

# The Audiology Quality Enhancement Tool

*(Including the DRAFT new Clinical Quality Domain – all other domains as per July 2009 update)*

<b>** DRAFT VERSION ** Clinical Quality (New Domain)</b>			
<b>Referral Criteria</b>			
1.1	Some form of referral criteria are used by the department and it is recognised that, if these are clear and consistently applied as a way into health services they will become a key element of service transformation processes		Level D
1.2	Protocols and referral routes are documented and clear for all professional involved in the service		
1.3	Patients are informed by letter, phone or email of their appointment		
1.4	Referral criteria are disseminated to GPs via Choose and Book and other initiatives		
1.5	The number of inappropriate referrals is monitored and action is taken to ensure these numbers are reduced		Level C
1.6	Patients are informed about the booking system that is used for new and follow-up appointments		
1.7	The department is aware of the importance of referral criteria and helps to propagate this knowledge out into primary care		
1.8	The department has assisted with or provided a validated questionnaire which will help primary care and other practitioners to make a decision about whether a new patient should be referred for a hearing or balance problem		Level B
1.9	Where necessary the department assists with carrying out the questionnaire or interpretation of the results to ensure that referrals are appropriate		
1.10	Audit of a number of referrals ensure that compliance with referral criteria are met		Level A
1.11	Patients are informed of the appointment choices available in a direct booking system		

**\*\* DRAFT VERSION \*\* Clinical Quality (New Domain)**

**Measurement and protocols in medically-led clinics (ENT, AVP)**

2.1	Hearing thresholds by air conduction are measured on at least 95% of patients using BSA recommended procedures		Level D
2.2	Hearing thresholds by bone conduction are measured as required and at least every 3 years using BSA recommended procedures		
2.3	Hearing tests in the medically-led clinic are carried out in acoustical conditions conforming to national and international standard requirements for 20 dBHL for air conduction and 30 dB HL for bone conduction, at least 95% of the time		
2.4	All test results are clearly documented in the patient's file according to BSA recommended procedures where relevant		
2.5	All equipment used in the medically-led clinic is calibrated annually to international standards and this is documented		
2.6	Daily checks are carried out to international standards on all equipment used in the medically-led clinic and this is documented		
2.7	There are written/electronic BSA recommended procedures or protocols available to all staff in the department and these include air and bone conduction testing with masking, thresholds of uncomfortable loudness levels, and tympanometry		
2.8	Tympanometry is carried out as required using BSA recommended procedures		Level C
2.9	Hearing tests in the medically-led clinic are carried out in acoustical conditions conforming to national and international standard requirements for 0 dBHL for air conduction and 10 dB HL for bone conduction, at least 50% of the time		
2.10	The department engages with ENT/AVP to ensure that patients attending these clinics receive the same information about their audiology test (both before and after testing) as patients seen by other referral routes		
2.11	The department engages with ENT/AVP to ensure that patients attending these clinics receive the same quality of service particularly in terms of time /staff allocated, as patients seen by other referral routes		
2.12	Hearing tests in the medically-led clinic are carried out in acoustical conditions conforming to national and international standard requirements for 0 dBHL for air conduction and 10 dB HL for bone conduction, at least 80% of the time		Level B
2.13	Hearing tests in the medically-led clinic are carried out in acoustical conditions conforming to national and international standard requirements for 0 dBHL for air conduction and 10 dB HL for bone conduction, at least 95% of the time		Level A

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**Taking a history**

3.1	A relevant medical history is taken on at least 95% patients		Level D
3.2	Sufficient detail is taken to apply "BAA Guidelines for Referral to Audiology of Adults with Hearing Difficulty" (Ex-TTSA Guidelines)		
3.3	Otoscopy is performed and findings are documented as part of the history for all patients		
3.4	A validated self-report questionnaire (e.g. the Glasgow Hearing Aid Benefit Profile (GHABP), and COSI) is part of the routine assessment protocol		
3.5	The results of the self-report questionnaire, hearing assessment and information gathered relating to social circumstances, psychological impacts, communication and listening expectations are recorded in the clinical record in at least 95% of cases		
3.6	A validated self-report questionnaire (e.g. the Glasgow Hearing Aid Benefit Profile (GHABP), and COSI) is used in at least 95% of assessments		Level C
3.7	Information is recorded in the clinical record in a standardised way in at least 50% of cases		
3.8	Details of why an assessment could not be carried out are recorded in the clinical record in at least 95% of cases		
3.9	Information is recorded in the clinical record in a standardised way in at least 80% of cases		Level B
3.10	Information is recorded in the clinical record in a standardised way in at least 95% of cases		Level A

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**Measurements and Protocols**

4.1	Hearing thresholds by air conduction are measured on at least 95% patients using BSA recommended procedures		Level D
4.2	There are written/electronic BSA recommended procedures or protocols available to all staff in the department and these include air and bone conduction testing with masking, thresholds of uncomfortable loudness levels, and tympanometry		
4.3	All equipment is calibrated to international standards annually and this is documented		
4.4.	Daily checks are carried out on all equipment to international standards and this is documented		
4.5	Hearing tests, with the exception of domiciliary visits, are carried out in acoustical conditions conforming to national and international standard requirements for 20 dBHL for air conduction and 30 dB HL for bone conduction, at least 95% of the time		
4.6	Uncomfortable loudness levels are measured on at least 95% patients using BSA recommended procedures unless clinically contraindicated		Level C
4.7	Hearing tests, with the exception of domiciliary visits, are carried out in acoustical conditions conforming to national and international standard requirements for 0 dBHL for air conduction and 10 dB HL for bone conduction, at least 50% of the time		
4.8	Additional / further diagnostic procedures are carried out as required		Level B
4.9	Hearing tests, with the exception of domiciliary visits, are carried out in acoustical conditions conforming to national and international standard requirements for 0 dBHL for air conduction and 10 dB HL for bone conduction, at least 80% of the time		
4.10	Hearing tests, with the exception of domiciliary visits, are carried out in acoustical conditions conforming to national and international standard requirements for 0 dBHL for air conduction and 10 dB HL for bone conduction, at least 95% of the time		Level A

