Universal Newborn Hearing Screening and Early Intervention Programme Service Standards:

Antenatal and Childhood Screening

Prevention Directorate

National Public Health Service



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Includes Guidance

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Definitions

For the purposes of the standard the following definitions shall apply:

Adverse event	An event or incident in which a person receiving health care experienced harm. Refer also to 'Harm' and 'Incidents'. **Serious adverse event:** An adverse event that meets the criteria for SAC 1, SAC 2 or Always Report and Review reporting under Te Tāhū Hauora Health Quality & Safety Commission's national adverse events policy and requires formal notification, review, learning and improvement action.
Best practice	Best practice is the current accepted range of safe and reasonable practice that results in efficient and effective use of available resources to achieve quality outcomes and minimise risk for the people using the services, and whānau. Current accepted best practice should also reflect standards for service delivery, where these exist.
Clinical Practice Guidelines	Guidance developed by consensus of experts informed by evidence, considered best practice.
Code of Health and Disability Services Consumers' Rights	A regulation under the Health and Disability Commissioner Act 1994.
Completed screen	A final screening outcome has been achieved for the baby with either a 'pass' or 'refer diagnostic' outcome. • **'Pass' or 'Clear Response':** Where the baby has a 'pass' or 'clear response' screen result for both ears. There is either no follow-up required, or hearing surveillance due to the identification of risk factor/s. • **Refer diagnostic:** Where a referral to audiology is indicated because the screening outcome on aABR2 is either 'refer' for one or both ears as indicated on the screening device or is an 'incomplete screen' due to too many attempts or not being able to achieve a successful screen.
Consumer/People	We use 'consumer', 'kiritaki', 'newborn', 'baby' or 'parents/guardians/whānau' in our documents for consistency across our work. We use these terms to refer to anyone who has used, or is currently using, a screening or audiology service or is likely to do so in the future. This includes individuals, community members, whānau and family, carers and patients
Continuous quality improvement process	Ongoing collection and evaluation of information about important aspects of a process to identify and rectify problems, control unintended variations, and identify and manage opportunities for improving the process.
Corrected age (also Adjusted age)	The age of the baby has been "corrected" because they were born prematurely. The corrected age is the premature baby's age from birth (chronological age) minus the number of weeks/months early that they were born.

Corrective action	An aspect of quality management that aims to rectify a task or process where these have produced errors or deviated from a standard.
Criteria	Principles by which something may be judged or measured.
Cultural safety	A principle that requires service providers and health care workers to examine themselves and the potential impact of their own culture in their interactions with people using their service. To practise cultural safety, service providers and health care workers acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of service provided.
Deaf/ Deaf community/Deaf culture	**Deaf** The Ministry of Education acknowledges that culture and language cannot be separated. "Deaf" is a label of cultural identity, a way of being and communicating shared by people who feel most akin to other deaf, regardless of gender, ethnicity, age, hearing loss, disability, or nationality. From Ministry of Disabled People: Important context | Whaikaha - Ministry of Disabled People **The Deaf community** Many Deaf people in New Zealand identify as members of a distinct linguistic and cultural group, who use New Zealand Sign Language (NZSL) as their first or preferred language. Whether a Deaf person identifies with the Deaf community is a personal choice. The NZSL Act defines the "Deaf community" as the distinct linguistic and cultural group of people who are Deaf and who use NZSL as their first or preferred language, and people who are Deaf and who identify with that group. The NZSL Act does not define the term "Deaf". As at the 2018 Census, 7,647 people were unable to hear at all, and 55,221 people had a lot of difficulty hearing. The Deaf community can include people of varying degrees of hearing loss, as well as family members of Deaf people and sign language interpreters. As with any community, the Deaf community has different groups of people who experience life in different ways – for example, young and old, rural and urban, Māori and Pacific Deaf, Deaf immigrants and refugees, Deaf people of differing sexual orientations and gender identities, Deaf people with disabilities, and Children of Deaf Adults (sometimes referred to as "CODAs"). **Deaf culture** Like any group of people who share a common language and similar life experiences, Deaf people have their own culture. This includes beliefs, attitudes, history, norms, values, literary traditions, and art. Deaf culture is fundamentally about valuing and celebrating Deafhood. Members of the Deaf community share a strong connection. Values include participation in the community, sharing resources, and providing mutual support and assistance.

	Deaf spaces – that is, safe spaces where Deaf people do not have to try so hard to communicate, such as Deaf clubs, community events or schools – are important, as is visual information and NZSL.
Deaf health workforce	*From New Zealand Health Strategy 2023 - Priority 3: Valuing our workforce* <u>Our health system is equipped with the people, skills and capabilities to meet New Zealand's health needs</u> The health system attracts, retains and develops highly skilled and diverse people to ensure we have an available workforce to deliver equitable outcomes, including for Māori, Pacific peoples, disabled people, ethnic communities and rainbow communities. Training and employment models recognise and incentivise active learning and cultural competency to increase the depth, breadth and availability of care across New Zealand. On-the-job training, digital-driven learning, and other more accessible and affordable training pathways make it easy to enter the workforce or change careers. Diverse models of care are funded and attract people into the health sector, where it is known that we produce positive and equitable health outcomes. Workplaces will be inclusive and multi-cultural, creating supportive and culturally safe working environments that retain our workforce. <u>Our workforce supports equitable access to care</u> A diverse and multi-disciplinary workforce will be equitably distributed across the country and in a range of settings that support people to easily access health services. People will be able to see a health professional that is competent and safe, whether they need health advice, treatment or support, wherever they live and work. There will be more choice for people to access health professionals that share their cultural background or have increased experience of capabilities in meeting the needs of disabled people, Māori, Pacific peoples, ethnic communities and rainbow communities. <u>Our workforce is responsive to the evolving needs of New Zealanders</u> The health system recognises, values and enables the development of diverse skills and capabilities to ensure we have an available workforce to deliver equitable outcomes. Mana Māori and mātauranga Māori are recognised as professional skill sets and Pacific worldviews, disability and cultural responsiveness will be considered core competencies for workforce safety. Increased representation of Māori, Pacific peoples and disabled people, particularly in leadership and decision-making roles, will mean we have a representative health system. The people who design services, develop training, and determine cultural safety requirements and employment conditions will be reflective of the population to increase the cultural responsiveness of our health system. 10-year ambition: The workforce will reflect our diverse communities and have the skills and capabilities required to meet their needs.

	New Zealand Health Strategy: New Zealand Health Strategy | Ministry of Health NZ
Decline	Following an informed consent process a parent/guardian/whānau explicitly indicates that they do not wish to proceed in the UNHSEIP. Parents/guardians/whānau can decline anywhere along the pathway. *Refer to Screener Manual.*
Did not attend (DNA)	**Did not attend (DNA)** When verbal confirmation (in person or via phone or text) of a screening appointment is received but the appointment is not kept. A baby has the outcome of DNA after three unsuccessful attempts have been made for the family to attend. *Refer to Screener Manual.*
Disengaged	Where parents/guardians/whānau have neither consented nor explicitly declined but indicate they do not wish to be engaged in the programme (Disengaged). *Refer to Screener Manual.*
District leadership/ governance	District leadership refers to the systems, processes and structures which ensure accountability, ethical decision-making, and effective management in delivering high-quality, safe and equitable screening services. Even in the absence of a formal governance board, governance responsibilities may be undertaken by the district leadership team or key roles within the organisation. This includes setting strategic direction, monitoring performance, ensuring compliance with relevant legal, clinical and ethical standards (such as those set by Health NZ and UNHSEIP), managing risks, and fostering a culture of continuous improvement and patient-centred care. District leadership also encompasses the commitment to uphold Te Tiriti o Waitangi principles, ensuring culturally responsive services that address the needs of Māori and other priority populations. Where UNHSEIP providers do not have a district leadership group, they show evidence of taking a meaningful approach to decision-making and implementing strategic and business plans to improve screening outcomes.
Early Intervention	Early intervention refers to the timely identification and support provided to babies diagnosed with hearing loss. The purpose of early intervention is to ensure parents/guardians/whānau are provided with information, counselling and resources to help them make informed decisions about their baby's hearing care when diagnosed with a hearing loss. A multidisciplinary team (MDT) is formed to develop an action plan for the baby and their parents/guardians/whānau. The team should include an audiologist, Adviser on Deaf Children (AoDC), and an ear, nose and throat specialist (ENT).

	Depending on the degree, type and cause of hearing loss and the needs of the parents/guardians/whānau, the audiologist or AoDC may recommend requesting support from other care providers. These providers may include: • paediatrician • speech-language therapist • First Signs Service (sign language specialist) • social support services • counsellors • other clinical and education professionals • community groups. Early intervention/support pathway includes (but is not limited to): • with parental consent, the audiologist requests AoDC support • AoDC starts to support the family • AoDC manages requests to other professionals/providers around education and language.
Eligible babies (eligibility)	The right to access publicly funded health services in New Zealand. All babies under three months of age are eligible for newborn hearing screening under the Health and Disability Services Eligibility Direction 2011. Health and Disability Services Eligibility Direction 2011 - 2011-go2492- New Zealand Gazette For audiology, however, babies are only eligible if they meet the criteria under the New Zealand Public Health and Disability Services Act 2000.
Equity	In Aotearoa New Zealand, people have differences in health that are avoidable, unfair and unjust. Equity recognises that different people with different levels of advantage require different approaches and resources to achieve equitable outcomes.
Ethnicity	In Aotearoa New Zealand, ethnicity is defined as the ethnic group or groups that people identify with or feel they belong to. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship. Ethnicity is self-perceived, and people can belong to more than one ethnic group. An ethnic group is made up of people who have some or all of the following characteristics: • A common proper name • One or more elements of common culture which need not be specified, but may include religion, customs or language • Unique community of interests, feelings and actions • A shared sense of common origins or ancestry • A common geographic origin. Ethnicity standard classification: Consultation | Stats NZ
Gestational age	Gestational age refers to how far along a pregnancy is, or the age of a pregnancy. It is typically taken from the beginning of the mother's last menstrual cycle.

Harm	Negative consequences for participants and whānau directly arising from or associated with plans made, actions taken or omissions during the provision of health care rather than an underlying disease or injury. Harm may be: • physical – harm that leads to bodily injury or impairment or disease. This includes limitations in cognitive functioning and skills, including communication and social and self-care skills • psychological – harm that causes mental or emotional trauma or that causes behavioural change or physical symptoms • cultural – the marginalisation of a participants' belief and value systems • spiritual (also known as spiritual distress) – a state of suffering, related to the impaired ability to experience meaning in life through connectedness with self, others, world or a superior being. (Healing, learning and improving from harm: National Adverse Events Policy, 2023. Website: Healing, learning and improving from harm: National adverse events policy 2023 | Te whakaora, te ako me te whakapai ake i te kino: Te kaupapa here ā-motu mō ngā mahi tūkino 2023 | Te Tāhū Hauora Health Quality & Safety Commission
Hauora concept	Hauora Māori is a Māori philosophy of health and well-being that recognises the interconnectedness of all aspects of a person's life. It is a holistic concept that encompasses physical, mental, and emotional, social, and spiritual well-being. In Aotearoa New Zealand, Hauora is a framework used to reflect a Māori worldview that values across all aspects of a person's life. Hauora tinana - Physical wellbeing: the physical body, its growth, development, and ability to function properly Hauora hinengaro - Mental & emotional wellbeing: thoughts, feelings and emotional resilience Hauora whānau - Social wellbeing: a sense of belonging, care, and connectedness within whānau, iwi hapu and wider community Hauora wairua - Spiritual welling: personal beliefs, values, identity and connection to something greater than oneself.
Health care and support workers	The people employed or contracted by a health and disability service provider involved in providing screening, audiology and/or support services. This includes volunteers, clinical and non-clinical staff, and regulated and non-regulated workers.
Health Information Privacy Code 2020	This code of practice applies rules to agencies in the health sector to better ensure the protection of individual privacy. The rules in the Code are enforceable by complaining to the Privacy Commissioner and, if necessary, later to the Complaints Review Tribunal. The Code is available at the Privacy Commission's website.
Hearing surveillance	The programme of hearing checks for babies who pass screening but are identified with one or more of a defined set of risk factors for late onset or progressive hearing loss.

Incident	A broader term referring to any unplanned event that could potentially lead to harm, including near misses.
Incomplete screen	Where a screen has not been able to be completed due to either: • Three unsuccessful attempts • An ear not successfully screened
Infection prevention	A process of actively monitoring, identifying and preventing the spread of infections with the goal of reducing harm to consumers and health care workers. An IP programme will include governance and implementation of education and training, policies and procedures, surveillance of infection and management of the environment.
Informed choice	When parents/guardians/whānau are given options to choose to engage with screening, diagnostic tests or support options knowing the details, benefits, risks and expected outcomes. Service providers should ensure people using the service understand their options, specific ways to overcome the barriers they face, and the potential risks and benefits of given decisions.
Informed consent	As in the Code of Health and Disability Services Consumers' Rights, informed consent is a process rather than a one-off event, involving effective communication, full information, and freely given, competent consent. A signature on a consent form is not, in itself, conclusive evidence that informed consent has been obtained.
Lead maternity carer (LMC)	A registered midwife, general practitioner, or obstetrician responsible for coordinating the maternity care of an individual pregnant person to this definition.
Māori	A word that is used to describe tāngata whenua, indigenous people of Aotearoa New Zealand.
Māori worldview	A worldview particular to Māori that envisages a natural order to the universe, with an overarching principle of balance and whakapapa as a central thread. The Māori worldview is holistic and entails an inter-relationship of all living things to each other. It links Māori wellbeing to the health of the environment.
Multidisciplinary team (MDT)	A multidisciplinary team (MDT) is formed to develop an action plan for a baby with hearing loss and their parents/guardians/whānau. The team should include an audiologist, Adviser on Deaf Children (AoDC), and an ear, nose and throat specialist (ENT).
New Zealand Sign Language (NZSL) / te reo Turi	New Zealand Sign Language or NZSL (Māori: te reo Turi) is the main language of the Deaf community in Aotearoa New Zealand. It became an official language of Aotearoa New Zealand in April 2006 under the New Zealand Sign Language Act 2006. Of note: Signs for Māori concepts are being added to New Zealand Sign Language as Māori Deaf people gain more opportunities to participate and acquire cultural knowledge in te ao Māori, which has been historically difficult for them to access. However, an interpreter who is fluent in both te reo Māori and NZSL can translate between the two languages, transferring and expressing concepts in a way that is meaningful within the vocabulary and structure of each language.

