NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Hearing loss in adults

NICE quality standard

Draft for consultation

February 2019

This quality standard covers assessing and managing hearing loss in adults (aged 18 and over). It includes people presenting with hearing loss for the first time in adulthood whether it started in adulthood or earlier. It describes high-quality care in priority areas for improvement.

It is for commissioners, service providers, health and social care practitioners, and the public.

This is the draft quality standard for consultation (from 12 February to 12 March 2019). The final quality standard is expected to publish in July 2019.

Quality statements

Statement 1 Adults with earwax contributing to hearing loss or other symptoms, or preventing ear examination, have earwax removal in primary care or community ear care services.

Statement 2 Adults with sudden onset or rapid worsening of hearing loss are referred for immediate or urgent specialist medical care.

Statement 3 Adults presenting with hearing difficulties not caused by impacted earwax or acute infection are referred for an audiological assessment.

Statement 4 Adults presenting with hearing loss affecting their ability to communicate and hear are offered hearing aids.

Statement 5 Adults with hearing aids have a face-to-face follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted.

NICE has developed guidance and a quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside these quality statements.

Other quality standards that should be considered when commissioning or providing hearing loss services for adults include:

- Mental wellbeing and independence for older people (2016) NICE quality standard 137
- Mental wellbeing of older people in care homes (2013) NICE quality standard 50
- Dementia (update) Publication expected June 2019
- Care and support of people growing older with learning disabilities Publication expected July 2019

A full list of NICE quality standards is available from the quality standards topic library.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?

Question 3 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Local practice case studies

Question 4 Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to NICE local practice case studies on the NICE website. Examples of using NICE quality standards can also be submitted.

Quality statement 1: Earwax removal

Quality statement

Adults with earwax contributing to hearing loss or other symptoms, or preventing ear examination, have earwax removal in primary care or community ear care services.

Rationale

Earwax build-up can cause hearing difficulties and discomfort, and can contribute to outer ear infections. It is important to remove earwax quickly because it can prevent ear examination, which will delay assessment and management of hearing loss and underlying pathology. Hearing loss caused by impacted earwax can be frustrating and stressful. If untreated, it can contribute to social isolation and depression. Providing earwax removal closer to home, in primary or community ear care services, will prevent inappropriate use of specialist services.

Quality measures

Structure

a) Evidence of local arrangements for healthcare professionals to have training to use earwax removal methods.

Data source: Local data collection, for example, training records.

b) Evidence of the availability of equipment to remove earwax in primary care or community ear care services.

Data source: Local data collection, for example, service specifications.

Process

a) Proportion of attendances where earwax is contributing to hearing loss or other symptoms, or preventing ear examination, in which earwax is removed in primary care or community ear care services.

Numerator – the number in the denominator for which earwax is removed in primary care or community ear care services.

Denominator – the number of attendances where earwax is contributing to hearing loss or other symptoms, or preventing ear examination.

Data source: Local data collection, for example, audit of electronic case records.

Outcome

Health-related quality of life for adults with earwax that has contributed to hearing loss or other symptoms, or prevented ear examination.

Data source: Local data collection, for example, a patient survey.

What the quality statement means for different audiences

Service providers (primary care and community ear care services) ensure that locally agreed referral pathways are in place for removing earwax for adults when it is contributing to hearing loss or other symptoms, or is preventing examination or effective management. Service providers also ensure that healthcare professionals are trained to use earwax removal methods, and that they have access to the correct equipment.

Healthcare professionals (such as audiologists, practice or community nurses and GPs) carry out earwax removal in adults when it is contributing to hearing loss or other symptoms, or is preventing examination or effective management. Methods that can be used include ear irrigation, microsuction or manual removal. Ear irrigation may be contraindicated for some patients.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission services with the appropriate equipment, capacity and expertise to carry out earwax removal for adults in primary or community care if their earwax is contributing to hearing loss or other symptoms, or is preventing examination or effective management.

Adults with earwax that is affecting hearing or causing other symptoms, or needs to be removed so that the ear can be examined, have the earwax removed in primary care or community ear care services.

Source guidance

Hearing loss in adults: assessment and management (2018) NICE guideline NG98, recommendation 1.2.1

Definition of terms used in this quality statement

Other symptoms

Although some people are asymptomatic, the most common symptom from impacted earwax is hearing loss. People may also complain of:

- blocked ears
- ear discomfort
- feeling of fullness in the ear
- earache
- tinnitus
- itchiness
- cough.