**\*\* DRAFT VERSION \*\* Clinical Quality (New Domain)**

**Development of the Individual Management Plan**

5.1	The IMP forms part of the clinical record, and contains details of hearing status in at least 95% of cases		Level D
5.2	The IMP is agreed with the patient and significant other(s) at each appointment		
5.3	A copy of the IMP is sent or given to patients within 7 days of each appointment in at least 50% of cases		
5.4	Information is updated over the period of the patient's journey through the IMP, and this is recorded in the clinical record in at least 50% of cases		
5.5	All information gathered during the assessment is used to support the development of the IMP in at least 50% of cases		Level C
5.6	In at least 50% of cases the IMP contains details of: agreed needs based on the assessment, options for rehabilitation (including hearing instrument management), referral to other agencies and specific goals associated with assessment information		
5.7	A copy of the IMP is sent or given to patients within 7 days of each appointment in at least 95% of cases		
5.8	At least 95% of patients who need and are clinically suitable for bilateral hearing aid fitting are offered 2 hearing aids		
5.9	All information gathered during the assessment is used to support the development of the IMP in at least 80% of cases		Level B
5.10	In at least 80% of cases the IMP contains details of: agreed needs based on the assessment, options for rehabilitation (including hearing instrument management), referral to other agencies and specific goals associated with assessment information		
5.11	Information is updated over the period of the patient's journey through the IMP, and this is recorded in the clinical record in at least 80% of cases		
5.12	A copy of the IMP is given to the patient at each appointment in at least 50% of cases		
5.13	The IMP includes details of the implementation plan and proposed timescales in at least 50% of cases		
5.14	All information gathered during the assessment is used to support the development of the IMP in at least 95% of cases		Level A
5.15	In at least 95% of cases the IMP contains details of: agreed needs based on the assessment, options for rehabilitation (including hearing instrument management), referral to other agencies and specific goals associated with assessment information		
5.16	Information is updated over the period of the patient's journey through the IMP, and this is recorded in the clinical record in at least 95% of cases		
5.17	A copy of the IMP is given to the patient at each appointment in at least 80% of cases		
5.18	The IMP includes details of the implementation plan and proposed timescales in at least 95% of cases		

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**Implementing the Individual Management Plan**

6.1	Where referral to an external agency or service is indicated, referral is made from Audiology within 7 days of appointment in at least 95% of cases		Level D
6.2	The clinical record includes the details, justifications and effectiveness of all non-instrumental interventions in at least 95% of cases		
6.3	The clinical record includes the details, justifications and effectiveness of all instrumental (hearing aid) interventions in at least 95% of cases		
6.4	Prior to issue every hearing aid has its technical performance tested to specification using either a test-box or Real Ear Measurement (REM)		
6.5	Local protocols are in operation concerning selection, fitting and verification of hearing aids		
6.6	Real Ear Measurement (REM) of hearing aid performance is to be used to verify at least 95% of hearing aid fittings, unless clinically contraindicated for individual patients		Level C
6.7	Local protocols concerning selection, fitting and verification of hearing aids comply with the latest professional body and/or national guidance		
	Details of why an intervention could not be carried out are recorded in at least 95% of cases		
6.8	Where REM is performed the acoustical target is verified at soft, moderate and loud input levels (e.g. 50, 65, 80dB) in at least 75% of cases		Level B
6.9	The maximum power output of the hearing aid(s) is checked in at least 95% of cases by REM, if performed, or by coupler measurement		
6.10	Adjustments are made if required to insure that an individual's uncomfortable loudness level is not exceeded		
6.11	Where REM is performed measurements do not deviate from the recommended target at more than one frequency in at least 95% of cases unless clinically indicated		Level A

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**Follow ups and outcome measures**

7.1	Each patient is offered a follow-up appointment following hearing aid fitting		Level D
7.2	Clinical records are used for at least 95% of patients who have a follow-up to judge the extent to which intervention has helped to meet patient specified goals (outcomes		
7.3	Patient reported validated outcome measures (e.g. the Glasgow Hearing Aid Benefit Profile (GHABP), IOI-HA and COSI) are used with at least 95% of patients to evaluate the outcome of intervention where clinically appropriate		
7.4	Patients are offered follow-up appointments that are within 12 weeks of hearing aid fitting		Level C
7.5	Patient reported validated outcome measures (e.g. the Glasgow Hearing Aid Benefit Profile (GHABP), IOI-HA and COSI) are used with at least 95% of patients to further develop their IMP where clinically appropriate		
7.6	Patient reported validated outcome measures (e.g. the Glasgow Hearing Aid Benefit Profile (GHABP), IOI-HA and COSI) are compared against national level data to further develop the IMP in at least 95% of patients where clinically appropriate		Level B
7.7	Patient reported validated outcome measures (e.g. the Glasgow Hearing Aid Benefit Profile (GHABP), IOI-HA and COSI) are compared against departmental level data to further develop the IMP in at least 95% of patients where clinically appropriate		Level A
7.8	Staff level quarterly batch sampling of clinical outcome measures is carried out and compared with aggregate local/national normative data		
7.9	Annual aggregate clinical outcome trends are used to assess, monitor and proactively manage and improve service quality		