Newborn	Newborn refers to a baby from birth up to three months of age. To be eligible for UNHSEIP screening, a baby must be under three months of age (corrected age).
No clear response	The terminology used for communicating results of a screen to parents/guardians/whānau when either the test result is 'refer' or the screen is unable to be finished due to too many unsuccessful attempts.
Offer	An offer to screen is made, and information about the UNHSEIP is provided.
Open communication	Open communication means sharing information honestly, clearly and respectfully, where all parties feel comfortable expressing their thoughts, feelings and concerns. It involves active listening, being receptive to feedback, and fostering an environment of trust and understanding. Refer to Rights 5 and 6 in the Code of Health and Disability Services Consumers' Rights.
Oranga	Wellness, wellbeing, welfare
Pacific peoples	A term used to refer to people from Tonga, Samoa, Fiji, the Cook Islands, Tokelau, Tuvalu, Niue, and Kiribati.
Pacific worldview	The way Pacific peoples view the world and how it operates and the Pacific purpose in the world, and why things happen the way they do. This determines how Pacific peoples address their daily life.
Pae ora	The government's vision for Māori health. It provides a platform for Māori to live with good health and wellbeing in an environment that supports good quality of life. A focus on pae ora encourages everyone in the health and disability sector to work collaboratively, to think beyond narrow definitions of health and to provide high-quality and effective services. Pae ora is a holistic concept and includes three interconnected elements: mauri ora (healthy individuals), whānau ora (healthy families), and wai ora (health environments). These are interconnected and mutually reinforcing and further inform the strategic direction for Māori health for the future.
Pae Ora (Healthy Futures) Act 2022	New Zealand legislation that establishes the statutory framework for the health system and requires health services to work towards equitable health outcomes, Te Tiriti-aligned decision-making, consumer and whānau engagement, and pae ora - healthy futures for all New Zealanders.
Parents/guardians/ whānau	In this document, this term is used to refer to people who are using or receiving the screening and audiology service. When the term 'parents/guardians/whānau' is used, it also encompasses whānau where permission has been granted by the parents/guardians.
Policy	Written statement that declares intentions, objectives or goals. Policy directs action according to/following the standard.
Primary health care provider (PHCP)	Most primary health care services are provided by health practitioners such as general practitioners (GPs), nurse practitioners (NPs) and registered nurses (RNs) working within a general practice team. Primary health care providers – Health New Zealand | Te Whatu Ora
Protocol	Plans that specify which procedures are to be followed in which situations.

Service provider	The organisation/service responsible for the screening, audiology and early intervention services or care that consumers, newborns/babies, and parents/guardians/whānau receive.
Reusable medical device (RMD)	Any device used in the delivery of care that is designed for decontamination and subsequent reuse on another person.
Standard	A document, established by consensus and approved by a recognised body, that provides specifications for service providers. Provides a reliable basis to share the same expectations about service delivery/provision to establish consistently safe and reasonable levels of care for consumers/kiritaki services. Standards provide a basis for measuring screening provider performance and compliance with relevant legislation.
Te reo Turi	Refer to New Zealand Sign Language (NZSL).
Tino rangatiratanga	Māori self-determination and authority, expressed in newborn hearing screening through whānau-led decision-making, Māori participation in programme governance and design, respect for tikanga and te reo Māori, culturally safe informed consent, equitable access to screening and follow-up, and protection of Māori data and health interests.
Transfer	Health care of an individual transferring from one District to another, or from one healthcare unit to another (e.g., babies transferring into neonatal intensive care unit/NICU).
UNHSEIP Advisory Group	The UNHSEIP Advisory Group is a national multidisciplinary body with representation from professional bodies, Māori, Pacific and consumer groups. From Terms of Reference: The purpose of the UNHSEIP Advisory Group (the Group) is to provide independent advice and expertise to the Prevention Directorate. The scope of the Group includes all aspects of the UNHSEIP pathway and changes to the UNHSEIP including the introduction of new technologies or advances in screening practice.
Unreported	A baby for UNHSEIP, for whom coordinators have not been notified by LMCs, etc., and no contact has been made with the parents/guardians/whānau and the baby is now more than three months old (corrected age). this information may be picked up through Datamart reports.
Unscreened baby	A baby for whom no verbal offer of screening has been made and no contact has been made with the parents/guardians/whānau and the baby is now more than three months old (corrected age). *Refer to Screener Manual.*
Verification	Confirmation, through provision of objective evidence, that specified requirements have been fulfilled.
Whānau	The family, extended family, or family group of people who are important to a person who is receiving a service. Family includes a person's extended family and whānau, their partners, friends, guardian, or other representatives chosen by the person.

Abbreviations

aABR	Automated auditory brainstem response
A&CS	Antenatal and Childhood Screening
AoDC	Adviser on Deaf Children
BOA	Behavioural observation audiometry
CPA	Conditioned play audiometry
DAP	Diagnostic and Amplification Protocols
dBHL	Decibels hearing level
DNA	Did not attend
ENT	Ear, Nose and Throat (also known as Otolaryngology Head and Neck/ORL)
Health NZ	Health New Zealand | Te Whatu Ora
IP	Infection prevention and control
LMC	Lead maternity carer
MDT	Multidisciplinary team
MOE	Ministry of Education
MOH	Ministry of Health
NICU	Neonatal intensive care unit
NP	Ngā Paerewa Health and Disability Services Standard
NPQS	UNHSEIP National Policy and Quality Standards
PHCP	Primary health care provider
RECD	Real-Ear-to-Coupler Difference
SCBU	Special care baby unit
UNHSEIP	Universal Newborn Hearing Screening and Early Intervention Programme
VRA	Visual reinforcement audiometry

UNHSEIP Service Standards

Introduction to UNHSEIP

The Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP) is an essential component of child health services in Aotearoa New Zealand. It aims to identify moderate to severe hearing loss as early as possible, enabling timely intervention and support that can profoundly influence a child's development, communication, and overall wellbeing.

The programme's primary aim is "Early identification of newborns with hearing loss so that they can access timely and appropriate interventions, inequalities are reduced and the outcomes for these children, their families and whānau, communities and society are improved". [1]

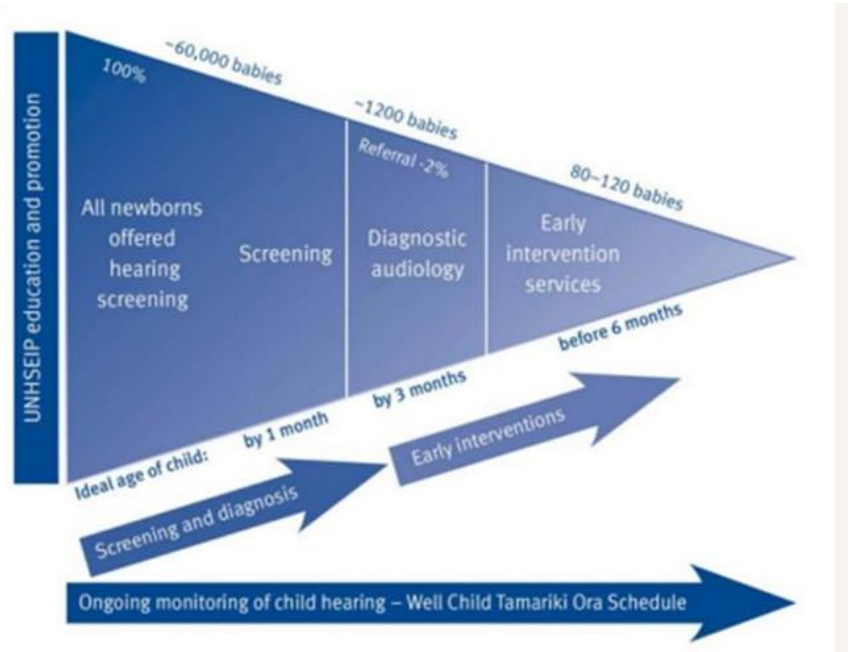
The programme's goals are described as "1-3-6 goals". They are based on international newborn hearing screening programme benchmarks:

1 month = All babies complete screening for hearing loss by 1 month of age

3 months = Audiological diagnostic assessment for babies who are referred from screening will be completed by 3 months of age

6 months = All babies identified with a hearing loss will begin receiving family/whānau-centred intervention services by 6 months of age

[1] UNHSEIP Implementation Advisory Group, 2007



Introduction to UNHSEIP Service Standards

The programme has evolved significantly since its national rollout in 2010. Originally guided by the National Policy and Quality Standards (NPQS), the programme has now transitioned to these new Service Standards. This shift reflects a comprehensive review aimed at ensuring the standards are more whānau-centred, fit for purpose, and enable effective evaluation across the entire newborn hearing pathway.

The UNHSEIP Service Standards define nationally consistent requirements for safe, equitable, and culturally grounded delivery of universal newborn hearing screening and early intervention across Aotearoa New Zealand.

These standards should be interpreted in a manner consistent with Te Tiriti o Waitangi obligations, as well as people's rights and service provider obligations under the Code of Health and Disability Services Consumers' Rights and the Code of Expectations of Health Entities' Engagement with Consumers and Whānau. The standards sit alongside programme manuals, protocols, and monitoring frameworks, and should be read in conjunction with them. As the standards mature, associated documents will be aligned to ensure a coherent system for implementation and assurance. These Service Standards provide the nationally consistent framework that underpins this work, setting clear expectations for quality, safety, and equity in service delivery.

The standards guide services across every step of the journey: from early contact with whānau, to screening, diagnosis, intervention, and ongoing support. Importantly, they affirm that hearing loss should never define a child's potential, and that timely, equitable access to interventions and supports, whether through audiology, speech and language services, and/or engagement with the Deaf community, can open pathways to thrive.

Structure

The Service Standards are organised into five key areas:

- Standard 1 – Our rights
- Standard 2 – Workforce and structure
- Standard 3 – Screening pathway
- Standard 4 – Facilities and equipment
- Standard 5 – Infection prevention

This document is intended for screening teams, audiology and education partners, Health New Zealand | Te Whatu Ora (Health NZ) district governance and leadership, and allied services that interact with the UNHSEIP pathway. It details what whānau should expect at each stage and what rights and supports are available to them, including access to New Zealand Sign Language (NZSL) interpreting where needed.

Communication is fundamental to connection and learning. By embedding these Service Standards across Aotearoa New Zealand, every pēpi and their whānau can look forward to a future of opportunity, inclusion, and wellbeing, one in which both spoken language and NZSL are valued, and where Deaf culture is recognised as a rich and integral part of Aotearoa New Zealand's identity.

What consumers can expect when taking part in the programme

In newborn hearing screening, the direct recipient of clinical care is the pēpi. Informed consent is provided by the whānau. Practitioners must uphold the right of whānau to exercise tino rangatiratanga in decision-making, ensuring clear information, shared planning, and seamless transitions to diagnostic and early intervention services.

Whānau are enabled to make informed decisions about what care and support they require to support language, social, and educational development.

Each stage of the screening pathway is to be delivered with both clinical excellence and cultural safety, and whānau are partners in decision-making at every point.

A defining aspect of this programme is the recognition that Deaf culture is an important and valued part of Aotearoa New Zealand's diversity. While the programme focuses on identifying hearing loss and providing intervention options, the programme affirms the rights of whānau to information about all pathways, including those of NZSL and Deaf identity. Respecting Deaf culture ensures that whānau can make informed choices about what is best for their pēpi, in ways that uphold dignity, belonging, and self-determination.

Background to creation of UNHSEIP Service Standards

The Prevention Directorate at the National Public Health Service (NPHS) made a strategic decision in 2023 to align all current national screening programmes' standards to NZS 8134:2021 Ngā Paerewa Health and Disability Services Standard (Ngā Paerewa).

Ngā Paerewa was chosen as it reflects the fundamental shifts towards more person-centred and whānau-centred health services: people are empowered to make decisions about their own care and support to achieve their goals, and there is a stronger focus on outcomes for people receiving support and care.

Many key components of Ngā Paerewa have been identified and adopted. Some amendments have been made to ensure relevance for screening services, including screening-specific guidance for providers. As a result, the numbering in the UNHSEIP Service Standards differs from the full version of Ngā Paerewa.

By aligning with Ngā Paerewa, the UNHSEIP Service Standards integrate more effectively with Aotearoa New Zealand's broader health system and reinforce commitments to Te Tiriti o Waitangi. This also aims to improve better experiences and outcomes for those traditionally underserved by our health system – Māori, Pacific peoples, tāngata whaikaha (disabled people), rural communities, and rainbow communities, amongst others.

More about the Ngā Paerewa Health and Disability Service Standard can be found here: **Resources for Ngā Paerewa Health and Disability Services Standard | Ministry of Health NZ**

The development of the UNHSEIP Service Standards has been a collective effort. Antenatal and Childhood Screening, on behalf of Health NZ, acknowledge and sincerely thank all those who have contributed their time, expertise, and support to this work. The Expert Advisory Panel included whānau with lived experience, Māori and Pacific representatives, Deaf organisations, clinicians, screeners, audiologists, educators and scientists who have all helped shape the standards, ensuring they are not only evidence-based but also grounded in real lives and practical realities.

We also acknowledge and thank the Māori caucus of the BreastScreen Aotearoa Standards Review Project for their expertise and guidance in developing criteria for Māori, reinforcing UNHSEIP's commitment to Te Tiriti o Waitangi. In addition, we acknowledge the wider health sector and UNHSEIP key stakeholders for their thoughtful responses to the draft Service Standards. Their insights from across the sector have strengthened the standards and ensured they are responsive, inclusive, and future-focused.

