NCHA response to Stakeholder Consultation: Proposed Changes to the NHSP Targeted Follow-Up Pathway

About you

1. Please indicate which stakeholder group you are responding on behalf of.
Selected response: Primary care

2. Are you responding as an individual or on behalf of an organisation, network or professional group?
Selected response: On behalf of an organisation.

3. If responding on behalf of an organisation, network or professional group, please provide the organisation name and describe how the response was developed.
Response: National Community Hearing Association (NCHA). NCHA is the representative body for primary care audiology providers in the UK. NCHA members do not generally provide services to the patient cohort covered by the NHSP targeted follow-up pathway. This response was therefore developed from a wider hearing-care stakeholder perspective, informed by review of the consultation paper and discussion of the proposed safeguards and implementation considerations.

Overall views on the proposal

4. To what extent do you agree or disagree with the proposal to replace routine 7–9 month targeted follow-up appointments with a PIFU-based approach for children identified with recognised NHSP risk factors?
Selected response: Strongly agree/Agree/Neither agree nor disagree/Strongly disagree/Not sure

5. Please explain the reasons for your answer, including any benefits, concerns or conditions that would need to be addressed before implementation.
Response: NCHA supports the proposed move to patient initiated follow up (PIFU). The recommendation paper presents a credible rationale for change, particularly given the high non-attendance rate, limited clinical yield and substantial use of paediatric audiology capacity associated with routine targeted follow-up. Our principal concern is delayed identification if a parent, carer or professional does not recognise or act on a concern. Implementation should therefore include clear and accessible information, direct routes back into audiology, strengthened professional

referral routes, alternatives where PIFU is unsuitable and robust evaluation. NCHA additionally recommends a prompt from the responsible audiology service every six months during the PIFU period, reminding parents and carers about relevant milestones, signs of concern and how to request review.

6. Do you consider the proposal to be clinically appropriate, proportionate and consistent with the available evidence?
Selected response: Yes/No/Not sure

Acceptability for children, families and professionals

7. How acceptable would the proposed PIFU model be to families whose child has an NHSP risk factor?
Selected response: Very acceptable/Acceptable/Neither acceptable nor unacceptable/Not at all acceptable/Not sure

8. What information, support or communication materials would families need to understand when and how to access audiology services if concerns arise?
Response: Families should receive clear, reassuring and accessible information explaining that later-onset or progressive hearing loss can occur; the hearing, speech, language, communication and developmental signs that should prompt concern; how to contact the responsible audiology service directly; what will happen after contact; and the period for which direct access remains available. Materials should be available in different languages and accessible formats, with non-digital options. NCHA additionally recommends six-monthly prompts from audiology during the PIFU period, reiterating these messages and providing a direct route to request review.

9. How acceptable would the proposed model be to professionals involved in newborn hearing screening, paediatric audiology, primary care, public health, child health, education and safeguarding services?

Newborn Hearing Screening teams

Selected response: Very acceptable/Acceptable/Neither acceptable nor unacceptable/Not at all acceptable/Not sure

Paediatric Audiology professionals

Selected response: Very acceptable/Acceptable/Neither acceptable nor unacceptable/Not at all acceptable/Not sure

Primary Care professionals

Selected response: Very acceptable/Acceptable/Neither acceptable nor unacceptable/Not at all acceptable/Not sure

Public Health professionals

Selected response: Very acceptable/Acceptable/Neither acceptable nor unacceptable/Not at all acceptable/Not sure

Child Health services

Selected response: Very acceptable/Acceptable/Neither acceptable nor unacceptable/Not at all acceptable/Not sure

Education or early years professionals

Selected response: Very acceptable/Acceptable/Neither acceptable nor unacceptable/Not at all acceptable/Not sure

Safeguarding professionals

Selected response: Very acceptable/Acceptable/Neither acceptable nor unacceptable/Not at all acceptable/Not sure

Feasibility and operational delivery

10. How feasible would it be for local services to implement a clearly defined PIFU pathway for children with recognised NHSP risk factors?

