Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES

Quality Standards for Adult Hearing Rehabilitation Services

Version 2 July 2016

OGL Digital ISBN 978 1 4734 7101 6 WG29276

Foreword

Welcome to the Quality Standards for Adult Hearing Rehabilitation Services (Wales) 2016. I am delighted to endorse the Quality Standards as the benchmark for NHS adult audiology services in Wales.

Building on the success of the earlier version published in 2009, the Quality Standards 2016 was designed by Wales' leading audiologists in collaboration with Scottish counterparts. The work supported by representation from Action on Hearing Loss and the Audiology Standing Specialist Advisory Group of the Welsh Scientific Advisory Committee clearly demonstrate a prudent healthcare approach to the provision of audiology services. The Quality Standards support co-production with a greater emphasis placed on evidence base and individual management plans involving patients in decisions more than ever before.

Wales' audiologists leading the development of these Quality Standards have responded to the evolved thinking of NHS service delivery to truly benefit the people utilising audiology services in Wales. I encourage all health boards to drive forward its audiology service delivery by the swift implementation and ongoing compliance.

I wish to thank everyone involved in this important development for audiology services.

Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport

Introduction

Background

The first version of Quality Standards for Adult Rehabilitation Services were published in 2008. Since 2009/10 all NHS audiology services in Wales have undergone self assessment and external audit against these Standards.

The use of the Standards in Wales has provided a means to measure significant advances in service quality across the country. However, a revision is now required in order for the Standards to remain consistent with advances in technology and practice. This also provides an opportunity to clarify and improve the functionality of the standards materials, ensuring that audit remain robust and efficient.

Development of Quality Standards Version Two

A Working Group was set up and included senior audiology clinicians, managers, a third sector representative from Action on Hearing Loss and external stakeholder representation. The working group also co-opted an academic to review the evidence base and develop the reference lists.

Working Group Objectives

The working group's main objective was to jointly develop the Second Version of the Quality Standards for Adult Hearing Rehabilitation Service considering five main areas for change:

1. consideration of the relevance of existing Criteria in light of the latest evidence-based practice and advances in technology
2. consideration and development of the Standards in areas that are not sufficiently detailed or specific
3. re-wording of existing Criteria to avoid ambiguity or misinterpretation
4. consideration of the appropriate place of Criteria within the Standards
5. scoring and weighting of the Criteria and development of guidance on the evidence required to support self assessment scores

Consultation

The draft version of these Standards has undergone two stages of Consultation. Stage One involved those that had significant experience in using the original version of the Standards. This included Heads of NHS Audiology and Adult Rehabilitation Services and external Auditors from both NHS Audiology Services and Action on Hearing Loss.

The second stage of the Consultation was with service users and included four face to face focus group events, an online qualitative survey and a paper based quantitative questionnaire.

Feedback from both consultation stages was used to further develop and revise the Quality Standards

Approach and Context to Describing Service Quality

The standards are sequenced to reflect the patient pathway and are as follows:

Quality Standards for Adult Hearing Rehab Services
Std 1 Accessing the Service
Std 2 Communicating with Patients
Std 3 Assessment
Std 4 Developing an Individual Management Plan (IMP)
Std 5 Implementing an Individual Management Plan (IMP)
Std 6 Clinical Effectiveness
Std 7 Clinical Skills and Expertise
Std 8 Collaborative Working
Std 9 Service Improvement

The scope of content is deliberately limited to items that are specific to Audiology or are particularly worthy of emphasis over generic health and care standards, legislative, organisational governance or good practice requirements. These service specific standards should therefore complement other requirements; they provide a more specific and evidence-based contribution to help define a good quality service that will provide the best outcomes for patients.

The standards describe good practice and use of tools to provide evidence of health outcomes. However, compliance with the standards should not be used in isolation to quantify the efficacy of services in terms of health outcomes and patients satisfaction.

Changes within Version Two

The key changes within this revised version of the Standards include:

- Development of additional rationale and criteria related to non-instrumental interventions
- New scoring range from 1-5 to 0-4 where non-compliance now is identified with a 0 score
- A list of suggested evidence to support compliance with criteria

The Standards

Format

The Standards are made up of nine *Standard Statements* that explain the level of performance that needs to be achieved. These are supported by an evidence base that provides the *rationale* for each Standard. The *Standard Statements* are expanded into a number of *Criteria* which specify what must be achieved for the standard to be met. The *Standard Statements* are listed below. The evidence base, the references that support them and the detailed *Criteria* are all detailed within the *Assessment and Audit Tool* that accompanies this document.

The Standard Statements

Standard 1. Accessing the Service

All patients with hearing problems and their significant other(s) who require access to Audiology services are able to:

- access an Audiology service that meets their needs,
- conveniently access the services they require,
- see Audiology or specialist medical professionals as first points of contact, as determined by agreed local clinical criteria,
- wait no longer to access Audiology by one referral route than any other.1
- wait no longer if they are an existing patient accessing the service for reassessment than a new patient accessing the service for the first time.
- gain access to the Audiology service as quickly as other comparable medical services.

