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## CLINICAL GUIDELINE FOR HABILITATION OF CHILDREN WITH PERMANENT AND TEMPORARY CHILDHOOD DEAFNESS

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

### 1. Introduction

The organisation for which these guidelines are applicable to Children’s Hearing Services provided by Worcestershire Acute Hospitals NHS Trust in a range of settings. Particularly all paediatric patients who require rehabilitation/habilitation due to hearing loss. To include patients from 0 -18 years of age with diagnosed hearing loss. Overall responsibility for the pathway is with the Countywide Audiology Services Manager.

This guideline is for use by the following staff groups:

- Paediatric Audiologists at WAHT
- Admin and Clerical Teams

Lead Clinician(s)  
Jessica Scully

Paediatric Audiology Manager

Approved by [Audiology Governance Team] on:

28<sup>th</sup> April 2026

Approved by Medicines Safety Committee on:  
*Where medicines are included in document.*

N/A

Review Date:

28<sup>th</sup> April 2029

This is the most current document and should be used until a revised version is in place

### Key amendments to this guideline

Date	Amendment	Approved by:

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## 2. Scope of Document

- This document provides recommendations for paediatric habilitation for permanent childhood hearing impairment and temporary conductive hearing loss. The guidelines reflect the management model of diagnostic assessment, hearing aid verification and evaluation ((UWO PedAMP 2011). This document should be used in conjunction with other departmental and trust policies and procedures where indicated. It is designed to support Audiology professionals in their work and should be used in together with clinical judgment and shared decision making with the family involved to obtain optimal outcomes for the children under the care of Worcestershire Acute Hospitals NHS Trust. Early identification and timely intervention should align with recognised best practice principles for early hearing detection and intervention, including those outlined by the Joint Committee on Infant Hearing (JCIH, 2019), emphasising family-centred care and prompt access to support services.

This document includes:

- The management guidance for children who require audiological habilitation/ rehabilitation pathway (patients who have hearing devices), referred from the Newborn Hearing Screening Programme (NHSP) and should align with standards set by the NHS Newborn Hearing Screening Programme for early identification and management of hearing loss due to presence of Sensorineural hearing loss (SNHL) and those with a permanent Conductive hearing loss (CHL)
- Management of children with PCHI who have acquired a hearing loss in childhood or those with a mild hearing loss
- Management guidance for children with transient conductive hearing loss
- Emerging evidence highlights the need for improved support for families of children with mild or unilateral hearing loss, who frequently report uncertainty regarding diagnosis and management. This guideline incorporates signposting to relevant resources to support shared decision-making and family understanding (NDCS, 2025).

It is the expectation of this document that clinicians will continue to use clinical judgement, knowledge in applying the general principles and recommendations contained in this document. Recommendations may not be appropriate in all circumstances and the decision to adopt specific recommendations should be made by the practitioner considering the individual circumstances presented by each patient and available resources.

## 3. Aims and Objectives

- To improve health outcomes for children with hearing issues
- To ensure care is aligned with national and international best practice guidance for paediatric audiology and early intervention
- To ensure standardised care across all sites for children with a PCHI or temporary conductive loss is in line with current standards and research
- To ensure that children are managed appropriately based on their diagnosis and to inform staff on how to action this
- To ensure timely intervention
- To assure high quality of care across the audiology service.
- To contribute to the audit process

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#### 4. Definitions

Term	Definition
AB	Auditbase
ALEX	The Alexandra Hospital
APD	Auditory Processing Disorder
BAHA	Bone Anchored Hearing Aid
BCHD	Bone Conduction Hearing Device
Bilateral	Both ear
Binaural assessment	Stimuli presented to both ears simultaneously, without ability to discern which ear responds
BTE	Behind the ear (hearing aid)
Caregiver	An adult who has legal rights and responsibility of taking care of the child
CHL	Conductive Hearing Loss
CP-IS	Child Protection – Information Sharing
CYP	Children and Young People
DSL	Desired Sensation Level
Ear-specific assessment	Stimuli presented to each ear separately
ENT	Ear, Nose and Throat clinic
HA	Hearing Aid
Headphone	Ear-specific audiological assessment using headphones
Insert	Ear-specific audiological assessment using insert earphone transducers
ISTS	International Speech Test Signal
KTC	Kidderminster Treatment Centre
NDCS	National Deaf Children's Society
NHSP	Newborn Hearing Screening Programme
OME	Otitis Media with Effusion (Glue Ear)
PCHI	Permanent Childhood Hearing Impairment
PIFU	Parent/Patient Initiated Follow Up
PTA	Pure Tone Audiometry
RECD	Real Ear to Coupler Difference Measure
REM	Real Ear Measurements
Recurrent AOM	Recurrent Acute Otitis Media
S4H	Smart for Hearing: A national Database of Newborn Hearing Screen records
SF	Soundfield - Test stimulus played through loudspeaker into freefield (binaural assessment – not ear-specific)
SNHL	Sensorineural Hearing Loss
TOD	Teacher of the Deaf - Deaf Support Service
Tymps	Tympanometry – assessment of middle ear function
Unilateral	One ear
VRA	Visual Reinforcement Audiometry
WDCS	Worcester Deaf Children's Society
WNB	Was Not Bought
WNL	Within Normal Limits
WRH	Worcester Royal Hospital

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## 5. Roles and Responsibilities

### 5.1 Audiology Management Group

The Audiology Governance team are responsible for approving this document and ensuring that it is reviewed in line with Trust Policy.

