

Screening Programmes

Newborn Hearing

Newborn Hearing Screening Programme (NHSP): Guidance for screening providers, commissioners and public health for changes in targeted follow up procedures

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Background

This evidence about targeted follow up and its associated recommendations is presented in the document “NHSP Targeted follow up consultation” available at <http://hearing.screening.nhs.uk>. The document was issued on 21/11/11 for consultation until 09/01/12, which included appropriate organisations including professional bodies, NHS organisations, DH and practising clinicians. This report summarises the recommendations for change following the consultation and careful consideration by the NHSP Programme Director

Recommendations for CHANGE to current practice

1. Incomplete screening (missed appointments, declines). Routine referral for targeted follow up to cease for this group. Screening teams should make vigorous efforts to maximise newborn screen coverage by 3 months of age (rather than relying on targeted follow up). Programmes should consider the following mechanisms to maximise coverage :-consideration of telephone/text /email reminders, outreach clinics, home visits, liaison with trust antenatal and newborn screening coordinators, midwifery and health visiting teams, contact with paediatric wards and intensive care units to identify readmitted unscreened babies. HVs and GPs must be informed of babies that have not completed screening. Screening teams will need to ensure that parents are provided with information about how to seek assessment in the event of future concern.
2. Cease routine referral for targeted follow up for babies that have a clear response on the screen with risk factors:
 - family history of hearing loss,
 - IPPV>5 days/ECMO,
 - neuro-degenerative or neuro-developmental disorder,
 - jaundice at or above exchange transfusion level.
 (Note that targeted follow up for babies whose only risk factor is a stay of >48 hrs in NICU has never been recommended).

Recommendations essentially representing NO CHANGE to current practice

1. Screen referrals. Audiology must make strenuous efforts to secure attendance of these babies at follow up including discussion with parents and liaison with the family health visitor and GP to facilitate attendance. Audiology and screening teams should liaise closely about these children to ensure that audiology staff are aware of the likelihood of PCHI in this group. In the event of inability to secure attendance the HV and GP should be notified and advised about how to make a referral should the family indicate a willingness to attend in future. Completion of follow up for

these children should be locally audited with responsibility for audit devolved to a named individual within screening or audiology.

2. NICU with NCR/NCR at OAE and CR/CR at AABR: this combination of screening results for babies tested under the NICU protocol to continue to be referred for targeted follow up at 8 months of age.
3. Clear response on the screen but with a syndrome associated with hearing loss (including Downs Syndrome), cranio facial abnormalities (including cleft palate) or confirmed congenital infection: These children to continue to be referred for targeted follow up.
4. Ototoxic drugs: Clear response on the screen but received ototoxic drugs. The responsibility for monitoring of children receiving ototoxic drugs and appropriate referral for audiological assessment in cases where the therapeutic range is exceeded lies with the medical team.¹
5. Meningitis: All survivors of strongly suspected or confirmed bacterial meningitis or septicaemia should be referred for a full audiological assessment on recovery from the acute episode. This is the responsibility of the medical team caring for the child. In the case of neonates, screening teams should treat these babies as screen referrals and continue to log them as such in eSP using the screening outcome of 'incomplete-screening contraindicated' and expedite and monitor their referral to audiology in conjunction with the medical team.
6. Parental concern: Any parental concern about hearing at any stage must be taken seriously and a referral made for audiological assessment, irrespective of screen outcome, by which ever professional is made aware of the concern.

Further actions

1. Recording risk factors: Screening programmes should continue recording of risk factors to facilitate ongoing assessment of the evidence. There should be local audit of the accuracy with which risk factor information is obtained and recorded.
2. Paediatric audiology and screening teams must work closely together to ensure that there is an active process for the audit of any later identified PCHI. The details of such cases must be entered into eSP and reported to the NHSP Programme centre as outlined in the relevant procedure. It is only by doing this that we can improve the screening protocol and identification of children who are missed and build the case for any further actions to improve late identification.
3. Screening teams will need to engage with child health professionals locally to ensure the rationale for these changes to practice is well understood.
4. The NHSP Programme Centre will ensure that training materials, documentation and care pathways are amended in line with these recommendations and that eSP business rules and logic are amended in line with these changes.
5. Outcomes for targeted follow up will be re-evaluated in 2015.

¹ See "Safer use of intravenous gentamicin for neonates" 9/02/10 DH Gateway reference 13534
<http://www.nrls.npsa.nhs.uk/alerts/?entryid45=66271>