This revision reflects more than updates to clinical and operational requirements. It also represents a commitment to inclusive and non-stigmatising language, ensuring that all whānau feel recognised and supported. By choosing words carefully, these standards affirm that pēpi and their whānau are seen, valued, and respected, regardless of their culture, language, or background. This inclusivity extends to recognising the importance of Deaf culture, and to ensuring that whānau are supported with information about all pathways available to them, including options that embrace Aotearoa New Zealand Sign Language and Deaf identity. In keeping with this aim, criteria in *Standard 1: Our rights* are written in the first person to centre the voice of people and whānau.

The standards are anchored in evidence-based practice and international guidelines, while also reflecting the unique cultural and social context of Aotearoa New Zealand. They embed Te Tiriti o Waitangi principles across all aspects of the programme, recognising Māori rangatiratanga in health and ensuring that services actively work to achieve equity in outcomes. They also give expression to Ola Manuia, the Pacific health strategy, affirming the importance of services that are accessible, culturally grounded, and delivered in partnership with Pacific communities.

In commitment to tāngata whenua and Te Tiriti o Waitangi, te reo Māori is included in this document.

The standards are inclusive and gender-diverse; culturally safe practice requires adaptation of language in partnership with each person and whānau.

Equity

New Zealand Deafness Notification data indicate that Māori are over-represented among children identified with hearing loss. Some evidence also points to later identification of hearing loss among Māori and Pacific children compared to non-Māori, non-Pacific children.

Therefore, equity is central to these standards. They set out a clear expectation that services will not only be clinically effective but also inclusive, responsive, and culturally safe. The adoption of inclusive and non-stigmatising language throughout this revision is a deliberate acknowledgement of the diversity of pēpi, whānau, and communities who engage with the programme.

Going forward

The UNHSEIP Service Standards will replace the existing UNHSEIP NPQS. Implementation of these standards will be supported by ongoing monitoring, evaluation, and feedback from whānau and service providers. This approach ensures continuous improvement and responsiveness to emerging needs. The UNHSEIP remains committed to delivering an equitable screening programme that upholds cultural safety and partnership, so that every pēpi and whānau can access timely, high-quality care.

Other relevant UNHSEIP documents

The most current version of the following programme documentation:

1. UNHSEIP Screener Manual
2. UNHSEIP Screening Form HP5065
3. UNHSEIP Risk Factors Form for Hearing Loss Requiring Surveillance
4. UNHSEIP Coordinator Manual
5. UNHSEIP Manual for Screener Trainers
6. UNHSEIP Monitoring Framework

7. UNHSEIP Diagnostic and Amplification Protocols
8. UNHSEIP Diagnostic Assessment Data Form
9. UNHSEIP Newborn Screener Annual Competency Exercise (ACE) Guidelines

After the finalisation of these UNHSEIP Service Standards, the next phase will review the current UNHSEIP manuals and protocols as a separate project.

Standard 1: Our rights

Outcome 1

People receive safe screening and audiology services of an appropriate standard that comply with consumer/kiritaki rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.

NB: Criteria 1.1 to 1.2 are for specific priority populations; the remaining criteria 1.3 to 1.8 are applicable to all eligible screening populations.

1.1: Pae ora healthy futures for Māori

I know what it means for me:

Te Tiriti o Waitangi: Māori flourish and thrive in an environment that enables good health and wellbeing.

As service providers: We work collaboratively to embrace, support and encourage a Māori worldview of health and provide high-quality, equitable and effective services for Māori framed by Te Tiriti o Waitangi and Te Hā model.

Criteria / Ngā paearu

1.1.1 Our service provider shall embed and enact Te Tiriti o Waitangi within all its work recognising Māori, and supporting Māori in their aspirations, whatever they are.

1.1.2 The service provider shall provide evidence that it gives effect to the Articles of Te Tiriti o Waitangi including kāwanatanga, tino rangatiratanga, ōritetanga and wairuatanga, through implementation of Te Tiriti o Waitangi principles and incorporation of hauora concepts in service planning, delivery, monitoring and improvement.

For guidance, refer to Appendix 2: Te Tiriti o Waitangi Self-Assessment Tool.

1.1.3 Our service provider shall ensure health care and support workers receive Te Tiriti o Waitangi training and that it is reflected in day-to-day service delivery.

1.1.4 Our service provider shall ensure our services are operating in ways that are culturally safe.

1.1.5 Our service provider shall actively recruit and retain a Māori health workforce across all organisational roles.

1.1.6 Our service provider shall work in partnership with iwi and Māori organisations within and beyond the health sector to allow for better service integration, planning and support for Māori.

1.1.7 Our service provider shall monitor the participation rates of Māori in newborn hearing screening to ensure screening targets are met.

1.1.8 Our service provider shall target delivery of UNHSEIP services to Māori newborns by:

1. developing relationships with Māori maternity and child health services, to assist with raising awareness of the UNHSEIP in communities
2. implement initiatives aimed at reducing access barriers to UNHSEIP, such as financial, transport and geographical barriers.

Guidance 1.1: Pae ora healthy futures for Māori

1.1.1 – 1.1.8

1. Annual plans show evidence of:
    a. equity of access (available, high-quality, and acceptable services) and outcomes for Māori
    b. Kaupapa Māori services
    c. fostering Māori community integration
    d. the application of Māori health models that incorporate rongoa Māori (traditional healing)
    e. proactively identifying and removing barriers to participating in New Zealand society, including te ao Māori, for Māori with disabilities and their whānau
    f. increasing Māori participation in decision making
    g. increasing Māori capacity and capability and the size of the Māori health workforce – actively recruiting and retaining a Māori health workforce
    h. providing effective healthcare services for Māori where services are operating in ways that are culturally safe.
2. Evidence shows that, at district leadership meetings that review health equity and Māori health indicators, discussion includes:
    a. checking progress on health equity and Māori health key performance indicators
    b. presenting monitoring data, including health equity and Māori screening coverage
3. All health care and support workers complete Te Tiriti o Waitangi training.
4. Te Tiriti o Waitangi training is reflected in day-to-day service delivery.
5. Service providers
    a. develop and incorporate the Tiriti o Waitangi Principles and Hauora concept
    b. demonstrate implementation of Te Tiriti o Waitangi Self-Assessment Tool
6. Evidence shows service providers seek comprehensive feedback from Māori receiving services and their whānau (through interviews, patient feedback forms, or similar).
7. Evidence shows the workforce reviews their practice at defined intervals through a health equity and quality lens.
8. Evidence shows service providers work in partnership with iwi and Māori organisations within and beyond the health sector to improve service integration, planning, and support for Māori.
9. Service providers engage with appropriate Māori expertise providers for their input into service design, planning and delivery of UNHSEIP. Where appropriate, the specific ways in which service provider contribute to improving hearing outcomes for Māori, may be included in screening service health plans or other relevant policy or plan.
10. Districts/service providers monitor the involvement of Māori and other population groups as appropriate, in newborn hearing screening for their service. Where rates are below UNHSEIP set target (95%) of live births who complete screening by one month, screening providers implement a plan of action to address the issue.

Self-review:

	1. Evidence shows self-review occurs at defined intervals, applying the sector guidance above to a culture of planning, review, and modification concerning Māori health and equity. 2. Robust performance improvement, monitoring, and accountability mechanisms demonstrate that organisations are on track to achieve equity of health outcomes for Māori.
Tools and resources	1. Website: Te Tiriti o Waitangi framework | Ministry of Health NZ 2. See Māori health models | Ministry of Health NZ: Māori health models | Ministry of Health NZ 3. Te Whare Tapa Whā: Te Whare Tapa Whā model of Māori health | Ministry of Health NZ.

1.2: Te Mana Ola: Pacific peoples in Aotearoa

I know what it means for me:

The people: Pacific peoples in Aotearoa are entitled to 'live powerfully' and enjoy good health and wellbeing.

Te Tiriti o Waitangi: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.

As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.

Te Mana Ola Health Strategy: Strengthening Pacific health foundations through community engagement, prioritising disease prevention and health promotion, empowering Pacific peoples to take charge of their health and wellbeing, ensuring timely access to health services, and fostering strong Pacific health leadership with a resilient, representative workforce.

Criteria / Ngā paearu

1.2.1 Our service provider shall focus on achieving equity and efficient provision of health and disability services for Pacific peoples.

1.2.2 Our service provider shall ensure services are operating in ways that are culturally safe, including commitment by our service provider to develop staff competencies to meet the cultural and spiritual needs of Pacific peoples through completion of cultural safety training.

1.2.3 Our service provider shall actively recruit and retain a Pacific health workforce across all organisational roles.

1.2.4 Our service provider shall work in partnership with Pacific communities and organisations within and beyond the health sector to enable better planning, support, interventions, research and evaluation of the health and wellbeing of Pacific peoples to improve screening outcomes.

1.2.5 Our service provider shall monitor the participation rates of Pacific peoples in newborn hearing screening to ensure screening targets are met.

1.2.6 Our service provider shall target delivery of UNHSEIP services to Pacific peoples' newborns by:

1. developing relationships with Pacific maternity and child health services, to assist with raising awareness of the UNHSEIP in Pacific communities
2. implementing initiatives aimed at reducing barriers to access UNHSEIP, such as financial, transport and geographical barriers.

Guidance 1.2: Ola manuia of Pacific peoples in Aotearoa

1.2.1 – 1.2.6

1. Service delivery should include:
   a. the strengthening of relationships with Pacific organisations or partners to assist with raising awareness of screening in their communities
   b. implementing initiatives aimed at reducing inequity for Pacific peoples
   c. working closely with Pacific peoples in the design, planning and implementation of new initiatives. (Pacific caucus, National Public Health Services).

	2. Service providers: a. have a cultural safety policy that is enacted in the service provision and reviewed annually b. evidence their ability to engage with people in a culturally appropriate way; for example, understanding that the Pacific worldview is underpinned by connectedness of a person to whānau, communities, land, atua, and ancestors c. develop staff competencies to meet the cultural and spiritual needs of Pacific peoples through completion of cultural safety training d. evaluate service provision at defined intervals to measure the quality and effectiveness of the service for Pacific peoples e. maintain ethnicity data on Pacific peoples to inform targeted interventions and solutions. 3. Information and resources about the screening services provided are relevant to the different nations of Pacific peoples and are readily available or displayed in appropriate forms and languages. These may include: a. the Code of Health and Disability Services Consumers' Rights b. complaints information c. UNHSEIP services that is being provided d. public health information. 3. Service providers: a. provide high-quality professional development for Pacific health care and support workers to enhance their health and wellbeing which may include Pacific-related content or context b. actively recruit, appoint, and retain Pacific peoples in leadership roles c. acknowledge the value of language and cultural expertise in their workforce d. recruit and retain a Pacific workforce that reflects the population they serve. 4. Service providers engage with appropriate Pacific expertise providers for their input into service design, planning and delivery of UNHSEIP. Where appropriate, the specific ways in which service provider contribute to improving hearing outcomes for Pacific, may be included in screening service health plans or other relevant policy or plan. 5. Districts/service providers monitor the involvement of Pacific peoples and other population groups as appropriate, in newborn hearing screening for their service. Where rates are below UNHSEIP set target (95%) of live births who complete screening by one month, screening providers implement a plan of action to address the issue.
Tools and resources	1. Link to Te Mana Ola (Ministry of Health): Te Mana Ola: The Pacific Health Strategy | Ministry of Health NZ 2. Yavu Engagement Framework (Ministry for Pacific Peoples): Ministry for Pacific Peoples — Yavu - Foundations of Pacific Engagement Tool 3. Pacific Peoples: Pacific Peoples and their language | NZ Digital government

1.3: Our rights during service delivery

I know what it means for me:

The people: My rights have meaningful effect through the actions and behaviours of others.

Te Tiriti o Waitangi: Service providers recognise Māori mana motuhake (self-determination).

As service providers: We provide UNHSEIP services and support to people in a way that upholds their rights and complies with legal requirements.

Criteria / Ngā paearu

1.3.1 Our services shall be provided in a manner that complies with our rights.

1.3.2 Our service provider shall know and understand our rights and ensure that we are informed of our rights.

1.3.3 Our service provider shall ensure our health care and support workers understand our rights to receive appropriate information, support or advocacy that is sensitive to our needs as parents/guardians/whānau.

1.3.4 Our service provider shall ensure our rights as Deaf people are met. This shall include:

1. having awareness and understanding of Deaf culture
2. approaching us in a sensitive manner
3. providing New Zealand Sign Language (NZSL) /te reo Turi interpreter services, when required.

Guidance 1.3: Our rights during service delivery

1.3.1 – 1.3.4

1. In addition to Te Tiriti o Waitangi and tikanga, health care and support workers' induction and education on the legal framework for rights relevant to the service being provided.
2. Adequate information on people's rights is available to people receiving services and their whānau in an accessible format for the people receiving services.
3. Service providers display the Code of Health and Disability Services Consumers' Rights so that it is visible and is also available in accessible formats in te reo Māori, New Zealand Sign Language, and English, so that Māori and other consumers understand their rights.
4. Service providers shall ensure they uphold the rights of disabled people especially that of Deaf people, including "the right to be treated fairly and without discrimination. the right to informed consent, the right to be treated with respect. the right to make decisions about your own care. right to receive a quality service."
5. Health care or support workers advise parents/guardians/whānau of their right to have a support person of their choice at appointments. Information is included in appointment letters, brochures and verbal interactions.
6. Service providers make reasonable accommodations to facilitate the presence of support persons, except in cases where safety concerns arise.

	7. Service providers equip health care and support workers with knowledge about advocacy services and support situations through initial and ongoing education as needed. 8. Service providers provide Deaf culture awareness training for health care and support workers to ensure they meet the needs of Deaf babies or parents/guardians/whānau.
Tools and resources	1. Health & Disability Commissioner, Online training on the Code of Health and Disability Services Consumers' Rights 2. Te Kāhui Tika Tangata Human Rights Commission website: Rights of Disabled People

1.4: I am treated with respect

I know what it means for me:

The people: I can be who I am when I am treated with dignity and respect.

Te Tiriti o Waitangi: Service providers commit to tino rangatiratanga.

As service providers: We provide UNHSEIP services and support to people in a way that is inclusive and respects their identity and their experiences.