### 5.2 Audiology Staff

Audiology staff are responsible for accessing, reading, understanding and following this document where it applies to their job role.

### 5.3 Detailed Administrative Guidance

- Administrative Accountability – Administration Team Leader for Audiology & ENT
- Clinical Accountability – Leading Audiologist for Clinic
- Other people involved – Administrative staff, other clinicians

Referral for hearing aid assessment will be accepted from ENT Consultants, Paediatric Audiologists, Teachers of the Deaf or GP's when a child who has a hearing aid device has recently moved into the area. All referrals will be received via the generic Audiology email account and triaged in line with Clinical Guideline WAHT-AUD-014.

- The Administrative Team will then cross-check details received with the Trust's patient management systems (PAS/Spine). Patient demographics are checked against any existing data and stored on Auditbase. The decision to proceed to fitting of hearing aid will be made by a Band 6 Paediatric Audiologist or above at the Assessment Appointment. Hearing aid fitting may be deferred while further information from the previous audiology department or information from the Teachers of the Deaf is sought, or where assessment shows limited benefit of the intervention.
- Referrals from out of area (GP not registered with Worcestershire) will be rejected back to the referrer for onward referral to local services
- If the decision is to fit hearing aids the initial fitting appointment offered must be within 4 weeks of the decision. Unless given by hand in clinic the administrative team will post or email an appointment letter. Please seek advice from the Paediatric Audiology Manager if a suitable appointment cannot be found
- If the appointment is declined another must be offered as soon as possible however this may fall outside of the 4-week time limit
- The Administration team will monitor the PAED >4 HEARING AID CLINIC and PAEDPD2 <4 HEARING AID CLINIC waiting list entries and book paediatric reassessment appointments as appropriate

#### **Appointment Staffing:**

All assessments will be undertaken by appropriately trained and competent audiology staff in line with BSA recommended procedures. Minimum of band 6 Paediatric Audiologist with extensive experience in Paediatric Habilitation to confirm hearing loss and first fitting of children below 5 years of age. The second Audiologist assisting must be competent in children's assessment, be conversant in the protocol for children's hearing aid clinics and must be participating regularly in paediatric assessments. Minimum band 5 audiologist with experience in Paediatric Audiology can carry out hearing aid reviews and first fitting appointments on children above 5 years of age should they be deemed competent by band 6 staff or above and be regularly peer reviewed. The lead Audiologist will decide on a case-

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## **For All Appointments**

All Audiologists will be responsible for Stage A pre-test check of audiometers, Tympanometer and other equipment in line with departmental procedures.

- Patient is booked in by the reception staff and the appointment status 'A' is placed by their name on Auditbase to indicate arrival. Demographic details are checked at this point by reception
- Audiologist to check CP-IS to see if the child has a safeguarding alert on their records (Please see SOP **WAHT-TP-037**)
- 'B' to be placed before the name of any patient before being called into the room
- Demographic details are rechecked by the Audiologist before proceeding with the appointment
- Audiologists will introduce themselves to the child and accompanying adults and outline what will happen during the appointment.
- All patients must be asked if they have a PVP shunt and this will be documented in the Hotkey Journal Entry. Standard precautions for testing these patients must be used as there is a risk that the use of headphones/BC and hearing aids may affect the output of the shunt. If the answer is yes, the audiologist must clarify which side the PVP shunt is fitted use inserts with the transducer as far away as possible from the mastoid that has the shunt. Place the BC on the contralateral side of the PVP shunt. Do not use headphones
- All patients must be asked if they have a pacemaker, implantable cardioverter defibrillator or other active implantable device and this will be documented in the Hotkey Journal Entry. With regards to Pacemakers do not connect to aids using the neck loop FittingLink, if connecting to older aids that are not compatible with the NoahLink Wireless or FittingLink without the neck loop then you must connect using wires. It is worth also making the patient aware not to put their hearing aids or Connect clip in their breast pocket although it is generally accepted that hearing aids at ear level are unlikely to interfere with a pacemaker

## **6.Clinical Guidance**

### **6.1 New Diagnosis**

Management and counselling at the point of diagnosis should reflect family-centred care principles and early intervention standards as outlined by JCIH (2019), ensuring that families are supported to make informed decisions.