Selected response: Highly feasible/Feasible/Neither feasible nor unfeasible/Not at all feasible/Not sure

11. What would need to be included in a national PIFU operational specification to support consistent implementation?

Response: NCHA agrees that the specification should define eligibility, the PIFU period and discharge point, minimum safety-netting requirements, circumstances requiring extended or alternative follow-up, direct-access and professional-triggered referral routes, triage and response standards, roles and responsibilities, information requirements, documentation, transition arrangements and evaluation measures. If six-monthly prompts are adopted, it should also define their required content and responsibility for maintaining contact details, issuing and recording prompts, responding to concerns and managing families who cannot be reached.

12. What local systems, processes or workforce requirements would be needed to support direct access, triage, booking, documentation and monitoring?

Response: Services would need a clearly publicised direct-access route, timely clinical triage and booking processes, consistent documentation of risk factors and contacts, mechanisms to maintain family contact details, accessible communication routes, escalation arrangements, data collection for monitoring, and sufficient administrative and clinical capacity. If six-monthly prompts are introduced, systems should record when prompts are issued, responses received, concerns raised and follow-up completed.

13. What timescale should apply to PIFU eligibility?

Selected response: 12 months/2 years/3years/School entry

14. How should the end point of the PIFU period be defined?

Response: The end point should be nationally defined and communicated from the outset. Families should receive a clear notification before discharge, a final reminder of signs of concern, and information about the routine routes available after PIFU

ends. Extended or alternative follow-up should remain available where clinical or social circumstances indicate that standard discharge would be inappropriate.

Safety, safeguarding and safety-netting

15. What safety-netting arrangements would be required to ensure children with delayed-onset, progressive or acquired hearing loss can access timely audiology assessment?

Response: NCHA supports the safeguards proposed in the paper: clear and accessible parental information, direct access back into audiology during the PIFU period, professional-triggered referral routes, strengthened professional education, and alternative arrangements where PIFU is unsuitable. NCHA additionally recommends a light-touch prompt from audiology every six months, reminding parents and carers about relevant milestones and signs of concern and providing a direct route to request review.

16. How should professional-triggered referral routes operate where a concern is identified by a screener, health visitor, GP, paediatrician, early years practitioner, teacher, safeguarding professional or other relevant practitioner?

Response: Relevant professionals should have a clear, nationally consistent route to refer or request assessment without unnecessary delay or duplication. Guidance should describe signs of concern, required information, the responsible service, expected response times and escalation routes. A professional referral should remain available irrespective of whether a parent or carer has initiated contact.

17. What safeguarding considerations should be addressed to ensure children and families who may be less able to initiate follow-up are not disadvantaged?

Response: The pathway should avoid relying solely on families recognising a concern and initiating contact. Services should identify where PIFU may be unsuitable, provide alternative or enhanced follow-up, use accessible and non-digital communication routes, maintain accurate contact details, and define action where families cannot be reached. Information should be shared appropriately across relevant child health and safeguarding services, with clear accountability for escalation.

18. Are there specific groups of children or families for whom a PIFU model may not be appropriate without additional safeguards or alternative follow-up arrangements?

Response: Yes. Additional safeguards or alternative follow-up may be required where there are communication or language barriers, low health literacy, digital exclusion, disability, unstable contact details, limited engagement with universal services, safeguarding concerns, social complexity, or clinical factors that increase the risk of delayed identification. Suitability should be assessed and documented rather than assumed.

Equality, accessibility and health inequalities

19. What equality, accessibility or health inequality impacts should be considered before implementing the proposed model?

Response: A passive PIFU model could widen inequalities if families face barriers to understanding information, recognising concerns or contacting services. Implementation should consider language, literacy, disability, digital access, deprivation, unstable housing or contact details, social complexity and differing levels of engagement with universal services. Access, outcomes and delayed identification should be monitored across relevant population groups.

20. What adaptations may be required for families with communication, language, literacy, digital access, disability, social complexity or other support needs?