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**Long term support**

8.1	Each patient is offered a follow-up appointment following hearing aid fitting		Level D
8.2	Patients are regularly advised that they can self refer for review or repairs at any time		
8.3	Following the successful completion of their management plan at least 95% of patients/referring agents are advised to request ongoing hearing reassessment appointment every 3-years, if it is appropriate for their primary condition		
8.4	Over the course of an average year at least 95% of hearing aid maintenance support (i.e., supplying batteries and tubing) is given within 5 working days from receipt of the request in the department (for postal requests this is the date of receipt of the hearing aid in the department)		
8.5	Over the course of an average year at least 95% of malfunctioning hearing aids are repaired/replaced within 5 working days from receipt of the request in the department (for postal requests this is the date of receipt of the hearing aid in the department)		
8.6	Following the successful completion of their management plan at least 95% of patients are offered an ongoing hearing reassessment appointment every 5-years, if it is appropriate for their primary condition		Level C
8.7	Over the course of an average year at least 95% of hearing aid maintenance support (i.e., supplying batteries and tubing) is given within 2 working days from receipt of the request in the department (for postal requests this is the date of receipt of the hearing aid in the department)		
8.8	Over the course of an average year at least 95% of malfunctioning hearing aids are repaired/replaced within 3 working days from receipt of the request in the department (for postal requests this is the date of receipt of the hearing aid in the department)		
8.9	Following the successful completion of their management plan at least 95% of patients are offered an ongoing hearing reassessment appointment every 3-years, if it is appropriate for their primary condition		Level B
8.10	Over the course of an average year at least 95% of hearing aid maintenance support (i.e., supplying batteries and tubing) is given within 1 working day from receipt of the request in the department (for postal requests this is the date of receipt of the hearing aid in the department)		
8.11	Over the course of an average year at least 95% of malfunctioning hearing aids are repaired/replaced within 2 working days from receipt of the request in the department (for postal requests this is the date of receipt of the hearing aid in the department)		
8.12	Following the successful completion of their management plan where clinically appropriate, at least 95% of patients are given written information on how to access local ear care/wax management services		
8.13	Over the course of an average year at least 95% of malfunctioning hearing aids are repaired/replaced within 1 working day from receipt of the request in the department (for postal requests this is the date of receipt of the hearing aid in the department)		Level A

## The Quality of the Patient Experience

### Provision of Information to Patients or Significant Other

QE1.1	Patients have an opportunity to ask questions before any test is carried out.		Level D
QE1.2	Patients are told before the appointment that they can bring a significant other to the department with them		
QE1.3	Information sheets are available in electronic form (and hard copy or reusable laminate sheets where requested) for all tests/procedures carried out in the department.		
QE1.4	Where patients attend the department for a test, they are given written information within a week of their appointment about the outcome action they can expect to be taken as a result.		
QE1.5	Where appropriate patients leave the Department with written information about what to do if they have any problems as a result of a test/procedure		
QE1.6	Patients are provided with test-specific information about the time their test/procedure/treatment will take, and the possible effects of the tests		
QE1.7	The department helps patients to access information in electronic form (and in hard copy if requested) about their condition (hearing loss, tinnitus, balance problems etc.) and devices that they may be given to assist their condition (e.g. hearing aids, white noise generators etc).		
QE1.8	Advice and information is available about the benefits of bilateral fittings where appropriate		
QE1.9	Patients are provided with written information about the purpose of their appointment (including what will happen, why, and how long should be allowed) in advance of that appointment with their appointment letter		Level C
QE1.10	Patients are told who (what type of health professional) will perform their test or undertake their treatment on their appointment letter		
QE1.11	Patients are provided with information before or at the time of the tests about what will be the next stage of their treatment / management		
QE1.12	Patients leave the department with written information about what action they can take if they have concerns about their test results or devices issued and how they can re-contact the department (telephone / text / SMS / email / type-talk).		
QE1.13	All patient information sheets are reviewed internally at least annually		
QE1.14	There is an annual survey of patient and service user satisfaction, using a validated instrument, which specifically enquires about the provision of information		Level B
QE1.15	Where a patient is advised about access to ongoing care; An ongoing review is offered in writing within 3 years in 50% of cases		
QE1.16	Patients are provided with information (Contact number) about how they can enquire about the nature of their tests, voice concerns, or ask questions, prior to their appointment		Level A
QE1.17	When clinically appropriate, patients leave the Department with written details of the time and date of any necessary follow-up appointment		
QE1.18	Where a patient is advised about access to ongoing care; An ongoing review is offered in writing within 3 years in all cases		

## The Quality of the Patient Experience

### The Quality of Staff – Patient Communication

QE2.1	All new staff who will have contact with patients undertake deaf and disability awareness training such that they have general awareness of communication requirements (including sign language, Braille etc.)		Level D
QE2.2	There is a contact number posted in the department and included on the patient appointment letter for patients who have questions or experience problems.		
QE2.3	All visual displays within the department are accessible (e.g. if there is a TV then it should show Subtitles).		
QE2.4	All patients are asked if they have any special communication needs before a 1st visit (e.g. In appointment letter or choose and book form)		
QE2.5	Refresher deaf awareness training for staff is available where required		Level C
QE2.6	The department is easily contactable by patients with a hearing loss in a variety of ways i.e. fax, text phone, generic email address and voice phone		
QE2.7	Each patient receives an accessible written plan of care (in large print, Braille etc. if necessary)		
QE2.8	A text / type-talk or SMS phone is either available in the department (and staff are trained to use the facility) or the department is registered with a type-talk service.		
QE2.9	At the time of their appointment, patients are individually greeted from reception / waiting area; or the department possesses a visual or vibrating alert system that enables patients with sensory impairment(s) to know that it is their turn to be seen.		
QE2.10	A patient comments and complaints procedure exists, and patients are informed about how to find out the outcome (e.g. via PALS)		
QE2.11	A survey that incorporates questions related to patients' views about their communication with staff has been carried out in the last 2 years		Level B
QE2.12	Users review of staff – patient communication from recent surveys and patient comments is monitored as appropriate at departmental meetings		
QE2.13	Appointment durations are extended to allow for communication needs and support		
QE2.14	A survey that incorporates questions related to patients' views about their communication with staff has been carried out in the last 6 months, and there is evidence that the results have been acted upon		Level A
QE2.15	There are readily available badges, stickers and communication cards issued to patients that can assist with improving general communication		