Please see clinical guidelines WHAT-AUD-011 for full details on paediatric diagnostic assessment. Audiological assessment and diagnostic procedures should be carried out

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in accordance with current British Society of Audiology recommended procedures, including guidance on otoacoustic emissions and behavioural assessment. At time of diagnosis, audiologists will explain the following information to the family and child where applicable -

- Clear explanation of hearing impairment
- Functional effects of hearing impairment
- Clear explanation of the development of hearing pathways and the effects of hearing impairment
- A clear discussion regarding the options and any potential consequences of delaying/ not managing the hearing loss - children with all types of hearing impairment should be considered for aiding as appropriate
- Signpost to the National Deaf Children’s Society (NDCS) for further advice, family support resources and information on childhood hearing loss
- Signpost families, particularly those of children with mild or unilateral hearing loss, to evidence-based support resources (e.g. National Deaf Children’s Society “Little Ears, Big Challenges” podcast and associated materials) to support understanding of diagnosis, management options and lived experiences
- Signpost to WDCS for further advice and support
- Identify child and caregiver(s) goals e.g. oral/sign language
- Consider if the child meets cochlear implant referral criteria. If they do, audiologists will discuss the referral with the family and action accordingly
- For temporary conductive loss, provide family with the Glue Ear Decision Making guide to help identify the best management plan for the child (see appendix)
- Where treatment plan involves BTE’s, discuss the colour of the aid and ear mould and put an order on the countrywide hearing aid spreadsheet. Take impressions and arrange a new patient fitting. If contact mini is required, measure the head and email a member of the Procurement team with the details so a P.O order number can be raised
- For permanent PCHI’s, complete the paediatric tab on the client information page in Auditbase to include confirmation of PCHI date

Recent research has identified that families of children aged 0–4 years with mild or unilateral hearing loss often experience uncertainty regarding the diagnosis, implications and management options, highlighting the importance of clear information and access to appropriate support resources (NDCS, 2025).

Family experience and understanding will be evaluated through parent-reported outcome measures where appropriate, to support shared decision-making and monitor the effectiveness of intervention.

## 6.2 Hearing Loss Criteria for fitting

The decision to fit hearing aids rests solely with the lead paediatric Audiologist using clinical discretion, however it is expected that certain minimum criteria should be met for the choice of hearing aids.

### Bilateral Conductive Hearing Loss

All prospective fittings must have had 2 hearing tests at least 3 months apart, to confirm persistency of loss. Where families have opted for grommet insertion as the primary management plan, patients over 3 years old should be offered a bone conduction headset with microphone whilst the wait for surgery. Children under the age of 3 can be offered a

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BTE or bone conduction hearing aid where there is significant concern. For children who have opted for hearing aid management rather than grommets, a shared decision should take place between the family and the audiologists as to whether BTE's or BCHD is most suitable. NICE guidelines recommend BTE's for stable conductive hearing loss and BCHD's for those children where the hearing has been proven to fluctuate (NICE,2023).

The only exception is in cases of bilateral/unilateral microtia/atresia where soft-band BCHD should be considered immediately and or referral to Birmingham Children's for BAHA assessment.

### **Sensorineural Hearing Loss**

All prospective fittings must have had 2 diagnostic hearing tests or ABR, 2 weeks apart from the initial test, showing a consistent hearing loss.

### **Unilateral Sensorineural Hearing Loss**

All prospective fittings must have had 2 diagnostic hearing tests or ABR, generally 2 weeks apart, showing a consistent hearing loss. BTE (in cases of mild unilateral loss), CROS Aids and Bone Conduction hearing devices may be considered for older children with Unilateral SN loss.

### **Specialist Aid Choice**

**Bone Conduction Hearing Devices** – Persistent Conductive hearing loss (not for temporary CHL whilst waiting for grommets, due to cost). However due to long waiting lists for grommets; depending on severity and long-term impact of hearing loss (may be determined by functional listening scores) this may be considered on an individual case basis at the discretion of clinician.

**BAHA Implant** – Refer to BCH for assessment.

### **6.3 Decision not to aid**

In collaboration with parents a decision may be made not to fit hearing aids, where hearing has returned to within normal limits or hearing loss is very mild and there are no parental/professional concerns. Advice should be given on hearing tactics and assistive devices. Provide appropriate signposting to external services where required. If hearing loss is confirmed but treatment is declined through shared decision making, offer continued monitoring, annual review for SNHL and 3-6 months review or PIFU for temporary loss caused by OME. Families should be offered additional information and support resources, particularly where hearing loss is mild or unilateral, to support informed decision-making and reduce uncertainty regarding management choices.