Response: Information should be available in translated, easy-read, large-print and other accessible formats, with interpreting and communication support where needed. Families should be able to use telephone, written and face-to-face routes as alternatives to digital access. Reasonable adjustments, nominated contacts, repeated communication and active follow-up should be available where required.

21. How should services monitor whether the PIFU model is being accessed equitably by different population groups?

Response: Services should monitor eligibility, successful communication, requests for review, referral source, time to assessment, non-response, later-identified hearing loss and family experience, with analysis by relevant equality characteristics, deprivation and other locally important indicators. Findings should be reviewed nationally and locally to identify variation, under-access and unintended consequences.

Benefits, risks and unintended consequences

22. What benefits do you think the proposed model could deliver for children, families, audiology services and the wider screening pathway?

Response: Potential benefits include more proportionate use of paediatric audiology capacity, fewer routine appointments and associated inconvenience for families, reduced activity within a pathway that has high non-attendance and limited clinical yield, and responsive access when parents, carers or professionals identify a concern. The approach could maintain surveillance through information, professional education and safety-netting rather than relying on a single routine appointment. This is of particular benefit if the PIFU period extends until school age; giving parents increased access over an extended period, as opposed to a single contact at an arbitrary time point.

23. What risks or unintended consequences should be considered, and how could these be mitigated?

Response: The main risk is delayed identification where a concern is not recognised or acted upon. Other risks include widening inequalities, variable local

implementation, unclear accountability, families interpreting PIFU as discharge, and insufficient capacity to respond promptly when concerns arise. Mitigations include nationally consistent specifications, accessible information, direct and professional-triggered referral routes, alternatives where PIFU is unsuitable, clear responsibilities, monitoring and evaluation. NCHA's proposed six-monthly prompt would provide an additional active safeguard.

Implementation requirements

24. What guidance, training, communication resources, digital tools or data requirements would be needed to support safe and consistent implementation?

Response: National guidance should define the pathway, responsibilities, referral and escalation routes, response standards, exclusions and monitoring requirements. Standardised family materials should be available in accessible formats. Training should support recognition of possible hearing change across screening, primary care, health visiting, paediatrics, early years, education and safeguarding. Digital tools should support direct access and prompts without becoming the only route. Data systems should record eligibility, contacts, referrals, assessments and outcomes.

25. What governance, assurance or monitoring arrangements should be in place nationally, regionally and locally?

Response: National governance should set the operational specification, minimum dataset, outcome measures and review arrangements. Regional and local assurance should monitor compliance, access, response times, variation, equality impacts, later-identified hearing loss, family experience and unintended consequences. There should be clear accountability for addressing any identified issues.

26. What transition arrangements would be needed if the recommendation were approved following consultation?

Response: A phased implementation should include clear national and local communications, staff training, identification of children already awaiting targeted follow-up, agreed handling of existing appointments, confirmation of PIFU eligibility and end dates, accessible information for affected families, tested referral and escalation routes, data-readiness checks and early monitoring. Families should not lose access during transition.

Final comments

27. Do you support progression to a second-phase implementation project to further develop the operational model, subject to the outcome of consultation?

Selected response: Yes/No/Not sure

28. Are there any additional issues, evidence, stakeholder perspectives or implementation considerations that should be taken into account?

Response: NCHA members do not generally provide services to this patient cohort,

so this response is offered from a wider hearing-care stakeholder perspective. The second-phase project should prioritise input from families, paediatric audiology, NHSP services and the professionals responsible for ongoing child health surveillance. It should also test NCHA's proposed six-monthly prompt, including its effect on engagement, delayed identification, family experience and service workload.

29. Please provide any further comments on the proposed recommendation or consultation process.

Response: NCHA supports the proposed pathway change and agrees with the rationale and safeguards set out in the recommendation paper. Our principal additional recommendation is a prompt from audiology every six months during the PIFU period, reminding parents and carers about relevant milestones, signs of concern and how to request review. This would complement, rather than duplicate, the proposed arrangements and provide an additional safeguard against delayed identification.

30. Would you like to be contacted directly in response to this consultation?

Selected response: No