## The Quality of the Patient Experience

### Use of Patient Self-Help and Support groups

QE3.1	Up to date written information about patient self help and support groups is posted in the department, and updated regularly		Level D
QE3.2	The advantages of the use of volunteers are covered in staff meetings or training courses		
QE3.3	Written information about lip-reading classes is readily available		
QE3.4	The department keeps details of appropriate peer groups that patients can access if required		
QE3.5	Staff know current details about patient self help and support groups.		Level C
QE3.6	Where changes in local patient user groups and activities are sent they are acknowledged by the department		
QE3.7	Patient self-help and support groups are invited to one departmental meeting per year.		
QE3.8	Patient self-help and support groups are invited to be involved in the staff departmental training.		
QE3.9	Appropriate support for volunteer schemes that comply with available national guidance and local accreditation processes is available		
QE3.10	Patients are given the contact details of patient self help and support groups with relevant literature from the department.		
QE3.11	Written information is provided relating to the services offered by Hearing Therapy, and how this may be accessed at a local level		
QE3.12	Representatives from patient self help and support groups are invited to staff functions to spread the word about their existence		Level B
QE3.13	The head of department or representative regularly liaises with chairs of patient self help and support groups		
QE3.14	The service ensures and assists in the establishment of volunteer schemes		
QE3.15	Activities of patient self help and support groups are checked annually		Level A
QE3.16	Departments are in regular contact with patient self help and support groups.		
QE3.17	There is a mechanism to facilitate contact between patients and patient self help and support groups.		
QE3.18	Patient self help and support groups are invited to be actively involved in considering service development		

## The Quality of the Patient Experience

### The Quality of the Environment

QE4.1	There is basic monitoring of all rooms for cleanliness, temperature, accessibility, safety, light and acoustics		Level D
QE4.2	There is ultimately a named person responsible for liaising with relevant hospital maintenance staff		
QE4.3	Facilities are signposted consistent with the organisational requirements		
QE4.4	It is made certain that maximum permissible background noise levels in hearing test rooms are not exceeded.		
QE4.5	There are separate adult and child waiting areas where both services are offered		
QE4.6	Appropriate toilet facilities for adults, children and disabled patients are available		
QE4.7	The department follows organisational cleanliness and infection control policies (e.g. Alcohol hand gel is available and regularly used)		
QE4.8	Staff check that patients are comfortable during clinical intervention		
QE4.9	Patients are asked about their personal needs (such as mobility difficulties, visual impairment etc.) prior to any attendance		Level C
QE4.10	Key room types have floor area of at least the statutory minimum and are dedicated facilities		
QE4.11	A survey that incorporates questions related to patients' views about the departmental environment has been carried out in the last year		
QE4.12	Problems with general levels of departmental environmental quality are reported to management at least every year		
QE4.13	Dedicated rehabilitation rooms have the following essential features – Natural Light (or equivalent daylight bulbs), Hand-wash basin (or alcohol gel hand wash), Loop System and an Information Board.		Level B
QE4.14	A review is carried out every 2 years about how the department monitors the environmental comfort of patients, and any changed needs that they have		
QE4.15	Where inadequacies in the quality of environment are identified, action is taken within 1 month to restore the quality to agreed levels		
QE4.16	Action on the quality of the environment is reviewed every 6 months to ensure that all outstanding issues are dealt with		Level A
QE4.17	If the environment does not reach acceptable safety and comfort levels after a period of 2 months following a review (as above) of the individual department then remedial action is taken		

## The Quality of the Patient Experience

### Capturing of Patient & Service User feedback

QE5.1	The policy for patient complaints is available within the department in electronic form (and hard copy on request).		Level D
QE5.2	There is no discrimination (or evidence of discrimination) against patients who make a complaint		
QE5.3	Action is taken in response to patient complaints. Auditable outcomes are available		Level C
QE5.4	Action for patient complaints is reviewed within three months of the date of complaint to ensure it has dealt with the issues		
QE5.5	Samples of clinicians' journal entries are audited/accessed regularly for comments relating to specific patient feedback		
QE5.6	Comment forms are readily available within the department for patients' views on their clinical experiences		
QE5.7	Patient or service user feedback is sought via at least one method annually e.g. discovery interviews, focus groups, PPI forums, questionnaires, invited comments		Level B
QE5.8	Action is taken in response to patient feedback by at least two methods each year (letter, patient leaflets, phone calls, publicity etc). Auditable outcomes are available		
QE5.9	Action for patient feedback is reviewed by six months to ensure it has dealt with the issues		
QE5.10	A resource is available to help to resolve problems for patients, service users and carers and to act as a source of intelligence for service improvement. (In the NHS this would be fulfilled by PALS, but other options are acceptable).		
QE5.11	Users participate in planning and evaluating services		Level A
QE5.12	Details of changes made in response to patient feedback are communicated to all service users		

## The Quality of the Patient Experience

### Promoting Equality and Diversity within Departments

QE6.1	The department can show that it follows an EDP (Equality/Diversity Policy) or RES (Race Equality Scheme).		Level D
QE6.2	All staff have had induction on the EDP or RES		
QE6.3	A demographic/language profile of the local population (needs assessment) is available		
QE6.4	All patients with communication needs are offered a hospital medical interpreter, trained bilingual staff member, telephone interpreting service or signing interpreter		
QE6.5	Resources exist for medical interpreting for the majority of community languages, appropriate to the needs assessment		
QE6.6	Communication needs are recorded prior to the first assessment, including need for signing interpreter		Level C
QE6.7	Written information is available in the department in some of the community languages identified by a documented assessment of languages spoken in the local community.		
QE6.8	The use of family and friends as interpreters is discouraged unless it is the patient's choice to use them as interpreters. If patients exercise this choice it is documented in the patient's file		
QE6.9	Written information is available in the department in all of the community languages identified by a documented assessment of languages spoken in the local community.		Level B
QE6.10	Information is provided via different methods as appropriate to the needs assessment (e.g. In a patients preferred language). The Trust has a policy that clearly states how this is delivered to meet the needs of diverse groups		
QE6.11	All booking procedures are assessed for equality of access		Level A
QE6.12	Feedback is actively sought from minority groups on the services provided by the unit using questionnaires, telephone interview or focus group		
QE6.13	User participation in planning and evaluating services is representative of the local population in terms of gender, ethnicity and disability		
QE6.14	Regular training around specific needs of religious groups is available, so they know the procedures to follow when they attend an audiology department		