Service demand and referral data are accurately monitored, reviewed and reported against available indicators and used to guide service planning.

All hearing aid users have access to effective, ongoing lifetime maintenance and support.

Standard 2. Communicating with Patients

Timely and relevant two-way exchange of information to meet the needs of hearing impaired patients and their significant other(s), in formats that accommodate their communicative abilities.

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

Standard 3. Assessment

All patients receive an individually-tailored Audiological assessment which is carried out to recognised national standards, where available, and includes:

- measurement of hearing impairment,
- assessment of activity limitations related to hearing impairment,
- evaluation of social and environmental communication and listening needs and an evaluation of attitudes, expectation, motivation and behaviours as a result of hearing impairment,
- a relevant medical history.

Standard 4. Developing an Individual Management Plan

All patients should have an individually developed plan for the management of their needs. This plan:

- is initially based on information gathered at the assessment phase,
- is determined in conjunction with the patient and/or their significant other(s),
- is updated on an ongoing basis,
- is accessible to the clinical team,
- includes recommended interventions to best meet the needs of patients.

Standard 5. Implementing an Individual Management Plan

The Individual Management Plan is implemented over a series of appointments with the opportunity for revision of needs, actions and outcomes at each stage. The series of appointments is timely and may be multi-disciplinary.

Where provision of hearing aid(s) is required by the IMP the service ensures that:

- nationally agreed procedures and protocols for fitting and verification are followed at a local level,
- hearing aids fitted are functioning correctly,
- patients are offered a hearing aid for each ear where clinically indicated and patients are supported to make an informed choice
- performance of hearing aid(s) is carefully matched to individual requirements and settings are recorded.
- Where provision of hearing related assistive technology is required by the IMP the service ensures that:
- patients are supported to make a choice about their suitability
- patients are effectively signposted to providers of such technologies

The non-technological management of the hearing problem can be used as a sole management tool or to supplement the issuing of a hearing aid(s).

- Where provision of non-technological intervention is indicated, the service ensures:

- Patients and their significant other(s) have timely and convenient access to appropriate intervention(s)
- Non- technological interventions offered effectively meet the needs of patients and their significant other(s)

Following implementation of the IMP, a process of ongoing support and maintenance continues.

Standard 6. Clinical Effectiveness

The outcome and effectiveness of the Individual Management Plan are evaluated and recorded.

Outcomes and effectiveness of the service as a whole are evaluated and recorded to identify trends and patterns which may inform service development and planning.

Standard 7. Clinical Skills and Expertise

Each service provides, within a governed team approach, the clinical competencies necessary to safely and effectively support the assessments and interventions undertaken. All tasks are undertaken within an established, nationally-agreed, competency-based framework.

Standard 8. Collaborative Working

Each Audiology service has in place processes and structures to ensure effective collaborative working.

Collaborations appropriate to patient and service needs should be identified and established and may be with internal and external agencies and services.

Standard 9. Service Improvement

Each service has processes in place to measure service quality. Quality measures are used to plan and implement service improvements.

Each service has processes in place to regularly consult with patients and stakeholders.

Each service has processes in place to keep up to date with and employ key innovations relevant to Audiology.

The Individual Management Plan

The Individual Management Plan (IMP) is central to the Quality Standards for Adult Hearing Rehabilitation Services.. It is an idea firmly rooted in good practice. It involves a minute of the conversation between audiologist and patient about what the patient feels, wants or expects; what the audiologist is able to offer; and how the audiologist and patient agree to proceed.

There is no specified form or template for the IMP. It is assumed that services will keep detailed notes of these conversations in their patient records. The IMP is not a case history form or a record of assessment results, although the patient's case history and hearing status will certainly help to inform the IMP and are therefore likely to be summarised within it. What is important is that an audiology service can demonstrate that for each patient any planned assessments, interventions or onward referrals have been properly discussed and agreed with the patient. All of those taking part in the conversation through which a management plan is constructed, need to have the chance to agree that conversation. In other words they should know exactly what has been decided and why, and have a clear understanding of how and when the patient's further assessment treatment will proceed.

An audiologist may list a new patient's needs as: hearing assessment; hearing aid fitting; advice and information about communication tactics; advice about assistive listening devices; leaflets about tinnitus. The same patient may list his/her needs quite differently: get my spouse to stop arguing with me about my hearing; get reassurance that I don't have a serious illness; find out how likely it is that this hearing problem will get worse; find out how I can make the tinnitus go away; under no circumstances get a hearing aid. It is highly improbable that either list will be the one to eventually appear on the patient's IMP. Through conversation and an exchange of information at this and subsequent appointments, the audiologist and the patient will explore what can and cannot be done and the agreed needs and agreed actions for the patient will be reviewed and updated over time.

