

# **Universal Newborn Hearing Screening and Early Intervention Programme**

## **Newborn Hearing Screening and Audiology Workforce Strategy and Action Plan**

**June 2008**

## Executive Summary

In August 2005, it was announced a universal newborn hearing screening programme would be introduced to improve the outcome for babies born with permanent congenital hearing loss. The implementation of the Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP) will require new strategies to recruit and retain personnel, and to ensure that services are delivered at a high level of quality.

This workforce development strategy and action plan (the 'Strategy') addresses the development of the newborn hearing screening and audiology workforce required for the implementation of the UNHSEIP over the next three years. The Ministry of Education is developing a separate strategy for the early intervention workforce.

The National Screening Unit's UNHSEIP Workforce Working Group has identified newborn hearing screeners and audiologists as priority groups for workforce development to support the implementation of the UNHSEIP. Newborn hearing screeners are a priority because this is largely a new workforce. Audiologists are a priority because they largely lack experience with newborns.

The following objectives will focus the workforce development efforts of the National Screening Unit and DHBs over the next few years:

Objective 1: Identify the competencies required by the UNHSEIP workforce.

Objective 2: Develop and deliver training programmes for these competencies.

Objective 3: Develop a workforce capable of reducing inequalities.

Objective 4: Ensure competencies of the newborn hearing screening and audiology workforce are maintained.

Objective 5: Monitor the size and development of the UNHSEIP workforce on an ongoing basis.

The Strategy also considers the impact of implementation of the UNHSEIP on the entire relevant workforce. It identifies the need for the National Screening Unit to work collaboratively with DHBs and professional groups in regards to the hearing screening, diagnosis and intervention workforce.

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## 1.0 Introduction

In August 2005, it was announced a universal newborn hearing screening programme would be introduced to improve the outcome for babies born with permanent congenital hearing loss. This resulted in Budget 2006 including funding of \$16m over four years for the development of the Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP) in New Zealand.

Without a national screening programme the average age of detection of moderate and greater hearing loss in New Zealand has been around 45 months of age. By international medical standards our age of identification is late. Current information suggests that Māori and Pacific babies and children are more likely to have a hearing loss than other babies and children.

An effective UNHSEIP will identify babies with permanent congenital hearing loss soon after birth and will initiate medical and education intervention during the most important period of language development of between 0-3 years of age. International evidence shows that those infants who begin to receive appropriate intervention within six months of age are able to maintain language, social and emotional development commensurate with their physical development.

This workforce development strategy and action plan (the Strategy) addresses the development of the newborn hearing screening and audiology workforce required for the implementation of the UNHSEIP. It recognises that the effective delivery of the UNHSEIP requires a multidisciplinary team. The Strategy acknowledges that some newborn hearing early intervention workforce issues will be addressed separately by the Ministry of Education. The two Strategies will be linked through the work of the UNHSEIP Joint Ministry Steering Group.

The aims of this Strategy are to:

1. describe the UNHSEIP workforce
2. identify the priorities for UNHSEIP workforce development (excluding early intervention workforce specific priorities)
3. identify initiatives to meet workforce development priorities
4. present a recommended action plan consisting of short and long term initiatives.

The important roles of existing DHB newborn screening programmes are acknowledged and the recommendations take into consideration their perspective on the work required to successfully implement a national UNHSEIP.

Shortages across the professions are a sector wide issue and as such workforce development needs to be a sector wide solution where key organisations work together to build a sustainable workforce which supports the UNHSEIP and has long term benefits to the sector.

This Strategy outlines initiatives that need to be implemented by the National Screening Unit, DHBs, professional bodies and educational institutions in a collaborative manner. The intended audience for this Strategy is the National Screening Unit, DHBs and relevant professional bodies and education providers.

The National Screening Unit would like to acknowledge the advice and input of the UNHSEIP Workforce Working Group in the preparation of this Strategy.

## **2.0 Defining the UNHSEIP Workforce**

The newborn hearing screening and early intervention workforce is defined as those who work throughout the UNHSEIP pathway, providing maternity, Well Child, screening, diagnosis and intervention services. This workforce includes:

- Lead Maternity Carers
- Well Child providers
- Newborn hearing screeners
- Audiologists
- Audiometrists/audiology technicians
- Otolaryngologists
- Paediatricians
- Advisors on Deaf Children
- Early intervention teachers
- Speech language therapists
- Kaitakawaenga
- Educational psychologists
- Administration staff, data staff and programme managers.