## Workforce and Training

### Skill Mix Review and Recruitment

WT1.1	The organisational policy for recruitment and selection is available in the department in written and/or electronic form		Level D
WT1.2	When a vacancy occurs the job description for that post is reviewed and, if appropriate, amended		
WT1.3	The allocated funding and establishment for the service is documented		
WT1.4	There is a named person responsible for managing the rostering that meets service needs		
WT1.5	Skill mix is reviewed as vacancies arise or in light of changes in service demand. In any case this occurs at least annually		
WT1.6	The speciality team has a named HR link		Level C
WT1.7	The specialty is represented throughout the recruitment process, with professional and HR guidelines in place		
WT1.8	The establishment and its skill mix is reviewed when a vacancy arises and, if appropriate, modified		
WT1.9	The length of the recruitment process is monitored and fed back to HR		
WT1.10	National guidelines (such as DH, BAAP, ENTUK, NSFs, BSHAA, BTA, BSA and BAA guidelines) are taken into account when planning services.		
WT1.11	The service adopts a flexible approach to rostering in response to scheduling		Level B
WT1.12	There is an information pack about the service for potential applicants		
WT1.13	Opportunities for promoting recruitment into the service are identified and taken up		
WT1.14	The teams workforce requirements are fed back into the organisations workforce planning strategy		
WT1.15	If the service has concerns about the length and/or nature of the recruitment process these concerns are fed back to HR		Level A
WT1.16	The establishment and its skill mix is reviewed in anticipation of service changes and future vacancies		
WT1.17	If a workforce need remains unresolved because of resource constraints the need is placed on the organisation's risk register		

## Workforce and Training

### Orientation and Training

WT2.1	Department and organisational policies for induction, training and development are available in the department in written and/or electronic form		Level D
WT2.2	The service / department provides an informal induction programme		
WT2.3	Staff attend mandatory training within their working hours, or receive time off in Lieu where training occurs on a non-working day		
WT2.4	Specialty specific training occurs during work hours as opportunities arise		
WT2.5	A period of preceptorship, appropriate to the organisational induction policy, is arranged for each new member of staff		Level C
WT2.6	Time is allocated for staff to undertake specialty specific education and training during working hours		
WT2.7	There is a specialty specific formal induction and orientation programme		
WT2.8	Feedback on training received is gathered from staff at least annually		
WT2.9	Adequate resources are identified to meet the education and training needs of the service, and timely training is not constrained by pressure from service work		Level B
WT2.10	Patient feedback is used in training to develop awareness of the patient experience		
WT2.11	The induction programme is tailored to the needs of different staff groups		
WT2.12	Trainers have the appropriate competence (derived from appropriate courses e.g. Clinical supervision) for what they teach and have recognised teaching and assessment skills		
WT2.13	Induction programmes are modified in response to staff feedback		
WT2.14	Recommendations from staff feedback on training provision are acted upon within six months		Level A
WT2.15	There is an agreed annual education and training plan, supported by management, that reflects staff and service needs		
WT2.16	When training needs cannot be met by in house training staff are able to access suitable external training to meet their training needs		

## Workforce and Training

### Assessment and Appraisal

WT3.1	Organisational policies for Knowledge and Skills Framework (KSF) and appraisal are available in the department in written and/or electronic form		Level D
WT3.2	The policy for managing poor performance is available within the department in written and/or electronic form		
WT3.3	The National Workforce and speciality competencies are accessible in the department in written and/or electronic form		
WT3.4	Appraisers have undergone appraisal training		
WT3.5	All staff have a full KSF outline or clinical job plan		
WT3.6	A personal development plan (PDP) is agreed and written following every appraisal		
WT3.7	A database of registered individuals is kept and reviewed annually		
WT3.8	All staff are appraised using evidence against their KSF outline in a suitable environment and within working hours		Level C
WT3.9	Competencies are used to assess staff performance		
WT3.10	There is a mechanism in place to support managers in resolving issues raised during appraisal and assessment		
WT3.11	A record is kept of individual assessments, sign off of competences and appraisals		
WT3.12	Staff are only permitted to practice independently when they have achieved the required competencies		Level B
WT3.13	PDPs are monitored to ensure that objectives are achieved within the agreed timescales		
WT3.14	Action plans are in place to address performance issues identified during appraisal and assessment		
WT3.15	PDPs align individual objectives with team and organisational objectives, and they feed into the organisational training plan and budget		
WT3.16	Feedback is collated annually on staff experience of appraisal		
WT3.17	Staff are supported to attain competencies to encourage succession planning and career progression		Level A
WT3.18	The service supports developmental and remedial approaches to resolve performance difficulties. These are agreed and documented with the individual		
WT3.19	Individual work records cover good as well as poor performance and include informal notes as well as formal documentation		
WT3.20	Feedback from staff on assessment and appraisal is acted upon within 6 months		
WT3.21	Adequate resources are identified to meet assessment and appraisal needs of the service and if these are insufficient the problem is reported to HR		