The Evidence Base

"Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values," (Sackett et al., 2000 p. 1).

A comprehensive review of the current evidence base has been undertaken. Wherever possible the evidence base has been drawn from peer reviewed, published research. Articles from other literature have been included if deemed appropriate by the working group. To enable the reader to explore the relevant literature that supports each individual standard, the rationale column now contains numbered references. Full details of the references for each standard can be found within the Standard assessment tool. There are also a number of overarching documents that have informed the development of the second version and these are listed below.

Disability Discrimination Act 1995

Sackett, D.L., Straus, S.E., Richardson, W.S., Rosenberg, W. and Haynes, R.B. 2000. *Evidence-Based Medicine: How to Practice and Teach EBM*, (2nd ed.). Churchill Livingstone: Edinburgh

Welsh Assembly Government, 2003. *Fundamentals of Care*. Wales: Welsh Assembly Government

Welsh Assembly Government, 2003. *Signposts 2: Putting Public and Patient Involvement into Practice in Wales*. Cardiff. Welsh Assembly Government

Welsh Assembly Government., 2005. *Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century*. Wales: Welsh Assembly Government.

Welsh Assembly Government 2006. *National Service Framework for Older People in Wales.* Wales: Welsh Assembly Government

Scottish Executive, 2007. *All Our Futures: Planning for a Scotland with an Ageing Population.* Edinburgh: Scottish Executive

Department of Health. 2007. *Improving Access to Audiology Services in England*. London: The Stationary Office.

The Equality Act 2010

Department of Health, 2010. *Equity and excellence: Liberating the NHS (White Paper)*. London: The Stationary Office.

Welsh Assembly Government, 2010. *Doing Well, Doing Better. Standards for Health Services in Wales*. Wales: Welsh Assembly Government

Patient Rights (Scotland) Act 2011

Action on Hearing Loss. 2011. *Hearing Matters*. London: Action on Hearing Loss

The Scottish Government, 2011. *Reshaping Care for Older People: A Programme for Change.* Edinburgh: The Scottish Government

Welsh Government, 2011. *Together For Health. A 5-Year Vision For The NHS in Wales*. Wales: Welsh Government

Welsh Assembly Government, 2011. *Fairer Health Outcomes For All. Reducing Inequities in Health Strategic Action Plan.* Wales: Welsh Assembly Government.

Aylward, M., Phillips, C. and Howson, H. 2013. *Simply Prudent Healthcare – achieving better care and value for money in Wales – discussion paper*. Wales: Bevan Commission, Simply Prudent Healthcare

The Scottish Government, 2013. *See Hear: A strategic framework for meeting the needs of people with a sensory impairment in Scotland.* Edinburgh: The Scottish Government

Bradley, P. & Willson, A., 2014. *Achieving prudent healthcare in NHS Wales (revised).* Cardiff: Public Health Wales

External Audit Against the Standards

The process for self assessment and external audit against the Standards is outlined in detail within the *Arrangements for the External Audit of Adult Audiology Services Against the Quality Standards for Adult Hearing Rehabilitation Services* that accompanies this document.

Principles and Key Features of External Audit Process

- The objective of the audit process is to externally verify self-assessment scores (and evidence) limited to the standards. The objective is not to perform an appraisal of service management and/or make extensive recommendations for improvement.

- The audit process should be robust, relevant, efficient, fair and consistent.

- It is assumed that a full self-assessment will have been completed prior the external visit and evidential materials compiled for ready reference at the time of the visit of the external auditors.

- Visits will be conducted jointly by an external audit team; comprising of Lead Independent Auditor, Senior Audiologist from another service and one Service User.

- All Health Boards will be visited every two years by external auditors.

- The Head of Audiology at each Health Board will select whether to submit one self assessment score for the whole Health Board or whether to submit separate self assessment scores for each 'service' within the Health Board. Services are defined as substantive permanently manned departments (and their peripheral sites) – reflecting those that participated in previous self-assessment. Special provision will be made for Powys LHB whereby individual assessment will be performed on the three distinct services delivered by

different providers. However, there will be one site visit, to the only permanently manned site (to Brecon).

- The visit of the external auditors will be completed over a day (nominally 6-7hrs), with additional time required for travel. Only the base centre would be visited rather than peripheral sites. Where a Head of Audiology has selected to submit one self assessment for the Health Board the audit coordinator will select which Service department to visit to undertake the external audit visit.

- Externally assessed scores must be presented to the Chief Executives and Heads of Audiology for each respective service, prior to being made available to ASSAG and put in the public domain (eg on the WSAC website).

- A coordinator will be appointed by ASSAG to administer the scheme, collate results and report to ASSAG following each audit.

- An appeals mechanism will exist where external scoring or the audit process are challenged.