### **6.4 Onward referrals**

Care will be delivered in collaboration with the multidisciplinary team, including Teachers of the Deaf, ENT services and community paediatrics.

- All children who are going to receive a hearing aid device (the bone conduction headset and microphone is classed as an assistive device so does not apply here) should be offered a referral to the Deaf Support Team. See standard referral letter on Auditbase for TOD Referral Form (Teacher of the Deaf)
- For referrals to ENT, please see section 5.6 of WHAT-AUD-011. See Paed-ENT referral letter on Auditbase. Email to [wah-tr.audio2ent@nhs.net](mailto:wah-tr.audio2ent@nhs.net)
- All children identified as having speech and language delay, or where there are concerns about speech development, should be referred to the speech and language

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- For sensory neural hearing loss, please offer a referral to Community Paediatrics for aetiological testing. When a moderate or worse, bilateral or unilateral sensorineural hearing loss is diagnosed in a child of any age, a referral is to be made to the community paediatricians. A mild loss can be referred only if it is accompanied by other risk factors – syndromic features, family history of progressive loss, pattern of progressive loss or a positive cCMV result. The referral form is found in Letters on Auditbase, headed Community Paediatric Referral Form. Complete the form, highlighting if a baby/child has been referred for cCMV testing. If the baby/child has a mild sensorineural hearing loss, please add in detail why you are referring them and what other risk factors are present. Save the completed form to Documents on Auditbase. Email the form to the generic community paediatrics email address: [WHCNHS.CommPaeds@nhs.net](mailto:WHCNHS.CommPaeds@nhs.net)

### **6.5 Hearing Aid Fitting Appointment 90mins**

- Otoscopic examination – if this reveals minor wax it may be removed by an Audiologist qualified to do so; if substantial wax or other otological concerns are present the patient must be referred to ENT. If significant wax, hearing aids may still be verified using predicted RECDs via test box instead. If ears are discharging the Audiologist will use clinical judgement and may decide not to fit hearing aids or may give advice against using them if already fitted

Compliance with verification procedures (REM/RECD) will be included within audit measures.

#### **BTE hearing aids**

- Check fit of the new moulds and trim tubing to correct length. Ensure hearing aids are marked left and right and locking battery drawers are fitted for all children under 5 years or with complex needs (or if child has a sibling under 5yrs of age or with complex needs).
- Perform insert ear testing if required. If the child is likely to have RECD performed, inserts plus mould must be used. If the child is old enough for REAR, headphones are acceptable. Audiologist should ensure that masked and unmasked BC thresholds are plotted for both ears where possible and appropriate to ensure that the hearing aid prescription considers any conductive overlay. To avoid discrepancies in prescriptions calculated by the hearing aid software and the real ear measurement software, please ensure a four point audiogram is inputted for both AC and BC thresholds wherever possible
- If it has not been possible to obtain individual ear assessment, then hearing aids should be issued with caution, assuming that both ears are the same and equal to best previous sound-field thresholds
- Real Ear Measurements (REM) should be performed to most recent BSA guidelines (BSA, 2018). The choice of whether to perform REAR or RECD will depend on the child. Younger children and those with complex needs are less likely to sit still for

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REAR. If it is not possible to complete RECD or REAR, the hearing aids may be set up using the predicted coupler test age related averaged RECDs, but this should be the last option (assuming there are no contraindications). If one ear has otitis media with effusion (OME), it is advised that a predicted measurement should be performed for both ears. REAR or RECD measurement is gold standard. The reasons for not completing RECD or REAR **must** be documented in the journal

- It is recommended that RECD measurements should be taken and saved prior to opening the hearing aid software and connecting the hearing aids so that the RECD measurement can be brought into the software and allow it to adjust the programming. *See section on RECD for performing Gold Standard hearing aid fitting.*
- Software automatically generates initial hearing aid response using DSLv5. If alternative to DSL v5 is required, this must be manually changed in the software
- Once REM measurements are completed, record the SII value and save the programming to the hearing aids
- Complete HIT test (Full on gain at 65dB) on hearing aids once any changes have been saved. Do not use factory reset but record the performance of the hearing aid as it is set up for that child
- A paediatric care kit should be provided for each child with a permanent hearing loss, and each aspect should be shown and explained. This should include bag, drying tub, drying capsules, stetoclip, puffer, hearing aid box/es, and puffer
- Provide Oticon's Fitting your Child's Hearing Aids AUD-OTI-07
- Provide Data Logging Privacy Information Sheet-For Paediatrics AUD-PAED-40

#### Bone conduction hearing aids

- Discuss options with family, to include choices of soft or hard headband
- Child's safety is paramount, therefore where locking battery compartments are not available on a type of aid then this aid should not be considered. Locking Battery drawers must be fitted to children under 5 or where the child has siblings under 5.
- The bone conduction hearing aid must be fitted to manufacturers guidelines where available
- Check the position of the aid for physical comfort
- Check for loudness discomfort using sound-field warble-tones
- Check for feedback
- Resolve any problems arising from the above
- Give information about purchasing spare headbands and advise that the headband provided can be removed and washed
- Inform the care giver that the device is on loan and must be returned to the department when it is no longer needed.