[NICE's Clinical Knowledge Summaries on earwax, 2016]

Equality and diversity considerations

Access to hearing care services for care home residents was highlighted by the committee as an equality and diversity consideration. It is important that staff are aware that people in care homes have the same right to access healthcare as people living independently in the community. This is stated in the NHS Constitution for England. Housebound people with hearing loss may also have limited access to hearing care services.

Healthcare professionals should adapt their communication style to the person's hearing needs. This will help to ensure that the adult has the opportunity to be involved in decisions about their earwax removal.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Quality statement 2: Immediate or urgent referral for specialist medical care

Quality statement

Adults with sudden onset or rapid worsening of hearing loss are referred for immediate or urgent specialist medical care.

Rationale

Sudden onset or rapid worsening of hearing loss that is not explained by external or middle ear causes can be an emergency. This means that referral for immediate or urgent specialist medical care in appropriate healthcare services is needed. Sudden hearing loss that developed within the past 30 days needs referral for immediate care as the person needs to be seen by a specialist within 24 hours. Sudden hearing loss that developed more than 30 days ago, or rapid worsening of hearing loss, needs referral for urgent care as the person needs to be seen by a specialist within 2 weeks. Delay in care increases morbidity and in some cases can lead to death. This is a risk, particularly for people with auto-immune disease, necrotising otitis externa, stroke or large intracranial tumours.

Quality measures

Structure

Evidence of referral pathways in place to ensure adults with sudden onset or rapid worsening of hearing loss not explained by external or middle ear causes are seen immediately or urgently by an ear, nose and throat (ENT) service, an audiovestibular medicine service or an emergency department for specialist medical care.

Data source: Local data collection, for example, clinical protocols and documented, locally agreed pathways.

Process

a) Proportion of adults with hearing loss in 1 or both ears that has developed over 3 days or less within the past 30 days, who are referred for immediate (seen within 24 hours) specialist medical care in an ENT service or an emergency department.

Numerator – the number in the denominator who are referred for immediate (seen within 24 hours) specialist medical care in an ENT service or an emergency department.

Denominator – the number of adults with hearing loss in 1 or both ears that has developed over 3 days or less within the past 30 days.

Data source: Local data collection, for example, audit of electronic case records.

b) Proportion of adults with hearing loss in 1 or both ears that developed over 3 days or less more than 30 days ago who are referred for urgent (seen within 2 weeks) specialist medical care in an ENT or audiovestibular medicine service.

Numerator – the number in the denominator who are referred for urgent (seen within 2 weeks) specialist medical care in an ENT or audiovestibular medicine service.

Denominator – the number of adults with hearing loss in 1 or both ears that developed over 3 days or less more than 30 days ago.

Data source: Local data collection, for example, audit of electronic case records.

c) Proportion of adults with hearing loss in 1 or both ears that has worsened over a period of 4 to 90 days who are referred for urgent (seen within 2 weeks) specialist medical care in an ENT or audiovestibular medicine service.

Numerator – the number in the denominator who are referred for urgent (seen within 2 weeks) specialist medical care in an ENT or audiovestibular medicine service.

Denominator – the number of adults with hearing loss in 1 or both ears that has worsened over a period of 4 to 90 days.

Data source: Local data collection, for example, audit of electronic case records.

Outcome

Morbidity rates for adults who have sudden onset or rapid worsening of hearing loss.

Data source: Local data collection, for example, audit of electronic case records.

What the quality statement means for different audiences

Service providers (such as primary, community and secondary care) ensure that locally agreed referral pathways are in place for adults with sudden onset or rapid worsening of hearing loss in 1 or both ears to be referred for immediate or urgent specialist medical care at an appropriate healthcare service such as ENT, emergency department or audiovestibular medicine services. Service providers also ensure that healthcare practitioners have training and expertise to recognise symptoms and signs of sudden onset or rapid worsening of hearing loss in adults.

Healthcare practitioners (such as GPs, audiologists and community care nurses) refer adults with sudden onset or rapid worsening of hearing loss in 1 or both ears for specialist medical care at an appropriate healthcare service such as ENT, emergency department or audiovestibular medicine services. Practitioners have a checklist or table of symptoms and signs with the recommended action, referral pathway and timeframe.

Commissioners (clinical commissioning groups and NHS England) ensure that services they commission have the expertise to refer adults with sudden onset or rapid worsening of hearing loss in 1 or both ears for specialist medical care.

Adults with hearing loss that starts suddenly or gets worse rapidly in 1 or both ears that cannot be explained by outer or middle ear causes are referred to be seen by a specialist within 24 hours or 2 weeks (depending on the likely cause of the hearing loss).