## Workforce and Training

### Staff care and respect

WT4.1	Organisational policies for health and safety are available in the department in written and/or electronic form, including managing emergency situations		Level D
WT4.2	There is a health and safety risk assessment that meets the organisation's policy requirements		
WT4.3	The staff have access to additional support systems such as counselling and occupational health		
WT4.4	The organisational policy for Equality and Diversity is available in the department in written and/or electronic form		
WT4.5	Improving Working Lives (IWL) information is available within the department		
WT4.6	There is an agreed plan on how best to manage health and safety risks		Level C
WT4.7	All staff complete full mandatory training within 3 months of appointment and a register is kept to ensure that this is up to date		
WT4.8	There is a process in place for staff to confidentially raise concerns about discriminatory and/or unacceptable behaviour		
WT4.9	Individuals are encouraged to identify and record risks involved in work activities		
WT4.10	The service monitors the extent to which legislation, policies and procedures are adhered to		Level B
WT4.11	The plan to address health and safety risk issues is reviewed at least every 6 months		
WT4.12	All staff are invited to provide feed back at least once a year on how well staff are treated with care and respect		
WT4.13	Action plans are created if IWL standards are not achieved		
WT4.14	Agreed action plans for the IWL standards are acted upon within three months		Level A
WT4.15	There is evidence that the risk management plan is effective		
WT4.16	The service lead evaluates annually the extent to which health and safety legislation, policies and procedures are implemented in the environment		
WT4.17	Outcomes of service reviews are acted upon and fed into development plans for the service		

## Workforce and Training

### Staff views are respected

WT5.1	There are informal service team meetings where staff are able to contribute views and ideas on improving services for users		Level D
WT5.2	There is a process in place for exit interviews to be recorded and feedback given to clinical and general managers		
WT5.3	Recommendations from exit interviews are reviewed by the service lead		Level C
WT5.4	Multidisciplinary service team meetings are held at least every 3 months		
WT5.5	Action plans are developed in response to recommendations from exit interviews		
WT5.6	There is documented evidence that staff contribute views and ideas on improving services		
WT5.7	Staff are valued and their contribution to service development is recognised and recorded		
WT5.8	There is documented evidence that staff ideas on improving the service are acted upon		Level B
WT5.9	There is recognition of staff contributions to service development through informal reward systems		
WT5.10	Feedback is gathered from staff at least once a year on the quality of their work environment		
WT5.11	The team participates in appraisal of policies & strategies and is encouraged to suggest improvements		Level A
WT5.12	Action plans developed in response to recommendations from exit interviews are implemented within six months		
WT5.13	The staff actively promote and share knowledge of service developments and experience with other services within the organisation and externally		
WT5.14	There is documented evidence that action is taken in response to staff feedback within three months		

## Workforce and Training

### Students/trainees are Educated

WT6.1	Risk assessments for students/trainees, staff and patients are carried out annually in all placement areas		Level D
WT6.2	Students/trainees have access to learning resources (books, journals, IT facilities, including internet access)		
WT6.3	Poorly performing students/trainees are recognised		
WT6.4	All students/trainees are allocated a named, appropriately qualified placement supervisor for the duration of that placement		
WT6.5	All placement educators are aware of the student's/trainee's placement learning outcomes		
WT6.6	All placement educators are aware of student/trainee assessment requirements		
WT6.7	Time is allocated to provide students/trainees with feedback at the end of each clinical session		
WT6.8	Action plans are developed in response to periodic evaluation, monitoring and review processes		Level C
WT6.9	Placement numbers are strategically planned (and reviewed) to ensure sudden and significant reduction in capacity is avoided		
WT6.10	Placement supervisors agree an individual learning contract for the placement experience		
WT6.11	Appropriate and prompt action is taken to manage poorly performing students/trainees		
WT6.12	Opportunities for inter-professional working are provided for students/trainees		
WT6.13	A range of learning opportunities appropriate to the level and need of the student/trainee are supported by a network of local departments		Level B
WT6.14	All placement educators regularly contribute to the development of the practice component of the curriculum		
WT6.15	Action is taken on evaluation/feedback information from students to improve practice & learning		
WT6.16	All placement educators have recognised teaching and assessment qualifications		Level A
WT6.17	Patient feedback is used in student/trainee training to develop awareness of the patient experience		
WT6.18	All placement educators regularly obtain feedback on their educational activities from students/trainees and peers		
WT6.19	The department has an identified person (who may or may not be the clinical supervisor) to manage all student education and training in clinical practice		
WT6.20	There is an agreed annual education and training plan, supported by management, that reflects student/trainee and service needs		

## Systems and Performance

### Waiting Times for Audiology Services

PM1.1	The department has a waiting list management system that records new and recall (planned/follow-up) patients.		Level D
PM1.2	There is a named person responsible for all waiting lists		
PM1.3	Over the last 3 months all waits are <4 weeks for urgent tests (e.g. pre-operative audiogram) / assessments and/or <13 weeks for routines.		
PM1.4	Over the last 3 months all waits for recall (follow-up) tests / assessments are <26 weeks beyond the planned date.		
PM1.5	No more than two separate waiting lists are maintained (e.g. one urgent and one routine list) – it is recognised that more separate queues increases the average wait for all patients		
PM1.6	Referral to Treatment (RTT) wait time are monitored regularly and reduced if above national targets		
PM1.7	Over the last 3 months all waits are <2 weeks for urgent tests (e.g. pre-operative audiogram) / assessments and <6 weeks for routines.		Level C
PM1.8	Over the last 3 months all waits for recall (follow-up) tests / assessments are <6 weeks beyond the planned date.		
PM1.9	Waiting list information is communicated to the staff in the department at least monthly		
PM1.10	Where waits are greater than 6 weeks there is pooling of audiology lists (if no patient waits longer than 6 weeks then answer “Yes” to this measure).		
PM1.11	90% of admitted and 95% of non-admitted Patients wait less than 18 weeks from referral through to 1st definitive treatment (RTT) within the audiology department.		
PM1.12	Over the last 3 months all waits are <1 weeks for urgent tests (e.g. pre-operative audiogram) / assessments and <4 weeks for routines.		Level B
PM1.13	Over the last 3 months all waits for recall (follow-up) tests / assessments are <4 weeks beyond the planned date.		
PM1.14	There is regular administrative validation of waiting lists (only for 4+ wk waits)		
PM1.15	Patients who need broadly similar services are grouped together via clear guidelines (segmentation)		
PM1.16	Capacity can be flexed according to demand to ensure waits are as low as possible		
PM1.17	There is no distinction between Urgent and Routine waits, with waits for all tests over the last 3 months of <2 weeks.		Level A
PM1.18	Over the last 3 months all waits for recall (follow-up) tests / assessments are <2 weeks beyond the planned date.		
PM1.19	Initiatives are sought to reduce RTT waiting times and where clinically appropriate no patient waits greater than 9 weeks from referral through to 1st definitive treatment (RTT) within the audiology department		