All those involved in the UNHSEIP workforce will need to develop shared understandings and competencies and work as a team.

One initiative could be to develop a core set of competencies for the UNHSEIP workforce. However, there is currently work underway to develop broader core sets of competencies across the health and disability sector. Once this work is completed a core set of competencies for the UNHSEIP will be developed using the sector sets as a foundation.

Sections of the broader health and education workforce will need to be advised about their role within the UNHSEIP, but may not require UNHSEIP specific workforce initiatives (eg, their scopes of practice and competencies are not expected to change significantly as a result of the UNHSEIP). However, they will be expected to be involved in appropriate continuing professional development initiatives within their own professions developed under this Strategy.

The Ministry of Education is preparing a workforce strategy for early intervention services. The UNHSEIP Workforce Working Group has recommended that the two strategies should be linked to ensure continuity of UNHSEIP workforce and services across the screening and early intervention pathway.

There are also National Screening Unit-wide workforce and service development initiatives under way, including:

- Antenatal and Newborn Education and Training Strategy across all antenatal and newborn screening programmes
- a postgraduate screening short course, to provide a deeper understanding of screening issues
- initiatives to support and encourage more Māori and Pacific involvement in the screening workforce.

The primary health care sector has an important role in antenatal and newborn health, and the National Screening Unit is working on a number of projects to strengthen the links between screening and primary care. Workforce issues will be considered as part of that workstream and is not addressed in this Strategy.

### **3.0 Key Workforces for Development**

The National Screening Unit's UNHSEIP Workforce Working Group has identified newborn hearing screeners, audiologists and Advisors on Deaf Children as the priority groups for workforce development to support the implementation of the UNHSEIP. Newborn hearing screeners are a priority because this is largely a new workforce to be developed. Audiologists are a priority because they largely lack experience with newborns. Advisors on Deaf Children are a priority workforce for the Ministry of Education.

#### **3.1 Newborn Hearing Screeners**

There are currently only a small number of newborn hearing screeners employed in New Zealand. They are largely screening newborns in the DHBs who are involved in the early implementation of the UNHSEIP or in Neonatal Intensive Care Unit (NICU), Special Care Baby Unit (SCBU) and other high risk babies in a few DHBs. A national workforce would need to be developed either from other workforces or newly established.<sup>1</sup>

Newborn hearing screeners screen newborns for hearing loss and refer newborns who require diagnostic assessment to an audiologist. Screening newborns does not require prior experience provided specialist training is undertaken and potential screeners have appropriate communication skills.

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<sup>1</sup> Universal Newborn Hearing Screening Advisory Group (2005). Universal Newborn Hearing Screening for New Zealand 2005: A report of the Universal Newborn Hearing Screening Advisory Group to the National Screening Unit.

There is no difference in competencies between screening well and NICU/SCBU newborns. Currently newborn hearing screeners have a variety of backgrounds, including nurses and audiology technicians. The following groups have been utilised as screeners in local and international programmes:

- nurses
- midwives
- audiometrists
- vision hearing technicians
- audiologists
- health care assistants
- lay people.

In the USA many hospitals make the mistake of training too many people. Not only does this take extra time for training and supervision, but often results in a less efficient and potentially less effective programme because responsibility for screening newborns is diffused and the quality of screening technique suffers.<sup>2</sup>

Based on UK estimates of one screener per 1,250 births, New Zealand will need between 50 and 60 screener FTEs. Screening will need to be provided seven days a week in major birthing centres to ensure most babies are screened before discharge, which is more efficient and will facilitate a high coverage rate for the UNHSEIP.

Some DHBs with relatively low numbers of births may decide to work together to provide a regional screening service or employ more part-time screeners or train existing staff with other roles, eg, vision and hearing technicians, health care assistants, midwives, ear nurses, audiometrists.

Based on current experience at Waikato DHB and within international programmes training is expected to take approximately two weeks. Training requires a mixture of technical and practical sessions and substantial hands-on experience. It will be necessary for the training to be undertaken in centres where there are sufficient births to provide a specified minimum number of newborns within the two week training period.

There is currently no national qualification or training programme for newborn hearing screeners. These are required to ensure quality and consistency across the Programme and to provide the screeners with a sense of accomplishment and qualification transportability between DHBs.

There is a national qualification for vision hearing technicians (VHTs) being developed that has modules applicable for newborn hearing screeners. The National Certificate in Community Support (Vision and Hearing Screening) will be a level 3 (50-51 credits) qualification on the National Qualifications

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<sup>2</sup> National Centre for Hearing Assessment and Management (2007). Early Identification of Hearing Loss: Implementing Universal Newborn Hearing Screening Programs.

Framework. The National Certificate could lead onto the National Diploma in Community Support (Hearing Therapy). Aligning the newborn hearing screener qualification with the VHT qualification will speed up the qualification registration process and make it easier to work as both a newborn hearing screener and a VHT or to switch between these roles.

Once trained, the screeners will require a period of direct supervision by an experienced screener or audiologist and then regular monitoring of competency (eg, annually).

There is no professional body for newborn hearing screeners. Therefore, the National Screening Unit intends to develop continuing professional development initiatives for the screeners. This role will include training workshops and facilitating communication.

### **3.2 Audiologists**

Audiologists are trained in the assessment and management of hearing disorders and deafness. They provide a diagnostic, intervention and monitoring service for children and adults and accept referrals from a wide variety of sources including doctors, public health nurses, speech language therapists, Plunket nurses, Vision and Hearing Technicians and Advisors on Deaf Children.

Given that the UNHSEIP is new to New Zealand, the current audiology workforce has overall, limited experience in working with the newborn age group. Therefore, there are concerns that few audiologists are competent in newborn diagnosis and intervention. This will require the development of appropriate courses and work-related experience to upskill existing audiologists. Discussions should also be undertaken with the relevant Universities around the long-term education of audiologists in the areas of paediatric diagnosis, intervention, counselling and communication skills.

The implementation of the UNHSEIP is expected to lead to a marginal increase in public audiologist workload. However, there are a relatively large number of vacancies in both the public and private sectors. The majority of paediatric audiology services are provided by public sector audiologists. The New Zealand Audiological Society (NZAS) reported an increase of public audiologist vacancy rates, from 26% in July 2006 to 37% in July 2007.<sup>3</sup> There are also difficulties in finding clinical placements for student audiologists in paediatric audiology because of staffing problems, which compounds the lack of experience in some areas.

A significant pay gap exists between public and private audiology. While this Strategy will not address this issue directly, it will examine ways to improve the attractiveness of working in the public sector. The National Screening Unit will have ongoing discussions with DHBs on how retention and recruitment of audiologists can be improved.

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<sup>3</sup> NZAS (2007). New Zealand Audiological Society Staffing and Resource Survey.



An audiologist has a Master of Audiology (from Auckland or Canterbury Universities) or an equivalent qualification from overseas. While the Master of Audiology courses include paediatric audiology in their syllabi, students generally have limited exposure to newborns to gain sufficient experience in newborn hearing diagnosis and early intervention.

The NZAS does not recognise overseas undergraduate degrees or Master of Audiology degrees of only one year duration, eg, those from the UK. Members of the NZAS have completed a one year Certificate of Clinical Competence. Members of the NZAS are required to maintain a current practicing certificate, which involves a biannual peer review and continuing education.

The NZAS is the only New Zealand professional body representing audiologists and is working towards registration under the Health Practitioners Competence Assurance Act 2003. Currently, the NZAS provides for its voluntary members:

- a code of ethics
- a consumer, professional and external party complaint process
- biannual peer review
- clinical competence certification
- clinical protocols and standards
- an annual conference.

Some DHBs employ non-NZAS member audiologists. Initiatives will need to be developed to ensure that all audiologists involved in the UNHSEIP develop and maintain their competence with newborns.

The implementation of the UNHSEIP may require the development of senior roles for audiologists within the Programme. Initiatives may need to be developed to prepare and support audiologists in these roles.

Audiologists may be supported in their paediatric work by audiometrists / audiology technicians and/or Advisors on Deaf Children. Where this occurs these staff should have access to appropriate training and professional development.

#### **4.0 UNHSEIP Audiology Service Model**

The National Screening Unit's UNHSEIP Workforce Working Group has identified the need for a nationally consistent service model for audiology as a cornerstone for developing efficient and effective workforce development. The service model needs to be suited to the New Zealand context.

## **4.1 New Zealand Context**

New Zealand has a relatively low population density and correspondingly longer travel distances compared with other countries and states that have developed newborn hearing screening programmes. Therefore, overseas models of audiology services for newborn hearing screening programmes need to be interpreted with caution.

Travel distances are a particular issue for families with newborns. For example, 23% of births are caesarean sections, which prohibit mothers from driving within the first six weeks. Long distance travel during winter months, particularly in the central North and South Islands, is not reasonable with newborns.

A reasonable proportion of referred newborns will have been discharged from NICU / SCBU. They may have a range of additional needs including oxygen and feeding requirements. They may also require multiple specialist appointments in the first few months. The requirement for additional long distance travel may not be possible or sensible for these families, particularly for families that have no concerns about their babies' hearing.

## **4.2 Distributed Model**

Under a distributed model of service delivery each DHB will be responsible for supplying local paediatric audiology services, either through their own audiology departments, in collaboration with neighbouring DHBs or through local private audiology providers.

Families will not normally be required to travel outside of their DHB's region. Audiologists may need to travel or provide services through telemedicine via trained audiology technicians to cover for vacancies. DHBs should provide local assistance to families with transport difficulties. This could include health professionals or volunteers (eg, screeners, ear nurses, etc) collecting newborns and their families and bringing them to the service.

There are some areas within New Zealand where population density is relatively high (eg, Auckland) and other regions where travelling long distances to access hospital services is an expected part of life (eg, West Coast to Canterbury). In these areas it may be acceptable to develop a regional service. However, it may also be necessary to either provide a local option for service delivery or provide additional support to families to access regional services to ensure a high uptake of audiology services for newborn hearing screening referrals. The NSU will hold each DHB accountable for its own population's appointment attendance rate regardless of where audiology services are provided.

## **4.3 Distributed Model Requirements**

Each audiologist would need to attend and pass an upskilling course on newborn audiology funded by the National Screening Unit before they can

provide diagnostic and habilitation services for newborns referred from screening. Any audiology technicians, audiometrists, or AODCs assisting an audiologist would need to be trained in-house in this role by an audiologist (who has passed the upskilling course).

Each DHB will be required to have access to all the equipment necessary for newborn audiology either locally or through an access agreement with another DHB or private audiology provider. In the case of a vacancy, this would allow for the local provision of services by travelling audiologists, private audiologists or local technicians directed by an audiologist through telemedicine.

Under the distributed model each audiologist is likely to see only a small number of screening referrals. Therefore, audiologists will require additional support to maintain their competency.

Under the distributed model audiologists working with newborns would have potentially less peer contact than those working in a more centralised model. Therefore, audiologists will require additional externally supported continuing professional development opportunities. These could include an information sharing website, updates, regional and/or national meetings.

#### **4.4 Other Models Considered**

The following models were also considered for the UNHSEIP in New Zealand:

- regional
- centralised
- mixed.

##### ***Regional model***

Under the regional model DHBs would group themselves into approximately six geographic regions and provide services either centrally within the region or through a network of linked providers with regional oversight.

Many families would have had to travel longer distances to services. DHBs would have needed to provide greater support to families to access services. Many audiologists would still not be seeing a large enough number of referrals to maintain competency without support. Regional centres would still only have a small number of audiologists, which would make the region's service at risk from unfilled vacancies.

##### ***Centralised model***

Under the centralised model services would be provided from a few centres (eg, Auckland and Christchurch).

Most families would need to travel. DHBs would have needed to provide much greater support to families to access services. The central audiologists would be a relatively small pool of professionals, which would make the national service at risk from unfilled vacancies.

To offset the downsides of the distributed model a few 'centres of excellence' should still be developed over time as experience with newborn referrals increases. These centres should have a role in supporting education, research and providing coordinated services for high and complex need cases.

### ***Mixed model***

Under the mixed model DHBs would be free to choose which service model they preferred. The eventual service configuration is likely to be a mix of mostly distributed and a few regional models.

## **5.0 Reducing Inequalities**

In order to reduce the likelihood that inequalities are neither created nor increased the UNHSEIP workforce will need to be accessible, culturally competent and ethnically representative.

Newborn hearing screeners are likely to come from lower socioeconomic groups. To reduce existing economic inequalities the UNHSEIP hearing screening workforce should be empowered to develop a career path in health.

DHBs will be required to develop their own initiatives for reducing inequalities for UNHSEIP to meet local needs within their Māori Health Action Plans. Ideally services should be based as close to consumers as possible. This could include increasing the number of screeners or broadening the range of professions involved in the newborn hearing screener workforce to include community based providers, eg, training community health workers as screeners and/or enabling them to assist families to access services, and scheduling multiple outpatients visits on the same day for members of the same family (a 'one stop shop'). Diagnostic and early intervention services may also need to be more mobile.

The workforce should be culturally competent. Cultural competencies should include, as a minimum, Māori, Pacific and Deaf cultural awareness.

Significant changes to the ethnic composition of New Zealand's population are projected, and this will have an impact on both the services required and the workforce needed to provide those services. It is important that our future health and disability workforce reflects the population they support and care for. For example, although progress has been made, Māori practitioners currently make up only 2.7 percent of the medical workforce and 7 percent of the nursing workforce, compared to 15 percent of the population who identify as Māori. Similarly, for Pacific people the figures are 1.1 percent and 3 percent for medicine and nursing respectively (currently 6.9 percent of New

Zealand's population identify as of Pacific origin). There is also a need for workforce participation to reflect New Zealand's increasing Asian population.<sup>4</sup>

One way to improve ethnic diversity is to expand the newborn hearing screener workforce to include existing Māori and Pacific health practitioners such as community health workers and vision hearing technicians. However, this may be less cost-effective given the cost of the equipment required and continuing competency could be affected if a screener is only doing small volumes of newborns. Newborn hearing screeners may instead work with other health and community workers to locate unscreened newborns and assist with transport, childcare, etc.

Currently there are few Māori and Pacific audiologists. More will need to be done to encourage Māori and Pacific students to consider a career in audiology. As the numbers of audiologists in each DHB are likely to be small it would be difficult to achieve ethnic representation at the point of service delivery. However, at the national level there would be advantages in having ethnic diversity to inform policy development and practice. However, it takes five years to train an audiologist, so this will be a long term goal.

Other ways is encourage Māori and Pacific students to enter the health sector include career branding, scholarships, apprenticeships, developing career paths, etc.

## **6.0 Action Plan**

The implementation of the UNHSEIP presents a workforce development challenge in New Zealand as it requires a virtually new screening workforce to be created. A multi-strand approach is required, as well as a focus on short and long term approaches. There are high expectations, and high scrutiny of the implementation of a new screening programme.

The National Screening Unit has a strategic leadership role in developing the newborn hearing screening workforce. It cannot implement a screening programme without actively supporting the service providers to meet their workforce needs. The following objectives will focus the newborn hearing screening and audiology workforce development efforts of UNHSEIP over the next several years:

Objective 1: Identify the competencies required by the UNHSEIP workforce.

Objective 2: Develop and deliver training programmes for these competencies.

Objective 3: Develop a workforce capable of reducing inequalities.

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<sup>4</sup> DHBNZ and MOH (2007). A Career Framework for the Health and Disability Workforce in New Zealand: Consultation document.

Objective 4: Ensure competencies of the newborn hearing screening and audiology workforce are maintained.

Objective 5: Monitor the size and development of the UNHSEIP workforce on an ongoing basis.

**Initiatives have been categorised as either priority 1 or 2. The National Screening Unit will focus on the priority 1 initiatives in 2007/08 and 2008/09. Priority 2 initiatives are expected to be implemented in 2008/09 and 2009/10.**

**Objective 1: Identify the competencies required by the UNHSEIP workforce**

<b>Initiative name</b>	<b>Description</b>	<b>Timeline</b>
<b>PRIORITY 1 INITIATIVES</b>		
1a) Newborn hearing screener competencies	National Screening Unit to identify competencies for newborn hearing screeners.	2007/08 Completed
1b) Competencies for audiologists working with newborns	National Screening Unit to identify competencies for audiologists working within the UNHSEIP.	2007/08 Completed
<b>PRIORITY 2 INITIATIVES</b>		
1c) UNHSEIP workforce team competencies	National Screening Unit to identify longer-term team competencies for the broader UNHSEIP workforce.	2008/09 to 2009/10
1d) Newborn hearing screener career path	National Screening Unit to identify career pathways for newborn hearing screeners into related roles, eg, vision hearing technicians, audiology technicians, health care assistants, through alignment of common competencies and encouraging DHBs to develop career planning with their staff.	2009/10