Source guidance

Hearing loss in adults: assessment and management (2018) NICE guideline NG98, recommendation 1.1.2

Definition of terms used in this quality statement

Sudden onset or rapid worsening of hearing loss

Sudden onset refers to hearing loss that has developed over 3 days or less. Rapid worsening of hearing loss refers to when the change occurs over 4 to 90 days.

[NICE's guideline on hearing loss, recommendation 1.1.2]

Referred for immediate or urgent specialist medical care

Adults with sudden onset or rapid worsening of hearing loss not explained by external or middle ear causes are referred as follows:

- If the hearing loss developed suddenly (over 3 days) within the past 30 days, refer immediately (to be seen within 24 hours) to an ENT service or an emergency department.
- If the hearing loss developed suddenly more than 30 days ago, refer urgently (to be seen within 2 weeks) to an ENT or audiovestibular medicine service.
- If the hearing loss worsened rapidly (over 4 to 90 days), refer urgently (to be seen within 2 weeks) to an ENT or audiovestibular medicine service.

[NICE's guideline on hearing loss, recommendation 1.1.2]

Equality and diversity considerations

Healthcare practitioners should adapt their communication style to the hearing needs of the adult with sudden onset or rapid worsening of hearing loss. This will help to ensure that the person understands the need for an urgent or immediate referral for specialist medical care and is able to make decisions about their own care.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Quality statement 3: Referral for audiological assessment

Quality statement

Adults presenting with hearing difficulties not caused by impacted earwax or acute infection are referred for an audiological assessment.

Rationale

When adults first present with hearing difficulties not caused by impacted earwax or acute infection, they need an audiological assessment. This assessment, which includes a full history and assessment of hearing and communication needs, will identify any hearing loss and associated difficulties. The audiologist can then advise on management options, which might include the use of hearing aids. Early identification of progressive hearing loss in adults is important because early management can minimise the effect of hearing loss on social interaction, work, family relationships and quality of life.

Quality measures

Structure

a) Evidence of referral pathways in place to ensure adults presenting with hearing difficulties have an audiological assessment.

Data source: Local data collection, for example, referral criteria and documented, locally agreed pathways.

b) Evidence that healthcare practitioners have training and access to information to enable them to recognise hearing and communication difficulties for which referral for an audiological assessment is needed.

Data source: Local data collection, for example, training records and clinical protocols.

Process

Proportion of adults presenting with hearing difficulties not caused by impacted earwax or acute infection that are referred for audiological assessment.

Numerator – the number in the denominator that are referred for an audiological assessment.

Denominator – the number of adults presenting with hearing difficulties not caused by impacted earwax or acute infection.

Data source: Local data collection, for example, audit of electronic case records.

Outcomes

Hearing-specific health-related quality of life for adults presenting with hearing difficulties not caused by impacted earwax or acute infection.

Data source: Local data collections, for example, a patient survey. NHS England's Adult Hearing Service Specifications (2016) includes outcome 2 on improvement in service-user-reported quality of life using validated self-reporting tools such as the Glasgow Hearing Aid Benefit Profile (GHABP) or the Client-Orientated Scale of Improvement (COSI).

What the quality statement means for different audiences

Service providers (such as primary care services) ensure that locally agreed referral pathways are in place for adults who present with hearing difficulties not caused by impacted earwax or acute infection to be referred for an audiological assessment. Service providers also ensure that healthcare practitioners have training and access to information to help them initially recognise hearing and communication difficulties for which referral for an audiological assessment is needed.

Healthcare practitioners (such as GPs and community care nurses) refer adults who present with hearing difficulties for an audiological assessment in an audiological service after excluding impacted earwax and acute infections, such as otitis externa, and the need for immediate or urgent care or direct referral to specialist secondary care services.

Commissioners (clinical commissioning groups and NHS England) ensure that the services they commission have the expertise to identify hearing and communication

difficulties and refer adults who present with hearing difficulties for an audiological assessment.

Adults who go to healthcare services with hearing difficulties are referred for a hearing assessment once earwax, ear infection and the need for immediate or urgent medical care are ruled out.