## Systems and Performance

### Collection of Quality Information to Manage and Improve Services

PM2.1	The department has an electronic system for storing patient records and data on service activity, which is used for every patient in the department		Level D
PM2.2	The service has a tested local disaster recovery plan in place, should the main IT system fail, to allow critical data to be retrieved where necessary		
PM2.3	There is a protocol, in which all staff are trained, for them to follow when all or part of the IT system fails		
PM2.4	Data sets are maintained that record the type of referral, referral source including speciality, referral date, appointment date, attendance record, waiting and/or clearance times		Level C
PM2.5	The Audiology Department has a service level agreement with an ultimately named person in IT to ensure that data sets and records can be kept appropriately		
PM2.6	Demand Data (Number of referrals) is collected for all stages of the pathway		
PM2.7	The IT systems contains key pieces of information about each patient		
PM2.8	The IT system records key aspects of service performance		
PM2.9	The department fully complies with DSCN 31/2007 making the direct access audiology data collection mandatory, and has a data completeness measure within required tolerances.		
PM2.10	Extracts from the IT systems regularly discussed at departmental planning meetings and plans altered accordingly		Level B
PM2.11	The downtime of the IT system is monitored and appropriate actions are taken where necessary		
PM2.12	The IT system (or analysis from the IT system) permits reports to be generated cross-tabulating any combination of data fields and generating statistics on service activity		
PM2.13	Analysis from the IT system is discussed regularly by senior departmental managers (at least monthly), and appropriate actions / changes made as a result of key messages from the data		
PM2.14	Data is used to inform service redesign and models of provision, with demonstrated improvements in access		Level A
PM2.15	Patient flow is balanced into and out of the service associated for example with variations in demand and capacity		
PM2.16	Quarterly batch sampling indicates that 100% of electronic records are accurate; password protected, backed up daily and kept secure / confidential		

## Systems and Performance

### Systems in place to understand and manage capacity

PM3.1	The department produces regular information about DNAs, cancellations and other unused slots		Level D
PM3.2	A maximum of two separate waiting lists for each treatment pathway are maintained (e.g. one urgent and one routine list)		
PM3.3	A RTT PTL (Patient Tracking List) tool is in operation to ensure that routine patients are booked in chronological order of their referral		Level C
PM3.4	Greater than 50% of new referrals are directly booked		
PM3.5	There is a departmental policy on DNAs, and data on DNAs is monitored		
PM3.6	There is a departmental policy on Patient Cancellations, and data on Patient Cancellations is monitored. This incorporates a definition of "reasonableness" (of appointment date offer)		
PM3.7	Cancellations are handled consistently and in line with the organisations access or waiting list policy e.g. by booking at short notice into cancelled slots can improve capacity by 5%		
PM3.8	Greater than 75% of new referrals are directly booked		Level B
PM3.9	The departmental policy on DNAs is rigorously enforced reducing the DNA rate to below 5% of all appointments. If the DNA rate climbs above this level, urgent action is taken		
PM3.10	The departmental policy in Cancellations is rigorously enforced and incorporates a definition of 'reasonableness'		
PM3.11	The department annually undertakes a capacity planning exercise, to elucidate what steps can be taken to increase departmental capacity		
PM3.12	There is a partial booking system in place for recall (surveillance) appointments		
PM3.13	Greater than 95% of new referrals are directly booked		Level A
PM3.14	Specific slots and/or sessions are offered for particular activities (e.g. repairs, telephone follow up) instead of offering drop in or ad hoc provision		
PM3.15	Reports on service performance measures and individual patient management can be generated on demand		
PM3.16	Extended hours of operation are offered to enable more patients to be scheduled using the same physical resources		
PM3.17	Evidence of regular capacity planning is available for consultant led ENT and audio-vestibular outpatient services. This includes consideration of evidence based models of service provision (directly booked vs. ad-hoc services)		

## Systems and Performance

### Pathway Management and Improvement

PM4.1	Department has documented pathways available for some clinical conditions treated and tests carried out in the department.		Level D
PM4.2	Information collated on critical incidents is acted upon promptly (within 1 month)		
PM4.3	Pathways should have clearly identified points where onward referral should be made		
PM4.4	There are written SOPs relating to patient pathways within the department		
PM4.5	Department has documented pathways available for all clinical conditions treated and tests carried out in the department.		Level C
PM4.6	Pathways are compared with good practice available in the public domain, and changes made if appropriate.		
PM4.7	Lessons learned from critical incidents are written up and used in departmental training to ensure that similar events do not reoccur		
PM4.8	Onward referrals from documented pathways are audited to ensure that referral is made at the correct point		
PM4.9	Pathways are audited quarterly to ensure the correct patients are on them		Level B
PM4.10	Pathways are audited quarterly to ensure that patients follow them in an appropriate timeframe		
PM4.11	Clearly documented points on the pathway are identified at which patients should receive information / self-management resources		
PM4.12	Action is taken where audits reveal that onward referrals are not made at the optimal point in the pathway		
PM4.13	Relevant pathways, protocols and tests / assessments are annually disseminated to key stakeholders (such as PCTs, Patients etc.)		Level A
PM4.14	Points of delivery for information / self management resources are audited quarterly		
PM4.15	Points of delivery of information / self management resources to the patient are reviewed annually		

## Systems and Performance

### Systems in place to attend to complex and/or urgent cases

Examples of complex cases are:

(1) A patient who is experiencing tinnitus and a loss of hearing. Who is unable to accept the limitations of their loss of hearing and does not want to use the hearing aid/s which has been issued to them. Is therefore unable to discriminate speech or perceive warning sounds. The result is their quality of life is seriously impaired. They often respond positively to further constructive intervention which should include counselling, and auditory training.