## Objective 2: Develop and deliver training programmes for these competencies

Initiative name	Description	Timeline
<b>PRIORITY 1 INITIATIVES</b>		
2a) Newborn hearing screener training programme	National Screening Unit to fund newborn hearing screening training for screeners.	2007/08
2b) audiologist newborn training programme	National Screening Unit to fund a newborn training programme for audiologists.	2007/08
<b>PRIORITY 2 INITIATIVES</b>		
2c) National qualification for newborn hearing screeners	National Screening Unit to work with Careerforce to get a national qualification for newborn hearing screeners on to the National Qualifications Framework.	2007/08 to 2009/10

## Objective 3: Develop a workforce capable of reducing inequalities

Initiative name	Description	Timeline
<b>PRIORITY 1 INITIATIVES</b>		
3a) Reducing inequalities strategy	National Screening Unit will require DHBs to develop their own initiatives for reducing inequalities for UNHSEIP to meet local needs within their Māori Health Action Plans.	2007/08
<b>PRIORITY 2 INITIATIVES</b>		
3b) More Māori and Pacific Master of Audiology students	National Screening Unit to explore with relevant groups options to encourage Māori and Pacific students to study audiology.	2008/09

#### Objective 4: Ensure competencies of the newborn hearing screener and audiology workforce are maintained

Initiative name	Description	Timeline
<b>PRIORITY 1 INITIATIVES</b>		
4a) audiologist retention	National Screening Unit, New Zealand Audiological Society and DHBs will explore options for improving retention and recruitment of audiologists.	2008/09
4b) screener competency certification	National Screening Unit to examine options for a newborn hearing screener certification programme.	2008/09
4c) newborn audiology competency monitoring and supporting	National Screening Unit, DHBs and New Zealand Audiological Society to examine options for monitoring and supporting the competency of audiologists.	2008/09
<b>PRIORITY 2 INITIATIVES</b>		
4d) newborn hearing screener professional development programme	National Screening Unit will examine options to meet the development needs of newborn hearing screeners. Options may include the development of workshops, short courses, an annual meeting with a training focus and a distance education tool. In the longer term a professional body for newborn hearing screeners may be formed.	2008/09
4e) audiologist professional development programme	National Screening Unit, DHBs and New Zealand Audiological Society will examine options to meet the development needs of audiologists involved in the UNHSEIP. Options may include the development of workshops, short courses, an annual meeting with a training focus and a distance education tool.	2008/09

#### Objective 5: Monitor the size and development of the UNHSEIP workforce on an ongoing basis

Initiative name	Description	Timeline
<b>PRIORITY 1 INITIATIVES</b>		
5a) UNHSEIP workforce monitoring strategy	National Screening Unit to work with DHBs, DHBNZ, New Zealand Audiological Society to develop a strategy for monitoring the UNHSEIP workforce.	2008/09
5b) UNHSEIP centres of excellence	National Screening Unit and appropriate stakeholders will explore options for creating centres of excellence for the UNHSEIP.	2009/10



## 7.0 Implementation

When this strategy and action plan has been confirmed, the National Screening Unit will do the necessary detailed project planning to implement the initiatives. The major implementation tasks include:

- refine the initiatives and their implementation approach (including discussion with key stakeholders as appropriate)
- preparation of project plans
- finalisation of available funding
- identification of available human resources
- setting milestones and targets
- signoffs and approvals.

At this early stage, the National Screening Unit can signal that the first initiatives already being implemented are:

- development of competencies, a training programme and qualification for newborn hearing screeners
- development of competencies for audiologists and a training programme for audiologists.

The competencies for the newborn hearing screener training programme have been identified and the content for the training programme has been developed. Relevant modules of the vision hearing technician qualification have been used as a starting point in the development of the qualification.

The National Screening Unit will contract for a newborn hearing screener training programme providers in 2008. The National Screening Unit is working with Careerforce on the registration of the qualification on the National Qualifications Framework (NQF). As registration of the qualification on the NQF may take up to a couple of years to complete, the National Screening Unit is working with Careerforce on a recognition of prior learning programme to ensure trainees can have their training recognised once the qualification is registered.

The competencies for the audiologist training programme have been identified. The National Screening Unit will contract with a training programme provider to develop and deliver the training programme in 2008/09. The training programme will be broken into modules, some of which may be appropriate for other UNHSEIP workforce, eg, making ear moulds may be appropriate for Advisors of Deaf Children or audiometrists.