Source guidance

Hearing loss in adults: assessment and management (2018) NICE guideline NG98, recommendation 1.1.1

Equality and diversity considerations

Healthcare practitioners should be aware of the link between hearing loss and mild cognitive impairment, dementia and learning disability. Hearing loss can affect performance in cognitive function tests, which can lead to misdiagnosis. Those with mild cognitive impairment, dementia or learning disabilities may not be aware of their hearing loss, or may not have the capacity to ask for help. Their families and carers may not consider that hearing loss is a compounding factor given their other health needs. However, hearing loss that is not addressed will significantly affect understanding and social interactions, and will exacerbate underlying cognitive difficulties.

Quality statement 4: Provision of hearing aids

Quality statement

Adults presenting with hearing loss affecting their ability to communicate and hear are offered hearing aids.

Rationale

The primary management option for permanent hearing loss is hearing aids. People should be offered the number of hearing aids that they could benefit from. In most cases hearing loss affects both ears. If a person has hearing impairment in both ears, there is significant benefit to wearing 2 hearing aids rather than 1. Binaural amplification gives better sound quality and improved intelligibility of speech in background noise. Hearing aids can reduce the impact of hearing loss, improving communication and participation in everyday life.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with hearing loss affecting their ability to communicate and hear are offered hearing aids.

Data source: Local data collection, for example, service specifications.

Process

a) Proportion of adults presenting with hearing loss affecting their ability to communicate and hear who have aidable hearing loss in 1 ear who are given 1 hearing aid.

Numerator – the number in the denominator who have 1 hearing aid.

Denominator – the number of adults who present with hearing loss affecting their ability to communicate and hear who have aidable hearing loss in 1 ear.

Data source: Local data collection, for example, audit of electronic case records.

b) Proportion of adults presenting with hearing loss affecting their ability to communicate and hear who have aidable hearing loss in both ears who are given 2 hearing aids.

Numerator – the number in the denominator who have 2 hearing aids.

Denominator – the number of adults who present with hearing loss affecting their ability to communicate and hear who have aidable hearing loss in both ears.

Data source: Local data collection, for example, audit of electronic case records.

Outcome

Hearing-specific health-related quality of life for adults with hearing loss.

Data source: Local data collection, for example, a patient survey. NHS England's Adult Hearing Service Specifications (2016) includes outcome 2 on improvement in service-user-reported quality of life using validated self-reporting tools such as the Glasgow Hearing Aid Benefit Profile (GHABP) or the Client-Orientated Scale of Improvement (COSI).

What the quality statement means for different audiences

Service providers (audiology services) ensure that processes are in place for adults with hearing loss affecting their ability to communicate and hear to be offered hearing aids. They ensure that healthcare professionals are aware that they should offer 1 or 2 hearing aids depending on whether the person has aidable hearing loss in 1 or both ears.

Healthcare professionals (audiologists) discuss and agree hearing aid options with the adult based on their communication and hearing needs, and as part of an individual management plan. They offer 1 or 2 hearing aids depending on whether the person has aidable hearing loss in 1 or both ears.

Commissioners (such as clinical commissioning groups and NHS England) ensure that services they commission have the capacity and expertise to give hearing aids to adults with aidable hearing loss. They monitor whether services restrict hearing

aids by not offering them to people with aidable hearing loss in 1 ear, or by only offering 1 hearing aid to adults with aidable hearing loss in both ears.

Adults with hearing loss that affects their ability to communicate are offered hearing aids if they are likely to improve their communication and hearing. They are offered 1 or 2 hearing aids depending on whether they need hearing aids in 1 or both ears.

Source guidance

Hearing loss in adults: assessment and management (2018) NICE guideline NG98, recommendations 1.6.1 and 1.6.2

Equality and diversity considerations

Healthcare professionals should adapt their communication style to the hearing needs of the adult with hearing loss. This will help to ensure that the adult has the opportunity to be involved in decisions about their hearing management options, which should be documented in the adult's personalised care plan.

For adults with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Quality statement 5: Face-to-face follow-up audiology appointment

Quality statement

Adults with hearing aids have a face-to-face follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted.

Rationale

A follow-up audiology appointment is important for assessing how someone is adapting to their hearing aids and whether they fit well and also to resolve difficulties at an early stage. It also provides an opportunity to review the personalised care plan and give additional advice based on progress. Face-to-face appointments should be offered. This will ensure the audiologist can check the fitting and handling of the device, and make any necessary adjustments to the hearing aid. Not providing this service can lead to hearing aids not being used, which can have a negative impact on the person's quality of life as their ability to communicate and participate in everyday situations decreases.

Quality measures

Structure

a) Evidence of local arrangements to ensure that adults with hearing aids have a face-to-face follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted.