(2) A patient who undergoes a sudden profound loss of hearing. Who after medical intervention is still unable to perceive sound. The psycho/sociological effect is akin to bereavement. Early practical information counselling is essential for the patient and their significant others.

PM5.1	A dedicated communication channel is available for referring agencies to arrange an appointment as soon as possible		Level D
PM5.2	Waits are as short as possible for complex and/or urgent cases (ideally no longer than 2 weeks)		Level C
PM5.3	The department ensures that all professionals that come into contact with complex and/or urgent cases are aware of the potential urgent impact that they may have on a patient's quality of life		
PM5.4	Capacity can be flexed according to demand to ensure that significant time is available to offer prompt appointments to complex and/or urgent patients.		
PM5.5	The department has assisted with or provided a validated questionnaire which will help primary care and other practitioners to make a decision about the complications which may occur if the presenting problems are left unattended		Level B
PM5.6	Information is provided in different formats to inform the patient of strategies which may ameliorate their condition		
PM5.7	Emergency appointments are routinely included in the timetable of staff		
PM5.8	The additional needs of complex and/or urgent patients are assessed and referred to the appropriate agency within one working day		Level A
PM5.9	There is documented evidence that complex cases have completed their journey promptly and the outcome is recorded		

## Technology

### Evaluation of New Technologies drugs and investigative/treatment approaches

TG1.1	The department either evaluates new technologies, drugs and investigative/treatment approaches itself or demonstrates awareness of evaluation carried out by other services.		Level D
TG1.2	Innovative technologies, drugs and investigative/treatment approaches are considered for purchase at any time of the year.		
TG1.3	The department actively seeks out information about new technologies, drugs and investigative/treatment approaches.		Level C
TG1.4	A named individual within the department has access to journals/websites that allow the department to access information about the latest developments in technologies, drugs and investigative/treatment approaches.		
TG1.5	In general the department would like to explore using more innovative technologies, drugs and investigative/treatment approaches for both diagnosis and prescription.		
TG1.6	The department introduces available new technologies, drugs and investigative/treatment approaches to keep quality up and waiting times down.		Level B
TG1.7	Innovative technologies, drugs and investigative/treatment approaches are available to at least some patients who are seen in the department.		
TG1.8	The department evaluates new technologies, drugs and investigative/treatment approaches and makes its results available by publication in peer reviewed journals or presentation at conferences.		Level A
TG1.9	The department evaluates products and makes the outcomes available to the Centre for Evidence-based Purchasing for wider dissemination in the purchasing community		
TG1.10	Innovative technologies, drugs and investigative/treatment approaches are available to all patients, and are part of the mainstream service.		
TG1.11	The department regularly reviews new technology to assess, prescribe and modify patient services to encompass this technology.		

## Technology

### Procurement of New Technologies drugs and investigative/treatment approaches

TG2.1	Procurement processes within the organisation are well understood by senior staff in the department		Level D
TG2.2	The department has direct contact with the finance department within the organisation		
TG2.3	The Department has developed a Business case template to expedite submission of cases for procurement of new technology into the organisational procurement structure		Level C
TG2.4	A manager within the department is in regular discussion with organisational budget holders about procurement of equipment		
TG2.5	The department holds its own budget for the purchase of new equipment		
TG2.6	The department has a policy of regular review of the patient care pathway in order to identify potential improvements that could be brought via the use of new technologies, drugs and investigative/treatment approaches.		Level B
TG2.7	The department has a protocol for adopting NICE guidelines within the 3 month time scale		
TG2.8	Department clinicians and managers are aware of how the tariff for the Departments services is constructed		
TG2.9	New technologies, drugs and investigative treatment approaches are regularly reviewed as to their impact on the tariff and patient care pathway		Level A
TG2.10	The Department has a key contact within the PCT with whom to discuss new technologies that could impact on the service		
TG2.11	The department has a structure in place to evaluate the impact of new technologies, drugs and investigative/treatment approaches. implemented in the Trust		

## Technology

### The Department Technology Lead

TG3.1	A technology lead has been identified within the audiology department		Level D
TG3.2	The technology lead can identify key information sources for new technologies, drugs and investigative/treatment approaches.		Level C
TG3.3	There is an established mechanism in Department to provide regular opportunities for input from other members of Department		Level B
TG3.4	The technology lead disseminates information to Department for comment and evaluation		
TG3.5	The technology lead communicates opportunities that have been evaluated at Department level to organisational lead on new technology or to appropriate board level committees		Level A

## Technology

### Use of assistive listening devices

TG4.1	Written information sheets are available for patients to know about equipment and systems to assist with problems not solved by hearing aid amplification		Level D
TG4.2	Written information sheets are available advising patients where to obtain supplementary equipment from statutory bodies e.g. Social Services		
TG4.3	Accessible posters and written information are available advising patients about captions, subtitles and texting		
TG4.4	Each patient is informed in a written format about electronic devices which may assist with their hearing loss		Level C
TG4.5	An Inductive loop system is on hand to demonstrate the loop option /programme on a hearing aid		
TG4.6	Staff are provided with regular updates about advancements in electronic communication devices		
TG4.7	A designated budget is available to purchase assistive listening devices for patients to try		Level B
TG4.8	All staff are able to demonstrate assistive listening devices		
TG4.9	Supplementary electronic devices such as radio aids are available on loan if required		
TG4.10	Social services are regularly invited to explain about up dates in provision		Level A
TG4.11	A designated person is available to demonstrate equipment by appointment		
TG4.12	There is a display of assistive devices for patients to try		