#### For New Patient Fitting BTE & BCHD

- Audiologist must guide parents in the use of hearing aids to include controls, battery changing and safety, care of the hearing aid and ear mould and fitting of the aid. Include the child as much as is developmentally appropriate. Issue batteries, written information, box for hearing aid and any other accessories
- Perform Aided levels if time allows
- Agree management plan with family. Arrange follow up review appointment or add to waiting list >4PDS Hearing Aid Clinic or <4PD2 Hearing aid Clinic

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- If not already done offer referral to the TOD service. If consent is given, complete the referral form available on Auditbase "TOD referral form". If the referral has already been made, complete Individual Management Plan and sent to parents/guardians and TOD
- Book a paediatric review appointment to perform evaluation
- Complete outcome status by selecting "14,15 or 16" as appropriate and '£' for the appointment status
- Complete journal using Hotkey 09
- Update S4H as appropriate. See Clinical guidance for S4H

### **6.6 Paediatric Reassessment appointment (minimum of 1 hour 15 mins)**

- Audiologists to review functional listening data from TOD service and use this to inform management decisions
- Discuss with the parents/child how they have been managing with the aids to include how often is the aid worn, have they noticed and change in behaviour or speech, have they had any problems. Include the use of LittleEARS or Peach which may have been sent out to parents prior to appointment or can be given at appointment.
- Otoscopy
- Perform age-appropriate hearing assessment including BC. If unable to complete BC consider importing from a previous session- this must be noted on the session comments and in the journal. This is especially important for conductive hearing losses as DSL will change target by up to 9dB. Ensure BC is on both sides and consider removing 4k Hz if loss is Sensorineural and there is a large AC-BC gap at 4kHz. Insert plus mould must be used if RECD is anticipated. Ensure BC measurements are included in readiness of programming
- Save the audiogram
- Perform Tympanometry
- Perform REM/RECD. This is particularly useful when new ear moulds are fitted or when the hearing levels have changed. RECD should be repeated on children every 3 months for children of 3 years and under, every 6 months for children 3-5 years and every 12 months for children over 5 years. If hearing has significantly altered the hearing aids will require immediate adjustment with REM/RECD or using test box verification (as a last option) Aided thresholds, Phoneme Perception Test, or other assessment methods including but not limited to Ling Sounds, McCormick Toy Test, Manchester Word Lists etc or a combination of these should be used to assess effectiveness of amplification
- Complete HIT test on hearing aids once any changes have been saved. Do not use factory reset but record the performance of the hearing aid as it is set up for that child
- Complete LittleEars/Peach questionnaire if age appropriate or rebook for review for further evaluation if required
- Update Individual Management Plan. Email a copy to the TOD service and post a copy to parents
- Complete journal using appropriate Hot key 10
- Add outcome status "63" and select 'W' on Auditbase.
- Arrange follow up appointment or add to waiting list >4PDS Hearing Aid Clinic or <4PD2 Hearing aid Clinic. For children under the age of 5 they must be seen a minimum of every six months, over 5 at least annually. Temporary conductive loss with BTE's, every 12 weeks unless hearing appears to be stable then follow up test can be 6 months. Children with BCHD can be every 6 months
- Update S4H as appropriate. See Clinical guidance for S4H

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### **RECD Gold Standard (BSA,2018)**

- Complete age-appropriate hearing assessment including BC. If unable to complete BC consider importing from a previous session- this must be noted on the session comments and in the journal. This is especially important for conductive hearing losses as DSL will change target by up to 9dB. Ensure BC is on both sides and consider removing the 4k if loss is Sensorineural and there is a large AC-BC gap at 4kHz
- Save the audiogram
- Complete otoscopy and tympanometry. Record findings and note if there is a difference between the ears due to unilateral MEE or perforations
- Open the REM module and complete RECD according to instructions. If there is a difference between the ears with tympanometry, record RECD in both ears
- If the ears are the same, you can transfer the measurement to both sides. In the right-hand box entitled fitting prescription- right click on RECD and select use for both ears
- Save the RECD. You can then reopen it by selecting the previous session in the date line and right clicking the RECD measurement in the right hand of the screen. Select transfer to current session
- In the REM software select the RECD measurement coupler. Gold standard is HA1 using the earmold and acoustic putty although HA2 can be used if needed due to problems with sealing the putty and infection control concerns. Clinicians are free to use their own professional judgement on the use of HA1 coupler. However, HA1 seems to provide better fit to target (BSA,2018)
- Open hearing aid software and connect the aids. Import the RECD measurement and make sure the measurement set up is correct. Ensure you select the same method as you will be using and have selected in the REM software
- Ask the software to recalculate the gain of the aids
- TURN OFF FREQUENCY LOWERING and remove any feedback measures currently set
- Attach the aid to HA1/HA2 coupler using the aid and mould as used by the child
- Run 65dB curve using ISTS speech modulate input and match as close as possible to target. (within 5dB at all frequencies is gold standard). Check the Delta values.
- Check SII and use normative values to record this. If SII is outside normal values for child's PTA consider changing aids
- Run curves for 50dB and 80dB using ISTS speech modulated input. Run a 90dB sweep to check compression and loudness discomfort
- On 65dB curve work out the MAOF (maximum audible output frequency). The point where the output curve drops below the SPL audiogram. If using Affinities, you will need to set the REM settings to "IEC 60118-15". This can be done in temporary set up in the REM software
- If frequency lowering is required, change stimulus to /ss/. Does the peak of the /ss/ fall beyond the MAOF. If it does, consider the use of frequency lowering technology.
- Begin with the lowest level of frequency lowering and re-run SS sounds. Continue in small steps until the peak of /ss/ is just within the audible range

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- Run a /sh/ and check there is a separation between the peaks of the /sh/ and /ss/
- Complete Ling sounds to check for audibility and discrimination of the two sounds using age-appropriate techniques
- If time allows, evaluate the hearing aid performance using age-appropriate speech testing.

### **6.7 Paediatric Review appointment (minimum of 45 mins)**

Review appointments are booked following a reassessment appointment and are required if REM or evaluation was not completed.

- Audiologists to review functional listening data from the Teacher of the Deaf/Deaf Support Service and use this to inform management decisions
- Discuss with the parents/child how they have been managing with the aids to include how often is the aid worn, have they noticed any change in behaviour or speech, have they had any problems. Complete LittleEARS, Peach or LSQ. Discuss report from TOD service if available
- Otoscopy
- If required perform PTA or insert VRA.
- Tympanometry if indicated particularly if RECD is being completed.
- Perform REM/RECD if required. This is particularly useful when new ear moulds are fitted or when the hearing levels have changed. We would repeat RECD every 3 months for children of 3 years and under, every 6 months for children 3-5 years and every 12 months for children over 5 years. If hearing has significantly altered the hearing aids will require immediate adjustment with REM/RECD or using test box verification (as a last option) Aided thresholds and assessment methods including but not limited to Ling Sounds, McCormick Toy Test, Manchester Word Lists etc or a combination of these should be used to evaluate the effectiveness of amplification.
- Complete HIT test on hearing aids once any changes have been saved. Do not use factory reset but record the performance of the hearing aid as it is set up for that child.
- Mark 'W' on Auditbase and add outcome code and add to the appropriate waiting list i.e >4 PDS Hearing Aid or <4 PD2 Hearing Aid
- Complete journal using appropriate Hot key 11
- Complete Individual Management Plan and send to parents/TOD

### **6.8 Ongoing Hearing Aid Management Plan**

Frequency of review appointments may change due to individual circumstances. Please see appendix 3 for full details.

Guideline:

- Babies less than 12 months - At least every 2 weeks for impressions and mould issue plus full review every 3 months
- Children under 2 years- every 3 months / event driven
- Children two years to five years -every 6 months / event driven
- Children over five years of age – annual review /event driven
- Children aged 18 should then be transitioned to Adult Services. See WAHT-AUD-015 for transitioning guidelines

Annual review is appropriate only if hearing is stable and hearing aid use established.

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### **Spare Hearing Aids/Assistive Devices**

It is only in exceptional cases that spare hearing aids may be given and only with direct approval of the Countywide Manager. Spare hearing aids will be considered in the following circumstances:

- For a visually impaired child
- Safeguarding concerns

For children with the bone conduction hearing aids and microphone, parents are directed to purchase a second device from [Hear Glue Ear Headset & Microphone Kit - The Pi Hut](#)

### **Withdrawal of Hearing Aids**

For children with temporary conductive hearing loss, it is likely that hearing aids will be withdrawn when hearing has returned to within normal limits. Hearing aids should be handed in and decontaminated in line with local procedures. Returned items should be managed via the stock module on Auditbase. Any items that are not within the warranty period should be disposed of in line with WEEE Regulations or donated to charitable concerns as appropriate. Aids that are within the warranty period should be decontaminated and returned to loan aid stock.

Some aids may be withdrawn and kept for a period of no longer than 6 months reserved for the patient they have been withdrawn from. The aids will be kept in the children allocated area on each site. The ATO's will monitor and remove from reserved allocation after period has elapsed.

### **Lost/Neglected and Repair of Hearing Aids**

Worcestershire Acute Hospitals will not charge if the child has lost or damaged the hearing aid/s. Hearing aids that are working well but have cosmetic damage may not be replaced. If a replacement mould is needed, the child should be offered an impression appt within 24-48 hours of contacting the department. If the mould has been scanned, please contact the ATO on site to order a remake. If the device is a BCHD, please log the repair on the spreadsheet found on the shared drive. M:\Acute\Audiology\General\REPAIRS (Countywide)Spread Sheet

## **7 Safeguarding Deaf and Hearing-Impaired Children**

Audiology and Sensory Inclusion Teams work closely together to enable parents, carers, and children to understand the importance of amplification and the consequences of failing to use it. Frequent loss or neglect of hearing aids may indicate a family's lack of understanding of the benefit they provide; Audiologists must make every effort to address this in clinic. Lack of motivation by a family toward correct use and maintenance of a child's hearing aids may be part of a wider pattern of neglect.

In order to ensure that child neglect or other safeguarding issues do not go unnoticed the Audiologist will:

- Inform the TOD on every occasion where hearing aids are lost or damaged (other than expected wear and tear)
- Inform the TOD, GP, Health Visitor or School Nurse, Social Worker if they have one and all other professionals known to be involved with the child on each occasion where the hearing aids are lost or damaged, where this is more than the baseline of twice per year

<b>Clinical Guideline for Paediatric Habilitation</b>		
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- Consider the child's overall wellbeing at every contact and discuss any concerns with the TODs
- Ensure that concerns, and all actions taken, are documented appropriately.
- Maintain mandatory Safeguarding training and work within the RWT's Safeguarding Policy
- Follow WNB policy

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### 8 Monitoring

Audit of this guideline will be undertaken in line with British Academy of Audiology paediatric audiology quality standards to ensure delivery of safe, effective and patient-centred care. This will include assessment of both process and outcome measures, such as timeliness of intervention, adherence to clinical protocols, hearing aid usage, and patient-reported outcome measures. Key performance indicators will include time from diagnosis to intervention in line with BAA paediatric standards.

Audit findings will be reviewed within the Audiology Governance Group. Audit findings will inform service development and quality improvement initiatives, with re-audit undertaken to monitor the effectiveness of implemented changes.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: (Responsible for also ensuring actions are developed to address any areas of non-compliance)	Frequency of reporting:
	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?
5.3	All children identified with PCHI through recognised audiological provision are offered an appointment for the fitting of amplification / their hearing aid(s) within four weeks of decision to aid.	Audit	Annually on a random 1 month sample of referrals	Paediatric Team	Audiology Governance Meeting	Annually
6.5 & 6.6	Compliance with verification procedures (REM/RECD)	Audit	Annually on a random 1 month sample of referrals	Paediatric Team	Audiology Governance Meeting	Annually
6.6	Completion of outcome measures such as PEACH/Littlears to capture family experience and	Audit	Annually on a random 1 month	Paediatric Team	Audiology Governance Meeting	Annually

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	perceived benefit of intervention.		sample of referrals			
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## 9 References

Bagatto, M.P., Moodie, S.T., Malandrino, A.C., Richert, F.M., Clench, D.A. and Scollie, S.D. (2011) *Trends in amplification*. *Trends in Amplification*, 15(1), pp. 57–76.  
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British Society of Audiology (BSA) (2018) *Guidance on the verification of hearing devices using probe microphone measurements*. Available at: <https://www.thebsa.org.uk/guidance-and-resources/current-guidance/> (Accessed:4 March 2026)

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British Society of Audiology (BSA) (2019) *Position statement and practice guidance: Audiological assessment and hearing aid provision for patients with a programmable ventriculoperitoneal (PVP) shunt*. Available at: <https://www.thebsa.org.uk/guidance-and-resources/current-guidance/> (Accessed:11 December 2025)

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NHS Newborn Hearing Screening Programme (NHSP) (2023) *Operational guidance and care pathways*. Available at: <https://www.gov.uk/topic/population-screening-programmes/newborn-hearing> (Accessed:19 March 2026)

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Worcestershire Acute Hospitals NHS Trust (WAHT) (Year) *Standard Operating Procedure for the use of Child Protection – Information Sharing (CP-IS) (WAHT-TP-037)*. Available internally via Trust Intranet

**10 Appendix**

1. Hearing Aid Review Timings- updated January 2023
2. [Making a decision about glue ear](#)
3. Review/RECD/Outcome Measures timings for Paeds Hearing Aid Clinics

1>

Age of Patient	Recommended verification Measurement	Minimum frequency of measurement	Completion of Outcome Measure
< 2 years old	RECD	3 months/ event driven	Littleears
>2 years/ <5years	RECD	Annual/ event driven	PEACH
>5 years	RECD/ REM	Annual/ event driven	LIFE if appropriate
7-12 years	RECD/ REM	Annual/ event driven	LIFE + HEAR-QL or SSQ (child version) if appropriate

PCHI		Temporary Conductive Hearing Loss		
Review	Timescale	Review		Timescale
1st Review following fitting	6 weeks	1st Review following fitting		6 weeks
Ongoing Review until 2 years old	3 months	Ongoing Review until 2 years old		3 months*
Ongoing Review until 5 years old	6 months	Ongoing Review until 5 years old		3 months*
Aged 5 years+	12 months	Aged 5 years+		3 months*
Aged 18 years	Transition to Adult Services	Aged 18 years		

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**Contribution List**

This key document has been circulated to the following individuals for consultation:

Designation
Edward Southan - Principal Audiologist/ Interim County Manager
Kim Doughty - Principal Audiologist
Abigail Clevely - Principal Audiologist
Claire Carwardine - Principal Audiologist
Edward Southan - Principal Audiologist/ Interim County Manager

This key document has been circulated to the chair(s) of the following committee's / groups for comments:

Committee
Audiology Governance

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## Supporting Document 1 - Equality Impact Assessment Tool

### Equality and Health Inequalities Impact Assessment (EHIA) Tool

#### Herefordshire & Worcestershire STP - Equality and Health Inequalities Impact Assessment (HEIA) Form

Please read HEIA guidelines when completing this form

#### Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP	<input checked="" type="checkbox"/>	Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	<input checked="" type="checkbox"/>	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	Edward Southan	
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Details of individuals completing this assessment	<table border="1"> <thead> <tr> <th>Name</th> <th>Job title</th> <th>e-mail contact</th> </tr> </thead> <tbody> <tr> <td>Jessica Scully</td> <td>Paediatric Manager</td> <td>jessicascully@nhs.net</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </tbody> </table>			Name	Job title	e-mail contact	Jessica Scully	Paediatric Manager	jessicascully@nhs.net			
	Name	Job title	e-mail contact									
	Jessica Scully	Paediatric Manager	jessicascully@nhs.net									
Date assessment completed	04.03.2026											

#### Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	Title: <b>CLINICAL GUIDELINE FOR HABILITATION OF CHILDREN WITH PERMANENT/TEMPORARY CHILDHOOD DEAFNESS</b>			
What is the aim, purpose and/or intended outcomes of this Activity?	<ul style="list-style-type: none"> <li>To improve health outcomes for children with hearing issues.</li> <li>To outline the management of those children who have a Permanent Childhood Hearing Impairment (PCHI) or temporary hearing loss and to provide the correct management plan to ensure a good outcome.</li> <li>To ensure that children are fitted within 4 weeks from decision to treatment.</li> <li>To provide a guideline to staff undertaking paediatric Habilitation to ensure consistency between clinicians and across sites.</li> </ul>			
Who will be affected by the development & implementation of this activity?	<input checked="" type="checkbox"/> Service User <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Carers <input type="checkbox"/> Visitors	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Staff Communities Other _____	
Is this:	<input checked="" type="checkbox"/> Review of an existing activity <input type="checkbox"/> New activity			

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	<input type="checkbox"/> Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Following a significant clinical incident within paediatric audiology, major service improvements are underway. Documentation including Guidance follows best practice from several sources – British Society of Audiology Recommended Procedures, British Academy of Audiology Paediatric Quality Audit Tool have been reviewed along with other service guidelines, notably Wolverhampton and Nottingham as exemplars of good practice in UKAS IQIPS accredited sites.
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Guidance follows best practice from several sources – British Society of Audiology Recommended Procedures, British Academy of Audiology Paediatric Quality Audit Tool.
Summary of relevant findings	Improvements to documentation of procedural guidelines in a structured format are necessary.

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale.** Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential <u>positive</u> impact	Potential <u>neutral</u> impact	Potential <u>negative</u> impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	✓			
Disability	✓			
Gender Reassignment		✓		
Marriage & Civil Partnerships		✓		
Pregnancy & Maternity		✓		
Race including Traveling Communities		✓		
Religion & Belief		✓		
Sex		✓		

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Equality Group	Potential <u>positive</u> impact	Potential <u>neutral</u> impact	Potential <u>negative</u> impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sexual Orientation		✓		
<b>Other Vulnerable and Disadvantaged Groups</b> (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓		
<b>Health Inequalities</b> (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		✓		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	No negative risks identified	.		
How will you monitor these actions?				

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<p><b>When will you review this EIA?</b> (e.g in a service redesign, this EIA should be revisited regularly throughout the design &amp; implementation)</p>	<p>In 3 years when document has major review.</p>
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**Section 5** - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Jessica Scully
Date signed	28.04.2026
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	



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**Supporting Document 2 – Financial Impact Assessment**

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.