Data source: Local data collection, for example, service specifications.

b) Evidence of local arrangements to ensure that adults with hearing aids have their personalised care plan reviewed and updated if necessary during a face-to-face follow-up appointment 6 to 12 weeks after the hearing aids are fitted.

Data source: Local data collection, for example, service specifications.

Process

Proportion of adults who have a face-to-face follow-up audiology appointment 6 to 12 weeks after new hearing aids are fitted.

Numerator – the number in the denominator who have a face-to-face follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted.

Denominator – the number of adults with new hearing aids.

Data source: Local data collection, for example, audit of electronic case records.

Outcome

a) Proportion of adults continuing to wear hearing aids at review stage.

Data source: Local data collection, for example, data logging and self-reporting. NHS England's Adult Hearing Service Specifications (2016) includes a key performance indicator (KPI) on the proportion of patients continuing to wear hearing aids after first follow up, and at 12 and 24 months.

b) Hearing-specific health-related quality of life for adults with aidable hearing loss.

Data source: Local data collection, for example, a patient survey. NHS England's Adult Hearing Service Specifications (2016) includes outcome 2 on improvement in service-user-reported quality of life using validated self-reporting tools such as the Glasgow Hearing Aid Benefit Profile (GHABP) or the Client-Orientated Scale of Improvement (COSI).

What the quality statement means for different audiences

Service providers (audiology services) ensure that pathways, protocols and processes are in place for adults with hearing aids to have a face-to-face follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted.

Healthcare professionals (such as audiologists) work in partnership with adults with hearing aids (and their family or carers if appropriate) to assess how the person is adapting to their hearing aids and resolve any difficulties at an early stage. They will provide further advice and support, and onward referral if needed. They will

review and update the personalised care plan, ensuring that any unmet needs or goals are addressed, and provide the person with a copy.

Commissioners (clinical commissioning groups and NHS England) ensure they commission services with the capacity and expertise to provide a face-to-face follow-up audiology appointment 6 to 12 weeks for adults after their hearing aids are fitted.

Adults who have hearing aids fitted are offered a face-to-face follow-up appointment with the audiology service 6 to 12 weeks after their hearing aids are fitted. This is to check the hearing aids and discuss how well the person has adjusting to using them. The person will be given advice and support with using the hearing aids, and also have their personalised care plan reviewed to check if any further care or support is needed. The plan will also be updated and a copy given to the person.

Source guidance

Hearing loss in adults: assessment and management (2018) NICE guideline NG98, recommendations 1.7.1 and 1.7.2

Definition of terms used in this quality statement

Face-to-face audiology appointment

At the follow-up audiology appointment for adults with hearing aids:

- Ask the person if they have any concerns or questions.
- Address any difficulties they have with inserting, removing or maintaining their hearing aids.
- Provide information on communication, social care or rehabilitation support services if needed.
- Tell the person how to contact audiology services in the future for aftercare, including repairs and adjustments to accommodate changes in their hearing.
- Ensure that the person's hearing aids and other devices meet their needs by checking:

  - the comfort, sound quality and volume of hearing aids, including microphone and noise reduction settings, and fine-tuning them if needed
  - hearing aid cleaning, battery life and use with a telephone
  - use of assistive listening devices
  - hours the hearing aid has been used, if shown by automatic data logging.
- Review the goals identified in the personalised care plan and agree how to address any that have not been met (for information on the personalised care plan, see recommendation 1.5.2).
- Update the personalised care plan and provide them with a copy.

[NICE's guideline on hearing loss in adults recommendation 1.7.2]

Equality and diversity considerations

Healthcare professionals should adapt their communication style at the face-to-face follow-up appointment to the hearing needs of the adult with hearing loss. They should ensure that communication with the adult is effective enough to discuss any concerns or questions about their hearing aids to resolve difficulties at an early stage and review the goals identified in the personalised care plan.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See quality standard advisory committees on the website for details of standing committee 1 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the quality standard's webpage.

This quality standard has been included in the NICE pathway on hearing loss, which brings together everything we have said on a topic in an interactive flowchart.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references

to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes for adults with hearing loss:

- hearing ability
- patient experience of primary, community and secondary care
- health-related quality of life for adults with hearing loss, their families or carers and communication partners
- level of social functioning
- levels of participation in education
- employment rates.

It is also expected to support delivery of the Department of Health and Social Care outcome frameworks:

- Adult social care outcomes framework
- NHS outcomes framework

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact template and resource impact report for the NICE guideline on hearing loss in adults.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and equality assessments are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate

unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

ISBN: