3 – PAYMENT

D. Marginal Rate Emergency Rule: Agreed Baseline Value

In line with the requirements set out in the National Tariff, insert text and/or attach spreadsheets or documents locally – or state Not Applicable

SCHEDULE 3 – PAYMENT

E. Expected Annual Contract Values

Commissioner	**Expected Annual Contract Value** *(Exclude any expected CQUIN payments. CQUIN on account payments are set out separately in Table 2 of Schedule 4D, as required under SC38.3.)*
Insert text and/or attach spreadsheets or documents locally	
Total	

SCHEDULE 3 – PAYMENT

F. Timing and Amounts of Payments in First and/or Final Contract Year

Insert text and/or attach spreadsheets or documents locally – or state Not Applicable

SCHEDULE 4 – QUALITY REQUIREMENTS

C Local Quality Requirements

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
Outcome 1 **Children and Young People have Individual Management Plans** All children and young people with a permanent (or longstanding) hearing loss have an Individual Management Plan (IMP) that includes goals and intervention, and is produced and agreed jointly with them and their family	100% of children and young people have a plan within 3 months of diagnosis	Audit to review that all children and young people have an IMP	To be defined locally	Quarterly audit and accumulative annual report	
Outcome 2 **Children and young people achieve their personal goals in hearing and listening development** Children and young people making expected progress in hearing and listening development as a result of the intervention, as identified goals in their IMP	90%	Use of age appropriate validated tools such as: Nottingham Early Assessment Package (NEAP), Listening Progress Profile (LiP), Categories of Auditory Performance (CAP), Meaningful Auditory Integration Scale (MAIS), McCormick Toy Test, Manchester Picture Test, Listening Inventories for Education – Individual	To be defined locally	Quarterly and accumulative annual report to include a review of audit data from IMPs	

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
		Hearing Profile (LIFE IHP), Parents' Evaluation of Aural/Oral Performance of Children (PEACH), BKB Sentence Test, or other validated tools to show improvement			
Outcome 3 **Children or young people and their families receive clear and age-appropriate information** Families are given clear information to facilitate attendance and reduce anxiety. Children and young people's views are sought and listened to in respect of amplification options and their impact, and information about their hearing loss is provided to them at age-appropriate levels	90% of children, young people, and their families express satisfaction with the quality of information provided	Service User Satisfaction Survey and quarterly and accumulative annual report to include an analysis of number of children, young people, and their families surveyed, number of responses received, % of those satisfied or very satisfied with different aspects of information provision	To be defined locally	Quarterly and accumulative annual report	
Outcome 4 **Children or young people and families receive choice of intervention** Percentage of children, young people, and their families reporting being satisfied with their choice of intervention	90%	Service User Satisfaction Survey and quarterly and accumulative annual report to include an analysis of number of children, young people, and their families surveyed, number of responses received, % of those satisfied or very satisfied with the service	To be defined locally	Quarterly and accumulative annual report	
Outcome 5	90%	Service User Satisfaction	To be defined	Annual	

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
Young people transitioned to adult audiology following a period of preparation Percentage of young people and their families who report satisfaction with the preparation period prior to transition		Survey and quarterly and accumulative annual report to include an analysis of number of children, young people, and their families surveyed, number of responses received, % of those satisfied or very satisfied with the service	locally		
Service Performance Indicator Referral to Assessment Time All parents of babies that refer from the newborn hearing screen and wish to continue should be offered an appointment that is within 4 weeks of screen completion. All parents whose baby required targeted follow up should be offered an assessment before the baby is 9 months of age. Children referred for assessment post-newborn hearing screen should be offered an assessment within 6 weeks	100%	Review of Service Quality Performance Reports	To be defined locally	Monthly	
Service Performance Indicator **Assessment** Developmentally appropriate hearing	100%	Regional ABR Peer Review	To be defined locally	Quarterly	

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
assessments are undertaken. A comprehensive range of electrophysiological and behavioural assessments are offered and performed by competent staff.					
Service Performance **Permanent childhood hearing impairment (PCHI) confirmation** Permanent childhood hearing impairment (PCHI) confirmed and entered into eSP	80% of babies referred from newborn screening confirmed by 6 months of age, and 98% by 12 months of age	Review of Service Quality Performance Reports	To be defined	Quarterly	
Service Performance **Assessment to Fitting Time** Hearing aids should be fitted within 4 weeks of diagnosis	100%	Review of Service Quality Performance Reports	To be defined	Monthly	
Service Performance Indicator **Children or young people have in place an Individual Management Plan (IMP)**					

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
(as specified in Section 1 – Outcomes)					
Service Performance Indicator **Fitting of Hearing Aids** The selection, fitting and verification of hearing aids should follow accepted best practice guidelines , including RECD and REM (exceptions reported in IMP) E.g. MCHAS, British Society of Audiology	100%	Review of Service Quality Performance Reports	To be defined	Quarterly	
Service Performance Indicator **Follow Up Care** For children wearing hearing aids, there is same day access to a repair service, and a quick turn around postal service (three working days) for replacement batteries. Moulds are returned or replaced within five working days	90%	Review of Service Quality Performance Reports	To be defined	Quarterly	
Service Performance Indicator		Review of Service Quality	To be defined	Quarterly	

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
Multidisciplinary Team An integrated care pathway, which facilitates joined-up multi-agency working to ensure all aspects of the child's development, safeguarding, and hearing aid use in the real world are appropriately assessed, monitored and supported as needed. E.g. medical support for developmental assessment and aetiological investigations, Teacher of the Deaf, speech and language therapist etc.	Referral for aetiological investigations and paediatric assessment – 100% offered referral to appropriate medical consultant at an appropriate time Education services notified within 1 working day of confirmation of PCHI	Performance Reports			
Service Performance Indicators **Regular Reviews** Children and young people receive regular appointments (as identified in their IMP) to monitor progress against goals, interventions used, and review support needed and priorities. IMP is updated to reflect changes.	100%	Review of Service Quality Performance Reports	To be defined	Quarterly	
Achieving personal goals in hearing					

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
and listening development **(as specified in Section 1 – Outcomes)**					
Service Performance Indicator **Education, Health and Care Plans (EHCP)** Services must actively engage with the planning process for any child or young person who goes through assessment for, or review of, their EHCP to ensure their hearing and listening needs are appropriately addressed within the plan.	100%	Review of Service Quality Performance Reports	To be defined	Quarterly	
Service Performance Indicator **Information Sharing** Records and associated letters/reports are completed and sent to the family, and GP/other professionals involved in the child's care (with family's consent) within 5 working days of hearing assessment/ fitting/ review	95%	Review of Service Quality Performance Reports	To be defined	Quarterly	
Child, young person and family					

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
experience of service **(as specified in Section 1 – Outcomes)**					
Service Performance Indicator **Service improvement** Service user questionnaires and peer satisfaction surveys to capture areas for improvements. 100% of recommendations made and agreed with Commissioners are addressed	100%	Service user questionnaires and peer satisfaction surveys and annual report to demonstrate recommendations and actions taken to address areas of service improvement	To be defined	Annual	
Service Performance Indicator **Reducing Inequalities** Family questionnaire demonstrates a high satisfaction rate from all protected characteristic groups (PCGs)	95%	Accumulative annual service user questionnaire report analysis to include number of families surveyed, number of these in PCGs, response rates, response rates for PCGs, % of these specifying overall satisfaction	To be defined	Annual	
Service Performance Indicators **Reducing Barriers** An integrated care pathway, which facilitates signposting and referral to wider support services E.g. Specialist education hearing	100%	Provider provides demonstrable evidence of % families who receive information about these support services validated by feedback from service user questionnaires	To be defined	Annual	

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
support services, speech and language therapy, social care services, National Deaf Children's Society, local deaf children's support groups, etc.					

SCHEDULE 4 – QUALITY REQUIREMENTS

D. Commissioning for Quality and Innovation (CQUIN)

CQUIN Table 1: CQUIN Schemes

Insert completed CQUIN template spreadsheet(s) or state Not Applicable

CQUIN Table 2: **CQUIN Payments on Account**

Commissioner	**Payment**	**Frequency/Timing**	**Agreed provisions for adjustment of CQUIN Payments on Account based on performance**

SCHEDULE 4 – QUALITY REQUIREMENTS

E. Local Incentive Scheme

Insert text locally or state Not Applicable

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