Criteria / Ngā paearu

1.4.1 Our service provider shall be responsive to our identity, which could include our values and beliefs, culture, language, religion, disabilities, gender, sexual orientation, relationship status, and other social identities or characteristics.

1.4.2 Our services shall be provided in a manner that respects our dignity, privacy and confidentiality.

1.4.3 Our service provider shall ensure our health care and support workers treat members of the Deaf community with respect.

Guidance 1.4: I am treated with respect	
1.4.1 – 1.4.3	1. All health care and support workers complete: a. Te Tiriti o Waitangi training b. relevant training for other cultures (eg.e.g. Pacific peoples) c. relevant disability training, specifically that of Deaf culture d. rainbow awareness training specifically includes the unique needs of transgender and gender diverse people. 2. Service providers have and promote a philosophy of genuine inclusiveness (in terms of rainbow awareness, gender identity, cultural awareness) and show evidence of applying it in practice. 3. Service providers incorporate cultural protocols, such as tikanga Māori, where appropriate, and collaborate with cultural advisors for guidance. 4. Service providers implement policies and procedures for handling taonga, which include: a. providing an explanation to the parents/guardians/whānau before touching or removing taonga b. seeking permission from the parents/guardians/whānau before touching or removing taonga.
Tools and resources	Refer to the following websites on language guides when caring for the following: 1. disabled people: Disability language | NZ Digital government 2. rainbow community: Rainbow inclusive language guide - Te Kawa Mataaho Public Service Commission

1.5: I am protected from abuse

I know what it means for me:

The people: I feel safe and protected from abuse.

Te Tiriti o Waitangi: Service providers provide culturally safe services for Māori, so they feel safe and are protected from abuse.

As service providers: We ensure people using our UNHSEIP services are safe and protected from abuse.

Criteria / Ngā paearu

1.5.1 We shall receive services free of discrimination; coercion; harassment; physical, sexual, or other exploitation; abuse; or neglect.

1.5.2 Our service provider shall prioritise a strengths-based and holistic model, ensuring wellbeing outcomes for all including Māori.

1.5.3 Our service provider recognises, responds to, and supports those affected by family violence, ensuring our safety and connecting us to appropriate services.

1.5.4 Our clinical health records shall only contain respectful language that is free from discriminatory or derogatory statements.

Guidance 1.5: I am protected from abuse

1.5.1 – 1.5.4

1. Service providers demonstrate an understanding of best practice guidelines for abuse prevention and legal obligations.
2. Employment practices include criminal record-checking, particularly in regard to vulnerable children. This includes health care and support workers, contractors, access holders, and volunteers. Health care and support workers follow a code of conduct.
3. Service providers:
    a. recognise signs of family violence and provide support and referral to appropriate community resources
    b. have documented processes to facilitate effective referral pathways to support services, such as services for psychological and physical trauma
    c. provide family violence training for front-line staff, e.g. Violence Intervention Programme. Staff should complete this module as per organisational policy.
4. Service providers:
    a. develop strategies to reduce stigma, including by training health care and support workers to be non-judgemental, using rights-based messages and materials, and creating a caring and welcoming environment. This shall be reflected in clinical records
    b. provide regular training (intervals as per organisational policy) to staff on unconscious bias and inclusive practices

c. conduct regular reviews of practices, policies, and consumer feedback to ensure compliance with standards and identify areas for improvement.

5. Service providers look for opportunities to support Māori to engage with services and receive the care and support they need.

1.6: Effective communication occurs

I know what it means for me:

The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing.

Te Tiriti o Waitangi: Services are easy to access and navigate and give clear and relevant health messages to Māori.

As service providers: We listen and respect the voices of people who use our UNHSEIP services and effectively communicate with them about their choices.

Criteria / Ngā paearu

1.6.1 We shall receive information in our preferred format and in a manner that is acceptable to us.

1.6.2 Our service provider shall practise open communication with us.

1.6.3 Appropriate interpreter services shall be provided to us.

1.6.4 Our service provider shall make communication and information easy for all people to access, understand, and use, enact or follow, including pictorial aids.

1.6.5 We shall be provided with the time we need for discussions and decisions to take place.

1.6.6 We shall:

1. receive sufficient and relevant information about the UNHSEIP at the earliest opportunity; antenatally being the ideal time
2. be able to have questions answered by an appropriately qualified and authorised person.

Guidance 1.6: Effective communication occurs	
1.6.1 – 1.6.6	1. Service providers give parents/guardians/whānau understandable, clear, and concise written and verbal information about the UNHSEIP service. 2. Service providers provide access to appropriate interpreter services, including: a. independent interpreters b. New Zealand Sign Language interpreters c. technology where appropriate for the service. 3. Communication may include: a. using interpreters including New Zealand Sign Language and advocates b. providing information in a variety of languages and accessible formats c. a system of checking that information is understood

	d. providing information suggesting other available methods of treatment and therapy e. communicating with the whānau, person with enduring power of attorney, or nominated representative of the person receiving services, where applicable, so they are well informed f. using language appropriate for the person and whānau g. if providing services to non-verbal people, augmented communication. 4. Parents/guardians/whānau determine the format in which information is provided. This could include different technologies, such as text messaging, emails. 5. Service providers show in their service delivery that they: a. engage in open communication with people that aligns with national guidelines b. have a process to verify people are informed of their rights to information and open disclosure. 6. Service providers: a. regularly update materials to reflect current UNHSEIP guidelines, key messages, and best practices b. ensure staff are trained on national policies to provide consistent messaging. 7. Service providers: a. comply with UNHSEIP policy on communication with media b. have strategies regional/local radio and print media that complement any national media activities c. all communications issued as a result of activities of UNHSEIP comply with the brand guidelines including educational materials, advertising media communications and signage, but excluding letters on UNHSEIP letterhead. 8. Service providers have implemented processes to provide people receiving services with time for discussion, time to consider decisions, and opportunity for further discussion, if required. 9. Service providers have a policy outlining the communication provided to parents/guardians/whānau, including specific details about the screening process, timeframes and outcomes.
Tools and resources	National Screening Unit Policy Framework: Open Communication Policy (NSU 03) – Health New Zealand | Te Whatu Ora

1.7: I am informed and able to make choices

I know what it means for me:

The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why.

Te Tiriti o Waitangi: High quality services are provided that are easy to access and navigate. Service providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well.

As service providers: We provide people using our UNHSEIP services, or their legal representatives, with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice and control.

Criteria / Ngā paearu

1.7.1 We shall give informed consent in accordance with the Code of Health and Disability Services Consumers' Rights and operating policies.

1.7.2 Our service provider shall follow the appropriate best practice tikanga guidelines in relation to consent.

1.7.3 The discussion and outcome regarding consent for our newborn hearing screen shall be documented.

1.7.4 Our screening provider shall provide appropriate sign language interpreters and/or resources for Deaf parents/guardians/whānau to make informed consent for newborn hearing screening.

1.7.5 We shall be given the pamphlet 'Your Baby's Hearing Screen: About Newborn Hearing Screening' (HE2429).

Guidance 1.7: I am informed and able to make choices

1.7.1 – 1.7.4

1. Service providers are aware of legislation underpinning consent practices, including enduring powers of attorney, and the Code of Health and Disability Services Consumers' Rights.
2. Parents/guardians/whānau are made aware of national UNHSEIP data collection and/or reporting of personal data on procedures they are undergoing, where either or both of these activities occur.
3. Consent must be given freely, without any pressure or coercion. Parents/guardians/whānau should be made aware that they can decline or withdraw from the UNHSEIP pathway at any time without affecting their baby's access to future health services. They are fully informed about alternative options.
4. Service providers have implemented processes to provide people receiving services with time for discussion, time to consider decisions, and opportunity for further discussion, if required. This includes:
    a. service providers encourage parents/guardians/whānau to have support people or whānau attend discussions
    b. language among health care and support workers and between them and people receiving services is respectful.

	5. Service providers follow relevant best practice tikanga guidelines. Health care and support workers demonstrate competency. Some examples are: a. Capital & Coast District (2009): Tikanga Māori: A guide for health care workers (PDF, 195 KB) b. Auckland and Waitematā Districts: Āke Āke phone app c. Bay of Plenty District: Tikanga Best Practice Document (PDF, 273 KB) d. Waikato District (2004): Tikanga Best Practice Guidelines (PDF, 8.3 MB).
1.7.5	1. Screeners provide parents/guardians/whānau with the most current pamphlet Your Baby's Hearing Screen: About Newborn Hearing Screening (HE2429), which includes the information described above, is given to all parents / guardians. 2. Timing of when the pamphlet is provided depends on the point of contact, e.g. antenatally by LMC/midwife, via letter, at the time of screening, etc. Screeners, where appropriate, adhere to the timing as stated in the Screener Manual.

1.8: I have the right to complain

I know what it means for me:

The people: I feel it is easy to make a complaint. When I complain, I am taken seriously and receive a timely response.

Te Tiriti o Waitangi: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.

As service providers: We have a fair, transparent and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.

Criteria / Ngā paearu

1.8.1 We shall be informed about, and have easy access to, a fair and responsive complaints process that is sensitive to, and respects, our values and beliefs.

1.8.2 Information about the complaint process (including resources) is accessible to Deaf people, including in NZSL.

1.8.3 Our complaint shall be addressed and resolved in accordance with the Code of Health and Disability Services Consumers' Rights.

1.8.4 We shall be informed of the findings of our complaint.

Guidance 1.8: I have the right to complain

1.8.1 – 1.8.4

1. Service providers have an implemented policy and associated procedures around complaint management and resolution or escalation which complies with legislative and contractual requirements.
2. Health care and support workers understand their responsibilities in supporting the requirements of the Code of Health and Disability Services Consumers' Rights.
3. Service providers use national guidelines and resources to support the complaint process.
4. Service providers monitor trends in complaints, including the actions they take.
5. Service providers maintain an up-to-date register that includes all updates and actions related to complaints.
6. Service providers inform complainants of outcomes of internal investigations.
7. The complaint resolution policy and procedures, forms, surveys, guidelines, and resources are designed to adequately capture complaints made by Māori. Service providers consider:
    a. any under-reporting of complaints from Māori
    b. the level of access Māori have to the complaints process.
8. Service providers immediately inform the Antenatal and Childhood Screening (A&CS) at Health New Zealand | Te Whatu Ora (Health NZ) of any serious complaint that may have adverse effects on the programme.

Standard 2: Workforce and structure

Outcome 2

People receive quality UNHSEIP services through effective governance and a supported workforce.

2.1: Governance

I know what it means for me:

The people: I trust the people governing the screening service to have the knowledge, integrity and ability to empower the communities they serve.

Te Tiriti o Waitangi: Honouring Te Tiriti o Waitangi, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational and operational policies.

As service providers: Our governance body is accountable for delivering a high-quality UNHSEIP service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve. (Refer to definition of 'district leadership/governance')

Criteria / Ngā paearu

Governance structure

2.1.1 UNHSEIP district leadership shall ensure service providers' structure, strategic/service delivery plan, performance, UNHSEIP screening participation rates and goals are clearly identified, monitored, reviewed and evaluated at defined intervals.

2.1.2 UNHSEIP district leadership shall evidence leadership and commitment to the quality and risk management system.

2.1.3 UNHSEIP district leadership shall show they understand and use the principles of Te Tiriti o Waitangi, health equity, cultural safety, and tikanga Māori as a core part of how they lead and make decisions.

2.1.4 District leadership shall ensure there is a clinical governance structure in place that is appropriate to the size and complexity of the UNHSEIP service.

2.1.5 UNHSEIP district leadership shall ensure service providers deliver UNHSEIP services that improve screening outcomes and achieve equity for Māori and Pacific peoples.

2.1.6 UNHSEIP district leadership shall ensure service providers deliver UNHSEIP services that improve screening outcomes and achieve equity for Deaf people and tāngata whaikaha (disabled people).

Operational management

2.1.7 UNHSEIP district leadership shall appoint a suitably qualified or experienced person to manage all aspects of the service with authority, accountability, and responsibility for screening service provision.

2.1.8 UNHSEIP district leadership shall have a clearly documented organisational structure that includes the identification of the person/persons who has designated responsibility for the management of all aspects of the UNHSEIP service, and clarification of roles if accountability is shared across more than one person or department.

2.1.9 UNHSEIP district leadership shall ensure accountabilities are consistent with the UNHSEIP service level schedule, current programme policy, UNHSEIP Service Standards (this document) and manuals.

2.1.10 UNHSEIP district leadership shall ensure parents/guardians/whānau are made aware of newborn hearing screening in the antenatal period by establishing and maintaining external working relationships between key health and disability providers in each region, particularly lead maternity carers (LMCs), antenatal educators, primary health care providers (PHCP), Well Child providers and other key stakeholders.

2.1.11 UNHSEIP district leadership shall establish and maintain working relationships between:

1. all departments involved in the provision of UNHSEIP services
2. UNHSEIP providers in other districts, in order to facilitate national consistency of services, sharing of best practice and transfer of babies between regions and districts, and interdistrict flow of babies between neonatal units.

2.1.12 All UNHSEIP-related public communication shall be accurate and consistent with local district policies, and the philosophy of the UNHSEIP. UNHSEIP district leadership shall:

1. inform the Antenatal and Childhood Screening (A&CS), Health New Zealand | Te Whatu Ora (Health NZ) of any media enquiries relating to the programme
2. seek prior written approval from the A&CS to communicate with the media about the programme
3. forward promotional material relating to the programme to the A&CS for review before any public release.

2.1.13 UNHSEIP district leadership shall ensure the use of UNHSEIP branding in programme communications and publications.

Achieving equity

2.1.14 UNHSEIP district leadership shall ensure people with lived experience and professional groups have the opportunity to participate in the planning, implementation, monitoring, and evaluation of the UNHSEIP service.

2.1.15 Service providers shall work in collaboration with the UNHSEIP Advisory Group.

Guidance 2.1: Governance

Governance structure

2.1.1	1. District leadership work with management to meet the requirements of relevant standards and legislation. 2. When updating policies and procedures, service providers should ensure these reflect current standards and legislation as well as compliance. 3. District leadership use data that reflects the communities they serve in planning and delivering services. 4. Organisations have documented plans that include their mission, vision, and goals. 5. Documented plans are reviewed at defined intervals. Organisations are set up to deliver on the outcomes identified in the documented plan.
2.1.2	District leadership: 1. at defined intervals receive reports on quality and risk activity and endorse actions 2. are aware of and understand relevant national guidance on matters that affect the services being delivered (for example, in terms of reducing violence in the workplace) 3. understand the actions that contribute to patient safety 4. at defined intervals receive reports framed by Te Tiriti o Waitangi that relate to equity for Māori.
2.1.3	1. Evidence shows demonstrated expertise in Te Tiriti o Waitangi, health equity, and cultural safety 2. Evidence of training of district leadership members occurs which cover Te Tiriti o Waitangi and tikanga. 3. There is a member on the district leadership who champions Māori health equity as an integral component of quality.
2.1.4	1. A local clinical governance structure is in place for the specific UNHSEIP provider that: a. is multidisciplinary b. looks to national guidance to support development, such as the UNHSEIP Advisory Group and/or Health Quality & Safety Commission's Clinical governance framework (November 2024): Clinical governance framework | Te Tāhū Hauora Health Quality & Safety Commission 2. The clinical governance structure, depending on the size and setting, may be a part of the service provider's district leadership. 3. The UNHSEIP clinical governance members should include: a. audiologist b. screening coordinator c. screener d. maternity quality and safety coordinator/midwife equivalent e. paediatrician (where relevant).
2.1.5	1. Strategic and business planning documents align with: a. Ministry of Health strategies – in particular, He Korowai Oranga: Māori Health Strategy b. the government strategic direction for achieving outcomes for Māori – see Ministry of Health (2014): Equity of Health Care for Māori: A framework | Ministry of Health NZ 2. Service providers collaborate with mana whenua in business planning and service development.

	3. Where service providers do not have a district leadership, they show evidence of taking a meaningful approach to decision making and implementing this criterion so that it is reflected in the services provided. 4. Developing partnerships takes time. Service providers should be able to demonstrate interim solutions to address Māori capability gaps whilst meaningful partnerships are developed.
2.1.6	1. Strategic and business planning documents show evidence that they align with: a. Ministry of Health strategy – in particular, the Disability Support Services Strategic Plan and Ministry of Health (2018) Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan | Ministry of Health NZ b. government strategic direction to achieve outcomes for tangata whaikaha. 2. Tangata whaikaha have meaningful representation on the governance body.
Operational Management	
2.1.7 – 2.1.9	1. Managers appointed have appropriate qualifications, skills and experience for programme requirements. 2. Persons responsible for co-ordination of District UNHSEIP services shall be familiar with the Screener Manual, the Coordinators Manual and all relevant service policies, procedures, guidelines and standards, including the UNHSEIP Service Standards. 3. Service providers have processes in place to ensure that during the temporary absence of the manager there are appropriate resources, expertise or equipment to meet normal volumes/activities. 4. Organisational structure (organisational chart) includes the identification and accountability if of a shared management role. 5. There is a clearly documented multidisciplinary management and governance structure for UNHSEIP services, with clearly defined Terms of Reference which include: a. responsibilities and accountabilities of specific individuals, groups and/or committees and the relationship between them b. representation from relevant consumer and professional groups on any advisory and/or management groups c. clear delineation of the relationships and responsibilities of clinical and non-clinical staff. 6. Where a District subcontracts to another provider to deliver UNHSEIP services this must be consistent with the requirements outlined in the UNHSEIP Service Agreement.
2.1.10 – 2.1.11	Service providers: 1. have strategic plans that include collaboration with key health and disability providers in each region where they are available. These may include: a. LMCs b. antenatal educators c. primary health care providers (PHCP) d. Well Child providers e. Māori and/or Pacific providers or organisations. 2. demonstrate active collaboration with key health and disability providers to ensure newborn hearing screening is offered to parents/guardians/whānau of all eligible babies 3. have processes in place for the service to be notified of births by maternity services, local birthing units, lead maternity carers (LMCs) and other key providers

	4. have strategic plans that include collaboration with all departments that provide UNHSEIP services, including audiology, paediatrics, etc. 5. have strategic plans that include collaboration with other districts at national UNHSEIP meetings, etc. 6. demonstrate attendance at meetings 7. agendas and meeting minutes for any meeting relating to the delivery of UNHSEIP services must be kept in accordance with local record keeping requirements.
2.1.12 – 2.1.13	Service providers: 1. have processes in place to ensure UNHSEIP-related media enquiries and other communications follows local district and UNHSEIP policies 2. use UNHSEIP branding for media and communication to key providers, parents/guardians/whānau so it is recognised as official communications from the UNHSEIP.
Achieving Equity	
2.1.14	Service providers: 1. collaborate with the community on business planning and service development 2. use a variety of avenues to invite Māori members onto their Boards or, for smaller services, to provide executive leadership direction and advice. 3. are recommended to reach out to their local mana whenua or local Iwi and Māori communities, noting that not all Māori will identify with the local Iwi. 4. provide evidence of planning, developing, maintaining, and sustaining these partnerships. 5. have clear processes for gathering feedback: through surveys, complaints processes, or informal discussions. 6. district leadership membership includes expertise from people with lived experience. 7. service providers and their governance bodies report to, and are accountable to, people receiving services. They have implemented systems to evidence this practice. 8. could appoint a person receiving services to a position of 'person with lived experience' or 'consumer advisor' or similar. **9.** could appoint a Deaf whānau member to a position of Deaf Culture whānau advisor or similar. 10. include Pacific families for regions/districts with high concentration of Pacific population. Refer to: Yavu-Booklet.pdf Evidence: People with lived experience of the service state that they are involved in important decisions about service delivery.
2.1.15	Service providers: 1. work in collaboration with the national UNHSEIP Advisory Group as required 2. participate in working groups to provide advice on specific clinical and technical aspects of UNHSEIP development. *Refer to definition for scope and terms of reference for the UNHSEIP Advisory Group.*

2.2: Quality and risk

I know what it means for me:

The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.

Te Tiriti o Waitangi: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.

As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the UNHSEIP services and our health care and support workers.

Criteria / Ngā paearu

Quality and risk management

2.2.1 Service providers shall ensure the quality and risk management system has commitment from the district leadership and has input from the workforce and people using the service.

Quality management systems

2.2.2 Service providers shall implement their organisational quality management framework using a risk-based approach to improve service delivery and care.

2.2.3 Service providers shall ensure the development and implementation of a district UNHSEIP quality plan which includes:

1. regular assessment of management systems, policies, procedures and guidelines
2. systems and processes to assess continuous quality improvement activities
3. regular review to ensure the plan remains relevant
4. responsibilities and accountabilities for meeting quality standards.

2.2.4 Service providers shall ensure that their quality systems provide:

1. local programme data for quality assurance and improvement purposes
2. strategic oversight and accountability for UNHSEIP service quality assurance and improvement activity
3. quality management/improvement processes that are documented, implemented, evaluated and reported
4. routine internal monitoring of newborn hearing screening and audiology data, as per service level schedules (or other formal agreement with UNHSEIP)
5. auditing and reporting capabilities to meet A&CS requirements
6. results of UNHSEIP key performance indicators to the local UNHSEIP team each quarter.

2.2.5 Service providers shall:

1. have in place policies, procedures and guidelines to ensure that all services delivered for the UNHSEIP are consistent with the UNHSEIP Service Standards (this document)

2. review these documents as appropriate to ensure they are consistent with the requirements of the UNHSEIP
3. have in place effective document control processes.

2.2.6 Service providers shall ensure there are formal mechanisms for collecting feedback from parents/guardians/whānau to evaluate their experience of participation in the UNHSEIP.

Continuous quality improvement

2.2.7 Service providers shall evaluate progress against their defined continuous quality improvement activities, screening and audiology outcomes and the monitoring requirements of the UNHSEIP Service Standards (this document).

2.2.8 Service providers shall monitor and report quality outcomes and management to achieve the core '1-3-6' goals of the UNHSEIP (based on the corrected age):

1 = Babies to be screened by 1 month of age

3 = Audiology assessment completed by 3 months of age

6 = Initiation of appropriate medical and audiological services, and early intervention including education support services, by 6 months of age.

2.2.9 Where targets are not being met or where issues with any other aspect of service delivery are identified, service providers shall:

1. undertake quality assurance or audit activities to identify causes of the issue/s
2. implement any remedial actions or quality improvement activities to ensure the issue/s are addressed
3. ensure that all staff involved in delivering UNHSEIP services are informed of the issues and changes implemented
4. evaluate and report as to whether the changes implemented have been successful in addressing the issue/s
5. prepare a written report which documents the issue/s, changes in practice that are adopted and an evaluation of the effectiveness of the intervention.

2.2.10 Service providers shall identify external and internal risks, including potential inequities, and develop a plan in collaboration with the A&CS to respond to the risks.

2.2.11 Service providers shall include business continuity as part of their risk planning processes to minimise the risk of service disruption following risks or threats, which may include pandemic, natural disaster, episodes of extended leave, sickness or the resignation of the key roles that are crucial to the day-to-day operation of the programme.

2.2.12 Service providers shall improve health equity through critical analysis of organisational practices.

Quality systems

2.2.13 Service providers shall have internal quality systems that identify and minimise errors and potential sources of error in screening and audiology activities.

2.2.14 Audiology providers shall monitor wait times from screening to first audiology appointment and put in place corrective actions to achieve the UNHSEIP target.

Adverse events reporting

2.2.15 Service providers shall implement the National Adverse Events Policy, which includes the identification, reporting, investigation, analysis, action, feedback and open disclosure of incidents and adverse events.

Refer to the Health Quality and Safety Commission (HQSC) website.

2.2.16 Service providers shall at the earliest opportunity:

1. inform the A&CS manager of any adverse event in writing using an incident notification form available from the A&CS
2. inform the A&CS team of any near misses via**:** UNHSEIPadmin@tewhatuora.govt.nz**.**

Where programme quality has been compromised as a result of an adverse event or near miss, the A&CS and service provider shall work together to agree on a corrective action process that may include review by a designated party.

Essential notification reporting

2.2.17 Service providers shall understand and comply with statutory and regulatory obligations in relation to Essential Notification reporting.

2.2.18 Screening providers shall ensure screening data is submitted to A&CS as per the agreed timeframe (district specific).

2.2.19 Audiology providers shall ensure relevant audiologic records are submitted to A&CS as per the agreed timeframe (district specific) including:

1. for all audiology assessments undertaken for babies referred through the UNHSEIP, the UNHSEIP Diagnostic Assessment data forms, or electronic equivalent, shall be fully and accurately completed before submission.
2. timely submission of babies' records for those:
    a. who have started but not completed audiology assessment
    b. not assessed due to Did Not Attend (DNA)/decline/transfer/deceased.

2.2.20 If an audiology provider is unable to meet any UNHSEIP DAP requirements for babies referred to them through the UNHSEIP, the audiology provider shall:

1. raise this with the A&CS as soon as possible
2. working in collaboration with the A&CS to review documentation and clinical records involving any such departures from the protocol
3. Work with the A&CS to ensure appropriate remediation effort is put in place.

Guidance 2.2: Quality and Risk

Quality and risk management

2.2.1

1. Service providers demonstrate evidence of:
    a. discussion at district leadership meetings that review quality and risk indicators
    b. checking progress on key performance indicators
    c. presentation of newborn hearing coverage and monitoring data, including Māori health indicators that reflect whānau participation and Māori satisfaction with the service
    d. feedback to health care and support workers and documented links to the district leadership
    e. parents/guardians/whānau having input into the quality and risk management system
    f. a record of outcomes and agreed actions
    g. feedback to parents/guardians/whānau about outcomes from the quality framework, including experience of care and service feedback from parents/guardians/whānau.
2. Service providers have escalation mechanisms.

Quality management systems

2.2.2

1. Service providers use quality domains in their quality framework that are:
    a. safe, noting that cultural safety is part of the whole concept of safety for all people receiving health and disability services, ensuring engagement of Māori and Pacific peoples
    b. timely
    c. equitable, which includes equal access, equal experience of care, and equal outcomes of care
    d. effective
    e. efficient
    f. people- and whānau-centred.
2. Service providers' quality frameworks encompass:
    a. systems thinking
    b. leadership for improvement and positive change
    c. quality improvement and patient safety knowledge
    d. evidence-based improvement and innovation
    e. teamwork and communication.
3. Service providers' quality management systems include:
    a. performance evaluation through monitoring, measurement, analysis, and evaluation
    b. a programme of internal audit
    c. a process for identifying and addressing corrective actions.
4. Service providers can refer to the Health Quality & Safety Commission quality domains, which are embedded into a framework that provides a structure to improve and enhance quality of care. This framework consists of four components:
    a. consumer engagement and participation – enabling people and whānau as active members of the health team
    b. clinical effectiveness – evidence-based decision making derived from research and people's experience to focus improvement

	c. quality improvement and patient safety – increasing the capabilities of everyone participating in the health workforce in quality and safety improvement appropriate to their role and sphere of work d. engaged effective workforce – an engaged, effective workforce that works in partnership with people and actively participates in an ongoing process of self and peer review.
2.2.3 – 2.2.4	1. Service providers have a district UNHSEIP quality plan which is reviewed at regular intervals and includes: a. personnel responsible for quality assurance are clearly identified b. regular quality assurance or audit activities to identify causes of the standards not being met c. implement any remedial actions or quality improvement activities to ensure any issue/s are addressed and all staff involved are informed of the issues and changes implemented d. evaluate and report as to whether the changes implemented have been successful in addressing the issue/s. Copies of reports shall be forwarded to UNHSEIP and district leadership team (as appropriate). 2. Service providers: a. monitor and report on newborn hearing screening quality outcomes, targets and indicators to meet the core '1-3-6' goals of the UNHSEIP b. undertake quality assurance or internal audit activities to achieve the core goals c. demonstrate they monitor and report on monitoring indicators for screening and audiology assessments as per service level schedules d. include these in their service quality plans.
2.2.5 – 2.2.6	1. Service providers implement and maintain a current document control system 2. Service providers: a. have clear processes for gathering feedback: through surveys, complaints processes, or informal discussions b. analyse feedback regularly to identify patterns or recurring barriers for specific groups (e.g., Māori, Pacific, Deaf people, tāngata whaikaha (disabled people), transgender, Rainbow, and rural communities) c. use this feedback to inform future service planning and improvements, especially when designing policies, appointment systems, communication methods, or outreach activities d. where possible, work in partnership with parents/guardians/whānau, and community groups to co-design solutions e. document actions taken in response to feedback so they can be monitored and reviewed. 3. Service providers: a. evidence continuous quality improvement activities are discussed at district leadership and management team meetings b. implement and maintain an internal audit plan.
Continuous Quality Improvement	
2.2.7 – 2.2.9	1. Service providers are involved in continuous quality improvement activity, planning, and reporting progress on actions. 2. Service providers can evidence:

	a. improvement activity b. informed data analysis, including quality safety markers c. that quality and safety risk policies and procedures provide indicative time frames for corrective actions and reporting progress. 3. Service providers: a. implement any remedial actions or quality improvement activities if targets are not met b. evaluate and report as to whether the changes implemented have been successful in addressing the reasons targets are not met. Copies of reports shall be forwarded to UNHSEIP and district leadership team (as appropriate).
2.2.10 – 2.2.11	Service providers 1. undertake an internal and external risk assessment within defined intervals, or in response to level of risk 2. demonstrate that quality improvements are made and embedded into practice as a result of incidents, adverse events, complaints, and investigations, among other factors 3. include business continuity as part of their annual risk planning processes to minimise the risk of service disruption following risks or threats.
2.2.12	Service providers: 1. establish policies, practices, and training that will support and require their health care and support workers to review at defined intervals their organisation's practice through a health equity and quality lens 2. examine the interacting impacts of rurality, ethnicity, disability, and socioeconomic deprivation on screening outcomes and the use of a range of outpatient hearing clinics and inpatient services 3. evaluate how people move between urban and rural areas post discharge, especially Māori; and the overall per capita cost of providing UNHSEIP to rural and urban areas 4. evaluate if organisational practices meet high-quality, efficient, and equitable screening coverage for all newborns.
Quality systems	
2.2.13	Screening providers: 1. have internal quality assurance activities which include routine monitoring of completed screening forms and individual screener data downloaded from the screening equipment 2. maintain a current register of screener competency.
2.2.14	Audiology providers: 1. have internal quality assurance activities which include routine monitoring of audiology wait times from screening to first audiology appointment 2. have internal quality assurance activities which include effective review of individual audiologist performance to measure the quality of audiology services 3. maintain a current register of audiologist competency.
Adverse events reporting	
2.2.15	1. The purpose of the National Adverse Event Reporting Policy is to contribute to improved quality, safety, and experience of health and disability services through systems that: a. are safe b. are people- and whānau-centred c. provide for early identification and review of adverse events

d. verify lessons are learnt

a. demonstrate public accountability and transparency.

2. The policy supports a national approach to reporting, reviewing, and learning from adverse events and near misses, and is based on the following six key principles. (For more information, see Health Quality & Safety Commission (most up to date) National Adverse Events Reporting Policy

   a. Open communication

      i) Affected people are offered immediate support and an appropriate apology.

      ii) Affected people are informed of process and time frames and have the ability to provide comment on the draft review and final report.

      iii) A contact person for whānau is provided and there is an agreed regular communication process regarding review progress, and progress with review recommendations once the review is complete.

      iv) People receive a copy of the final review report and are appropriately supported.

   b. Consumer participation

      i) People who have been involved in an adverse event will be offered the opportunity to share their story as part of the review process.

      ii) Review findings and recommendations will be shared with them.

      iii) Independent representatives who have experience using the health and disability service are involved in the review process.

   c. Culturally appropriate review practice

      i) Hui process is followed as appropriate.

      ii) Reports have language at a level suitable for all to understand; that is, free of health and disability related jargon.

      iii) Service providers demonstrate they use culturally appropriate practices such as restorative practice.

   d. System changes

      i) Service providers demonstrate reviews are focused on system learnings.

      ii) Lessons learnt are shared locally and with other providers.

      iii) Deidentified copies of adverse event reports are sent to the Health Quality & Safety Commission to support national learnings, and for sharing with others such as the Health and Disability Commissioner and Coronial Services.

      iv) Reports state how the implementation of recommendations will be measured.

   e. Accountability

      i) There is evidence of learning, improving safety, and reducing the possibility of adverse events recurring.

      ii) Service providers demonstrate that the outcomes of internal reviews are communicated to all parties in an accessible format and the style of feedback is suitable to the person receiving services.

      iii) Evidence shows that processes are in place to verify Service providers implement and follow up recommendations; for example, providers have a recommendations action plan.

      iv) Adverse event review reports state who is the accountable person for the implementation and evaluation of the recommendations.

   f. Reporting must be safe

i) Service providers identify the immediate actions taken to mitigate risk to people receiving services.

ii) The review focuses on determining the underlying system failures and not blaming or punishing individuals.

a. Service providers update and implement operating policies and procedures to reflect a 'just and fair' culture of adverse event reporting and management.

b. Service providers support health care and support workers throughout the investigation.

c. Service providers implement a health care and support worker support programme, which may include debriefing.

d. Service providers understand statutory and regulatory obligations in relation to essential notification reporting and notify the correct authority where required.

For more resources, see HQSC website: Health Quality & Safety Commission | Health Quality & Safety Commission Te Tāhū Hauora

2.2.16

Service providers:

1. implement an adverse event management process to meet UNHSEIP requirements
2. Serious adverse events are reported in writing to the UNHSEIP at the earliest opportunity
3. Service providers have incident management processes that also addresses the following as result of an adverse event or near miss:
   a. corrective actions where programme quality has been compromised
   b. employment of personnel who do not meet the necessary requirements
   c. accidents, incidents, near misses and clinical events
   d. other reportable serious events, as indicated by legislation, regulation, professional practice standards and contracts.

Essential notification reporting

2.2.17

Essential notifications are a range of notification requirements that service providers must report. They include, but are not limited to:

1. those outlined in legislation, such as Section 31 of the Health and Disability Services (Safety) Act, The Fire and Emergency New Zealand Act
2. those required through regulation by other agencies such as WorkSafe for injuries/exposures under the Health and Safety at Work Act 2015
3. Public Health for notifiable and communicable diseases, or Responsible Authorities
4. ionising radiation incidents/exposures involving patients/not involving patients: under the Radiation Safety Act 2016, an incident that has resulted in unintended loss or release of radiation, or overexposure of a person to radiation, must be notified to the Director of the Office of Radiation Safety as soon as practicable
5. informed consent breaches or ethical issues is reported to relevant regulatory or ethics bodies
6. data breaches or cyber security incidents are notified to the Office of the Privacy Commissioner under the Privacy Act 2020 (if the breach is notifiable)
7. notifications to Māori health partners and SSS providers in alignment with equity and partnership obligations.

2.2.18 – 2.2.20

1. Service providers submit screening and audiology data that is accurate and complete, and sent to Antenatal and Childhood Screening as per the agreed timeframe.
2. Audiology providers comply with UNHSEIP DAP except in special circumstances. Any deviation from protocol requirements are reported to A&CS as soon as possible.

2.3: Service management

I know what it means for me:

The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.

Te Tiriti o Waitangi: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.

As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred UNHSEIP services.

Criteria / Ngā paearu

Operations

2.3.1 Service providers shall ensure there are sufficient health care and support workers to provide culturally and clinically safe services.

2.3.2 Service providers shall ensure there are systems that promote the wellbeing of health care and support workers, and create a positive work environment.

2.3.3 Service providers should work towards recruiting and retaining a Deaf health workforce in the UNHSEIP.

2.3.4 Service providers shall ensure that, during a temporary absence of the key UNHSEIP roles, the service provider shall have in place a clear process which ensures:

1. the availability of appropriately trained and designated replacements
2. the level of resources and expertise provided by the service is appropriate to meet normal volumes/activities.
3. the "return to work" competency requirements are met, and extra training supported as required.

Temporary absence includes, but is not limited to illness, leave and position vacancy. Key roles include service manager, coordinator, screener(s) and audiologist(s).

Where the absence extends beyond four weeks, the A&CS is notified so the district/service provider can work with A&CS to mitigate any potential or actual risks to the programme. Notification to A&CS shall be much earlier if there are any concerns or issues that may impact the safe delivery of the programme.

Competency and professional development

2.3.5 Service providers shall ensure their health care and support workers have the skills, attitudes, qualifications, experience and attributes for the service being delivered.

2.3.6 Service providers shall implement systems to determine and develop the competencies of health care and support workers to meet the needs of people equitably.

2.3.7 Service providers shall ensure there is a system to identify, plan, facilitate and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.

2.3.8 Service providers shall establish environments that encourage collecting and sharing of high-quality Māori health information.

Screener competency and professional development

2.3.9 Screening providers shall ensure all UNHSEIP screeners:

1. pass Newborn Hearing Screening initial training and assessment by UNHSEIP appointed trainer
2. complete Health NZ orientation and mandatory training modules for allied health professionals
3. pass the New Zealand National Certificate in Health and Wellbeing (Level 3) Newborn Hearing Screening Strand, or its equivalent, within one year of employment
4. achieve competency required in the Annual Competency Exercise (ACE) guidelines. Refer to UNHSEIP Coordinator Manual.

2.3.10 Screening providers shall implement systems to ensure screeners maintain the necessary skill level and competence which include:

1. screeners' individual competence assessed in accordance with the UNHSEIP Screener Competency Framework (and its revisions and updates)
2. internal quality assurance activities including routine monitoring of completed screening forms, referral rates, adherence to protocol, and individual screener data downloaded from screening equipment consistent with the guidelines 'Monitoring and Reporting for the UNHSEIP'
3. a register of screener competency assessments maintained by the screening service manager/programme coordinator.

2.3.11 Screening providers shall ensure training for hearing screeners includes content about Deaf culture and resources available to understand the UNHSEIP pathway.

2.3.12 Screening providers shall implement systems to ensure approved trainers of screeners maintain the necessary skill level and competence defined in the UNHSEIP Screener and Coordinator manuals.

Audiologist competency and professional development

2.3.13 Audiology providers shall ensure audiologic assessment and amplification services within the UNHSEIP are carried out by appropriately trained and competent audiologists who meet UNHSEIP requirements. Paediatric audiologists working in the UNHSEIP shall have either:

1. a New Zealand Master's degree in audiology or its equivalent, as assessed by the New Zealand Qualifications Authority (or other approved external organisations) or
2. an audiology postgraduate qualification and have passed an equivalency exam approved by the New Zealand Audiological Society.

2.3.14 Audiology providers shall ensure audiologists for paediatric screening services working in the UNHSEIP shall:

1. comply with the New Zealand Audiological Society Paediatric Certification requirements
2. have either completed or be in the process of completing a recognised New Zealand clinical competency programme that includes the diagnosis and habilitation of babies and children
3. be aware of the UNHSEIP Service Standards
4. meet professional code of ethics

5. complete Health NZ district orientation and mandatory training modules for allied health professionals.

2.3.15 Audiology providers shall implement systems that require appropriately qualified audiologists to supervise and ensure the competency of audiology assistants, audiometrists, or other staff providing support services where this is within their scope of practice.

Guidance 2.3: Service management

Operations

2.3.1

1. Service providers' documented rationale for providing culturally and clinically safe services and its implementation demonstrate:
   a. how shortfalls in health care and support workers' capacity and capability are managed
   b. a link to the quality and risk management framework that meets the required needs for safe and appropriate levels of service
2. Service providers demonstrate a commitment to:
   a. succession planning
   b. leadership and workforce development.
3. Service providers meet their contractual requirements.

2.3.2

1. In determining a safe and effective workforce, service providers have health and safety policies in place.
2. Workforce engagement surveys may be implemented to receive feedback on levels and skill mix, wellbeing and work environment.
3. Training, support, performance and competence of health care and support workers are related to legal obligations for a healthy work environment.
4. Service providers provide safe systems of work for health care and support workers (section 36, Health and Safety at Work Act 2015). Refer also to Te Mauri o Rongo (New Zealand Health Charter).

2.3.3

1. Service providers:
   a. actively recruit, appoint, and retain Deaf people in service roles
   b. acknowledge the value of Deaf language and cultural expertise in their workforce.

2.3.4

1. Position descriptions for designated lead roles and qualified health care and support workers reflect required mandatory key roles to be appointed to provide safe and high-quality UNHSEIP services: this includes those in the clinical multidisciplinary team.
2. Service providers demonstrate a commitment to:
   a. provide appropriate resources and expertise is available at all times to meet UNHSEIP targets and timeframes
   b. business continuity during temporary absence of key UNHSEIP roles
   c. work collaboratively with A&CS to mitigate any risks during prolonged absences of key roles.

Competency and professional development

2.3.5

1. Position descriptions reflect expected positive behaviours and values.
2. Descriptions of roles cover responsibilities and additional functions, such as holding a hearing coordinator or infection prevention portfolio.

	3. Recruitment practices meet current best practice, including through actively recruiting and retaining Māori, Pacific peoples and Deaf health care and support workers. 4. Service providers proactively support workers to work within their scope of practice and speciality practice. 5. Service providers support access to mandatory and other relevant training. 6. Service providers are aware of requirements in relevant legislation such as the Health Practitioners Competence Assurance Act 2003. 7. Service providers support Māori health care and support workers with targeted cultural and professional development opportunities.
2.3.6	Service providers consider: 1. developing a plan to enhance competencies that may be required when they extend their services. This plan should be linked to current business planning that would include the type of service, equipment required, the workforce, and people receiving services 2. surveying the workforce and community to determine new requirements 3. the cultural make-up of health care and support workers and people. This includes actively recruiting and retaining a Māori workforce.
2.3.7	1. Service providers establish a continuing education programme for the workforce. 2. Service providers have implemented policies and procedures that address the need for workers to be released from work for education and learning. 3. Service providers support Māori and Pacific health care and support workers to meet cultural and professional development needs. 4. All health care and support workers attend mandatory training. 5. Credentialling is in place for relevant professionals. 6. Service providers maintain a training register.
2.3.8	1. Service providers: a. encourage health care and support workers (at individual and team levels) to participate in learning opportunities that provide them with the most recent literature on Māori health outcomes and disparities, health equity, and quality, and enable them to use this evidence and learn with their peers b. support the development of expertise in te reo Māori for all health care and support workers c. support health care and support workers to build their own knowledge of how they can effectively provide health information for Māori. 2. Service providers give health care and support workers the opportunity to reflect on their own cultural assumptions about Māori, and how these might influence their capacity to provide high-quality care.
Screener competency and professional development	
2.3.9 – 2.3.12	1. For UNHSEIP screener roles, service providers: a. implement systems to provide ongoing education or training for individuals and participation in mandated training modules within timeframes b. implement systems to provide ongoing competency and participation in internal quality assurance activities c. maintain registers of screener competency assessments d. provide training about Deaf culture to better understand the UNHSEIP pathway e. monitor and feedback on individual clinical roles so they are qualified to work in the UNHSEIP service and meet the UNHSEIP Service Standards.

	2. Service providers implement systems to provide ongoing education or training for approved trainers of screeners in collaboration with A&CS.
Audiologist competency and professional development	
2.3.13 – 2.3.15	Audiology providers: 1. implement strategies and systems to monitor individual audiologist's performance for those involved in audiology assessment and amplification services for the UNHSEIP 2. implement strategies and systems for the supervision of new audiologists on the provisional paediatric registration pathway 3. any performance issues are notified to the lead audiologist 4. implement systems for to provide supervision and ongoing training to ensure competency of audiology assistants, audiometrists, or other staff providing support services. 5. personnel for support services include those assisting with Behavioural Observational Audiometry (BOA), Visual Response Audiometry (VRA), Conditioned Play Audiometry (CPA), distracting during Real Ear Coupler Difference (RECD) measurements, taking ear impressions and fitting ear moulds.

2.4: Health care and support workers

I know what it means for me:

The people: People providing support have knowledge, skills, values and attitudes that align with my needs. A diverse mix of people in adequate numbers meets my needs.

Te Tiriti o Waitangi: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.

As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care, and UNHSEIP services.

Criteria / Ngā paearu

Credentialling

2.4.1 Professional qualifications shall be validated prior to employment, including evidence of registration and scope of practice for health care and support workers.

2.4.2 Service providers shall ensure the skills and knowledge required of each position for health care and support workers in the UNHSEIP are identified, and documentation of the accountability, responsibilities, authority, functions and outcomes to be achieved in each position.

Orientation and induction

2.4.3 Health care and support workers shall receive an orientation and induction programme that covers the essential components of the services provided.

2.4.4 Screening providers shall ensure all newborn hearing screeners are employed by the district/screening provider, which is funded by Health NZ.

2.4.5 Audiology providers shall ensure audiologists new to UNHSEIP (without a paediatric certificate) shall be supervised by an audiologist with paediatric certification until they achieve their own paediatric certification.

Performance review

2.4.6 Health care and support workers shall have the opportunity to discuss and review their performance at defined intervals.

2.4.7 Annual performance appraisal for coordinators shall include:

1. discussion of objectives for the coming year
2. individual practice of the coordinator
3. operational and strategic leadership at district level
4. meeting screening targets and reporting, as required to ensure UNHSEIP quality and integrity
5. all other requirements set out in the UNHSEIP Coordinator Manual.

2.4.8 Audiology providers shall establish and demonstrate that processes are in place that enable effective review of audiologists' performance to ensure quality in audiology service provision including:

1. regular peer review of all audiologists working with babies referred from UNHSEIP
2. forums or clinical networks for regular discussions of cases between audiology colleagues and other team members
3. evaluation, audit and/or benchmarking of individual audiologist service provision
4. 100% chart review of ABR assessments.

Guidance 2.4: Healthcare and support workers

Credentialling

2.4.1 – 2.4.2

1. Service providers:
   a. have a documented and implemented recruitment procedure that includes interviewing, reference checking, worker safety checking, criminal record-checking, and providing an employment agreement that complies with relevant legislation. Relevant legislation may include the Children's Act 2014
   b. validate professional qualifications as part of the employment process and annually after employing each health care and support worker where applicable to their role.
2. Evidence shows that service providers have:
   a. an identified clinical lead who is responsible for clinical oversight and outcomes for the people receiving services
   b. position description statements with equity statements about recruiting Māori health care and support workers and those who have competency in te reo Māori.
3. Service providers recognise cultural skills to support different models of care.
4. Service providers may adopt a skills framework.

Orientation and induction

2.4.3

1. Service providers demonstrate that their orientation and induction programmes incorporate te reo Māori, and actively promote it throughout the organisation and workforce.
2. Service providers demonstrate that the orientation and induction programmes cover their health care and support workers to provide a culturally safe environment to Māori.
3. Service providers demonstrate new employees are provided with the knowledge and skills they need to become effective members of the UNHSEIP. Provide evidence of onboarding programme specific to the UNHSEIP. This may include the following:
   a. overview of UNHSEIP
   b. programme goals and importance of newborn hearing screening
   c. pathway from screening to diagnostic audiology and early intervention
   d. UNHSEIP Service Standards, relevant manuals and protocols
   e. role and responsibilities of healthcare and support workers within the programme
   f. role of the UNHSEIP within the district maternity service provision
   g. role of the UNHSEIP programme management team at A&CS.

	4. Service providers ensure health care and support workers are competent and have good understanding of the specific expectations and responsibilities, and requirements in the UNHSEIP protocols and manuals specific to their roles. 5. Where they use volunteers, service providers have an implemented policy on their recruitment, induction, and ongoing training. 6. Where they use bureau staff, service providers have an implemented policy around the use of these staff and the competency requirements that bureau staff must meet before working for the service provider. 7. Refer to the UNHSEIP protocols and manuals that specify the mandatory and qualified designated roles for health care and support workers working in the UNHSEIP service.
2.4.4	1. Screening providers have implemented policies in place to ensure all newborn hearing screeners are employed by the district/screening provider, which is funded by Health NZ. 2. Review of screeners' contracts reflect their employment status with the provider.
2.4.5	1. Audiology providers implement strategies and systems for the supervision of audiologists new to UNHSEIP (without a paediatric certificate) on the provisional paediatric registration. Supervision is provided by audiologists that are suitably qualified in the provision of audiology assessment and amplification services for the UNHSEIP.
Performance review	
2.4.6	1. Service providers have a performance management policy. 2. Appropriately trained staff complete performance reviews. 3. In the case of performance management, health care and support workers may have access to independent support. 4. Service providers undertake performance/goal-setting reviews at defined intervals. 5. Service providers use performance reviews to identify and support opportunities for professional development.
2.**4.7 – 2.4.8**	1. Service providers demonstrate: a. continuing education and professional development is at a frequency specified in their continuing education programme, and supported by associated policies b. Individual practice of screeners and coordinators are appraised annually c. continuing education and professional development for health care and support workers incorporate Te Tiriti o Waitangi and cultural safety training, including Deaf culture d. continuing education and professional development specific to the UNHSEIP service programme to provide a culturally safe environment to Māori, Pacific, Deaf, priority and other diverse populations. 2. Service providers maintain a training register.

2.5: Information

I know what it means for me:

The people: Service providers manage my information sensitively and in accordance with my wishes.

Te Tiriti o Waitangi: Service providers collect, store and use quality ethnicity data in order to achieve Māori equity.

As service providers: We ensure the collection, storage and use of personal and health information of people using our UNHSEIP services is accurate, sufficient, secure, accessible and confidential.

Criteria / Ngā paearu

Information management systems

2.5.1 Screening and audiology records shall comply with relevant legislation, health information and privacy standards and codes, and professional guidelines.

2.5.2 Service providers shall maintain an information management system that:

1. ensures the captured data is collected and stored through a centralised system to reduce multiple copies or versions, inconsistencies, and duplication
2. makes the information manageable
3. ensures the information is accessible for those who need it
4. complies with relevant legislation
5. integrates health and support records where appropriate.
6. ensures strong, culturally appropriate, and legally compliant data stewardship which is cognisant of data sovereignty and Māori data sovereignty principles.

2.5.3 Parents/guardians/whānau shall be informed about how information collected as part of the UNHSEIP shall be stored and used, and who is able to access it.

2.5.4 Service providers shall meet the security and backup requirements specified by Health New Zealand national standards in regard to UNHSEIP records.

Data integrity - Screening

2.5.5 Screening providers shall ensure that all UNHSEIP screening data is complete and accurate. Data must be sent electronically, at a minimum monthly, to the A&CS.

1. Patient screening information, including gestational age and results, must be captured. Ethnicity data must be collected according to HISO 10001:2017 (or subsequent editions), based on baby's ethnicity as declared by their parent/guardian/whānau.
2. Datamart reports sent to screening providers by the A&CS shall be completed and returned within an agreed timeframe (within two weeks to one month).

Data integrity - Audiology

2.5.6 Audiology providers shall ensure that audiology data for UNHSEIP audiology assessments are accurate and reliable. This shall include:

1. audiologic records that are consistent with the UNHSEIP DAP
2. records that are sufficient to facilitate consultative, clinical review and case conferencing, and are available to the A&CS on request

3. assessment and amplification records maintained in electronic and/or hard copy
4. an effective system of retrieval of records is maintained
5. appropriate and timely information is provided to PHCPs, ENT, paediatricians and Well Child providers.

2.5.7 Audiology providers shall ensure all data for UNHSEIP referred audiology assessments are submitted to the A&CS using the required format and systems.

Data used for research purposes

2.5.8 Service providers shall ensure research projects related to UNHSEIP shall be managed in consultation with the A&CS. This shall include:

1. the programme leader at A&CS is notified of any proposed research activity that uses UNHSEIP data or information prior to its commencement. The A&CS may seek feedback from the UNHSEIP Advisory Group about the proposed research activity prior to its commencement.
2. research projects are managed in accordance with relevant legislation and professional standards and approved by a human ethics committee.
3. for requests to use UNHSEIP data held by the A&CS, the Antenatal and Childhood Screening Programmes Application Form shall be completed. Enquiries regarding applications shall be sent to: UNHSEIPadmin@tewhatuora.govt.nz.

Guidance 2.5: Information

Information management systems

2.5.1

1. Service providers meet whole-of-government standards for collecting disability data.
2. Records are uniquely identifiable, legible, timely, signed, and dated, and include the name and designation of the service provider, following professional guidelines and sector standards.
3. Service providers only hold information about people that is relevant for safe support.
4. Sometimes the use of a person's previous name can be psychologically harmful. Service providers record people's preferred names and pronouns on documents related to the services they receive. Records of previous names people were known by are kept private. See Stats NZ standards and policies: Sex – Classification and Statistical Standard, Gender Identity – Classification and Statistical Standard, Data Protection and Use Policy.
5. People receiving services are able to request and review their records in accordance with privacy laws, and service providers give them their records in a format accessible to the person concerned.
6. Service providers have consent processes in place for data collection.
7. Service providers collect, record, and use ethnicity data in accordance with HISO 10001 2017: Ethnicity Data Protocols.
8. Service providers include an ethnicity audit as part of the internal audit programme, using a tool such as the ethnicity data auditing tool (EDAT).

2.5.2

1. The information management system complies with the:
    a. New Zealand Public Health and Disability Act 2000
    b. Health Act 1956

	c. Health Information Privacy Code 1994 d. Privacy Act 2020 e. Official Information Act 1982 f. Cancer Registry Act 1993 and Cancer Registry Regulations 1994 g. Public Records Act 2005 h. Health (Retention of Health Information) Regulations 1996. 2. When sharing personal information including Māori data, service providers consider how data access, sharing and protection practices reflect Māori rights over the information. Developed by Te Kāhui Rauranga, the Māori Data Governance Model is a foundational resource for Health NZ in data collection, data use and data sharing practices for Māori data. The model and its eight pou provide a rich set of practices for the ethical treatment of Māori data. 3. An overarching policy and related procedures govern a service provider's information management system. 4. Records are uniquely identifiable, legible, timely, signed, and dated, and include the name and designation of the health care and support worker, following professional guidelines and sector standards. 5. Service providers keep private information in a secure manner, ensuring it is unable to be publicly accessed or observed. 6. Service providers implement guidance relating to managing electronic information including social media, use of images, and emails. 7. Service providers follow the required procedures for the minimum duration of storage of people's records, as regulated under the Health Information Functional Disposal Authorities (FDA) (Department of Inland Affairs – National Archives). 8. Service providers maintain high-quality, complete ethnicity data consistent with HISO 10001 2017: Ethnicity Data Protocols. 9. Service providers use ethnicity data audit tools 10. Service providers use optional data fields to recognise the identities of people from rainbow communities to support equitable and high-quality health and support outcomes for people from these communities.
2.5.3	Service providers: 1. have documented processes for obtaining informed consent from parents/guardians/whānau 2. demonstrate parents/guardians/whānau have provided consent for the collection of information about their baby and this is clearly documented in baby's and other clinical records 3. parents/guardians/whānau state they were informed about how information collected is stored, used and who is able to access it before they gave consent.
2.5.4	Service providers are responsible for: 1. the overall data quality and consistency of information recorded in the patient record management system, and for ensuring the data comply with all the UNHSEIP Service Standards, and relevant protocols or manual 2. the use of appropriate information systems if supplied by the A&CS 3. implement failsafe processes to safeguard screening and audiology assessment data captured and stored on local patient record management systems.
Data integrity - Screening	
2.5.5	Screening providers:

1. have documented quality processes to manage and audit data collected for UNHSEIP screening
2. undertake quality data checks at all levels of the screening pathway to ensure:
    a. data is captured in a complete, timely and accurate manner
    b. checks are implemented to identify any errors that may arise during data entry
    c. definitions and edit rules are understood and followed
    d. inconsistencies are investigated and rectified.
3. implement strategies and systems that demonstrate screening records are completed and sent to A&CS within an agreed timeframe (within two weeks to one month).
4. implement strategies and systems that demonstrate Datamart reports from the A&CS are completed and returned within an agreed timeframe (within two weeks to one month).
5. as part of their internal audit programme, records are regularly monitored as to the quality of the documentation and the effectiveness of the information management system.
6. screening information relating to UNHSEIP records held in systems owned by providers is secure, protected from loss, corruption, inappropriate alteration or miscalculation, and is appropriately backed up for retrieval as needed.

Data integrity - Audiology

2.5.6 – 2.5.7

Audiology providers:

1. have documented quality processes to manage and audit data collected for UNHSEIP audiology assessments
2. undertake quality data checks at all levels of the UNHSEIP audiology assessment and amplification services to ensure:
    a. records adhere to UNHSEIP DAP
    b. audiology data is captured in a complete, timely and accurate manner
    c. checks are implemented to identify any errors that may arise during data entry
    d. definitions and edit rules are understood and followed
    e. inconsistencies are investigated and rectified.
3. implement processes for the appropriate and timely provision of audiology assessment information to PHCPs, ENT, paediatricians and Well Child providers
4. implement strategies and systems that demonstrate audiology assessment records accurate, completed and sent to A&CS within an agreed timeframe (within two weeks to one month)
5. as part of their internal audit programme, audiology records are regularly monitored as to the quality of the documentation and the effectiveness of the information management system
6. audiology information relating to UNHSEIP records held in systems owned by providers is secure, protected from loss, corruption, inappropriate alteration or miscalculation, and is appropriately backed up for retrieval as needed.

Data used for research purposes

2.5.8

Service providers:

1. have implemented policies and procedures in place for research applications and projects related to UNHSEIP are managed appropriately to meet A&CS requirements and relevant legislation and professional standards

2. ensure the programme leader at A&CS is notified prior to commencement of any research activity that uses UNHSEIP data or information. Requests and enquiries regarding applications shall be sent to: UNHSEIPadmin@tewhatuora.govt.nz
3. monitor and provide regular reporting to UNHSEIP as stipulated by the programme manager for any approved research activity.

Standard 3: Screening pathway

Outcome 3

Parents/guardians/whānau participate in their baby's UNHSEIP pathway, and receive timely screening and/or audiology assessment followed by services that are planned, coordinated and delivered in a manner that is tailored to their needs.

Babies identified with hearing loss will have initiation of early intervention services at the earliest opportunity.

3.1: Eligibility

I know what it means for me:

The people: Service providers clearly communicate access, timeframes, and costs of accessing screening services, so that I can choose the most appropriate service provider to meet my needs.

Te Tiriti o Waitangi: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care.

As service providers: When people enter our UNHSEIP services, we adopt a person-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.

Criteria / Ngā paearu

Offer of screening

3.1.1 Screening providers shall ensure that all parents/guardians/whānau of eligible babies are offered newborn hearing screening at the earliest opportunity, whether babies are born in hospital, a birthing centre, at home, or elsewhere such as overseas (if under three months of corrected age).

3.1.2 Screening providers shall have in place a process for screening services to be notified of births by district maternity services, local birthing units and independent LMCs (for babies who are born at home) and PHCP who identify missed babies.

3.1.3 There shall be clearly documented processes for determining a baby's access to screening that shall:

1. respect the rights and identity of the parents/guardians/whānau engaging with the screening services
2. allow for ongoing consultation with parents/guardians/whānau
3. ensure the parents/guardians/whānau receive timely updates where access to screening is delayed.

3.1.4 Screening providers shall make every attempt to ensure all babies aged between 36 weeks and three months (corrected age) are screened if medically well.

Guidance 3.1: Eligibility

Offer of screening

3.1.1

1. Screening providers have an implemented policy describing the UNHSEIP service pathway.
2. Screening providers implement and have effective strategies to provide screening services to the parents/guardians/whānau of eligible babies. This is demonstrated by regular monitoring and reporting of the coverage, especially Māori and Pacific groups.
3. Parents/guardians/whānau are made aware of screening in the antenatal period, including providing information to parents/guardians/whānau at antenatal class.
4. Information provided to parents/guardians/whānau consists of UNHSEIP-related media and other communications, information pamphlets, etc. which is accurate, most current and consistent with the philosophy of the UNHSEIP.

3.1.2

1. Screening providers establish and maintain good working relationships with district maternity services, local birthing units and independent LMCs, PHCPs and other key stakeholders.
2. There is an implemented and effective process in place so screening providers are notified of births for babies who born at home or missed screening.
3. There is current access agreements with LMCs at birthing centres/home to ensure screening is offered. Refer to Section 88 – re: Obligation of DA53 Service specification: Postnatal care: The provision of care and advice to the woman, including: (iii) providing appropriate information and education about screening; and (iv) offering to provide or refer the baby for the appropriate screening tests specified by the Ministry of Health and receive and follow up the results of these tests as necessary. Link: https://www.health.govt.nz/publications/primary-maternity-services-notice-2021

3.1.3

1. The documented processes for a baby's access to screening services, where relevant, may include:
   a. a system to identify potential risks to the babies that have been missed and prioritise those babies to meet target of screening under three months of corrected age. This includes considering parents/guardians/whānau background and their support needs
   b. evidence of communication with the parents/guardians/whānau about screening and time frames
   c. having suitably qualified, skilled, and experienced health care and support workers to perform this function competently.
2. Screening providers have documented evidence of baby's access to screening.
3. Screening providers should work towards enabling Deaf people and tāngata whaikaha (disabled people) to access screening at clinics/sites that are well resourced.

3.1.4

1. Screening providers have an implemented policy describing the UNHSEIP service pathway and the management of babies who are unable to be screened due to medical reasons. Decisions to defer or undertake screening should be in consultation with qualified clinical staff. Refer to Screener manual.
2. For babies that are unable to be screened due to medical reasons, screening providers offer feedback to parents/guardians/whānau. The feedback or information about alternative options is in a format appropriate to the needs and condition of the parents/guardians/whānau.
3. When they decline a baby's screening, service providers:
   a. communicate with the parents/guardians/whānau) the reason for this decision and provide an opportunity to discuss it if required
   b. inform parents/guardians/whānau of other options or alternative services that may help them such as a direct referral to audiology assessment

c. enact warm handovers if their alternative service does not adequately meet the needs of the baby and their parents/guardians/whānau.

3.2: Screening pathway

I know what it means for me:

The people: I work together with my service providers so they know what matters to me, and we can decide what supports my wellbeing.

Te Tiriti o Waitangi: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.

As service providers: We work in partnership with people and whānau to support their wellbeing and improve health outcomes.

Criteria / Ngā paearu

Screening pathway

3.2.1 Screening providers shall engage with parents/guardians/whānau to assess and plan their newborn's screening in a timely manner.

3.2.2 Screening providers shall ensure high screening completion rates are achieved through engagement with parents/guardians/whānau who miss screening appointments. Where contact is lost, every effort is made to re-engage with/without the assistance of other agencies.

3.2.3 Screening providers shall ensure newborn hearing screening is offered at accessible locations that may include outpatient or community-based clinics, hospitals/birthing facilities or at home. Where possible, providers should work with other health care organisations, for example, LMCs, immunisation teams, Well Child Providers and PHCPs to screen babies.

3.2.4 Screening providers shall ensure processes are in place for making appointments for:

1. babies who are not screened before discharge
2. babies who are born at home, elsewhere or overseas
3. babies who require further follow-up
4. babies who transfer to or from other districts
5. babies who missed screening and then identified on National Health Index (NHI) data shared by UNHSEIP.

Screening and results

3.2.5 Screening providers shall ensure that all screening is carried out in accordance with the UNHSEIP screening protocols.

3.2.6 Screening providers shall ensure newborn hearing screening is performed in optimal environmental conditions that are sensitive to the parents'/guardians'/whānau and baby's needs, and in a private and quiet environment.

3.2.7 Screening providers shall ensure all babies that pass newborn hearing screening (i.e. have a 'clear response' result) but have one or more risk factors for congenital or delayed onset/progressive hearing loss shall be offered an assessment at audiology at a clinically appropriate time.

Refer to 'Risk Factors Form for Hearing Loss Requiring Surveillance'.

3.2.8 Screening providers shall ensure ninety-five percent (95%) of live births are screened by one month of age (corrected age) to meet the UNHSEIP indicator.

3.2.9 Screening providers shall ensure the screening results and next steps are communicated to parents/guardians/whānau at the time of screening.

Refer to UNHSEIP Screener Manual.

3.2.10 When communicating results, newborn hearing screeners shall:

1. follow the script for the screening pathway, diagnostic audiology and surveillance where appropriate
2. provide relevant information
3. obtain consent for referral to audiology from parents/guardians/whānau where diagnostic audiology or hearing surveillance criteria are identified
4. document as per the UNHSEIP Screener Manual.

3.2.11 Parents/guardians/whānau shall be informed that their baby's screening results will be made available to other parties (with their prior consent), namely the baby's PHCP. In the event of a referral to hearing surveillance or audiology, their Well Child provider or health/education providers may also be notified.

3.2.12 Information about the audiology service, including the most current UNHSEIP pamphlet (HE1924 – Referral to Audiologist), shall be provided to parents/guardians/whānau when referred to audiology.

Screening declines or unscreened babies

3.2.13 Babies that are unable to be screened temporarily based on the Clinical Practice Guidelines shall be tracked until such time as they are able to be screened.

3.2.14 Babies unable to be screened due to direct referral to audiology criteria shall be tracked until the audiology appointment commences.

3.2.15 Screening providers shall implement processes to identify and track parents/guardians/whānau who miss screening appointments are clearly documented. This shall include a minimum of three attempts to contact the parents/guardians/whānau such as by letter, email, text and phone contact, with at least one verbal attempt.

3.2.16 Screening providers shall:

1. have a written policy and procedures to manage and record parents/guardians who decline the offer of newborn hearing screening
2. accurately record in their clinical records, UNHSEIP Screening Form, Well Child Tamariki Ora health book, that screening has been declined. Where possible, include the reason for declining screening.
3. monitor screening declines
4. ensure that parents/guardians/whānau who decline newborn hearing screening are aware that if they have any concerns about their child's hearing at any time they should talk to their Well Child provider or their PHCP and discuss an assessment at audiology.
5. ensure parents/guardians/whānau are aware they are able to opt back in if they change their mind, as long as their baby is under three months of age.

Guidance 3.2: Screening pathway

Screening pathway

3.2.1 – 3.2.3

1. Screening providers involve a baby's parents/guardians/whānau to obtain consent for screening.
2. Screening providers have an implemented policy describing the UNHSEIP screening pathway.
3. Where possible, screening providers work in partnership with parents/guardians/whānau, district maternity services, local birthing units and independent LMCs, PHCPs and other health care organisations to provide access to screening.
4. Screening providers:
    a. provide Māori and Pacific peoples the option to access Māori and Pacific service providers when support is required at any point of the screening pathway, where this service is available
    b. have processes to ensure the most current UNHSEIP resources are made available to parents/guardians/whānau and other health care organisations.
5. Screening providers:
    a. offer outpatient clinics and/or community-based newborn hearing screening as well as screening in hospitals/birthing facilities. Screening clinics must be provided with a view to accessibility for parents/guardians/whānau
    b. confirm screening appointments verbally or via text, email or voice message. Every effort must be made to ensure screening appointments are accessible to parents/guardians/whānau
    c. have processes for identifying and following parents/guardians/whānau who missed screening appointments are clearly documented
    d. there are a minimum of three attempts to contact the parents/guardians/whānau which include letter, text and phone contact, with at least one verbal attempt (spoken or via NZSL interpreter)
    e. alternative appointment times are offered that, where practicable, are responsive to the needs of the parents/guardians/whānau
    f. each offer and outcome is clearly documented in the baby's UNHSEIP Screening Form and other clinical records (if inpatient) as per the Screener manual.
6. Screening providers:
    a. create a safe and welcoming environment where parents/guardians/whānau feel comfortable to attend screening appointments
    b. have clear processes for gathering feedback through surveys, complaints processes, or informal discussions
    c. respond in a timely, respectful, and appropriate way to any issues raised
    d. analyse feedback regularly to identify patterns or recurring barriers for parents/guardians/whānau from priority groups
    e. address barriers when implementing policies, appointment systems, communication methods, or outreach activities.

Barriers to screening include:

1. difficulty making appointments

	2. location or transport issues 3. language or communication challenges, e.g. lack of translated materials in the preferred language of the parents/guardians/whānau 4. cultural needs not being met 5. accessibility issues (physical, sensory, digital) 6. hearing or visual impairments not being accommodated 7. limited health literacy or understanding of screening processes 8. lack of information about what to expect (e.g., discomfort, purpose of screening) 9. concerns about cultural safety, e.g., absence of Māori or Pacific staff 10. negative experiences with staff or services 11. fear, anxiety, or past trauma (e.g., survivors of abuse) that makes contact difficult.
3.2.4	Screening providers: 1. have implemented strategies and processes describing the appointment making for screening for eligible babies to ensure they are screened within the UNHSEIP target timeframes 2. have implemented strategies and processes to manage screening services for babies that have not been offered screening, or before the completion of the screening pathway.
Screening and results	
3.2.5 – 3.2.6	1. Screening providers have an implemented policy describing the UNHSEIP screening pathway in accordance with the UNHSEIP screening protocols regardless of where babies are being screened (e.g. maternity ward, neonatal intensive care unit or outpatients, etc). 2. Screening providers ensure health care and support workers are competent and have good understanding of requirements specified in the UNHSEIP protocols and manuals when screening babies. 3. Screening providers are responsible for providing optimal environmental conditions for screening to reduce potential interference which may impact on screening. Factors to consider include: a. a private and quiet environment b. minimised external disturbance or acoustic noise c. absence of electrical noise or other electric equipment d. provision of a comfortable and inviting environment that is sensitive to the needs of parents/guardians/whānau and baby.
3.2.7 – 3.2.8	Screening providers: 1. have an implemented policy describing appropriate referrals to audiology assessment for babies with one or more risk factors for congenital or delayed onset/progressive hearing loss which are in accordance with the UNHSEIP screening protocols 2. have implemented strategies and processes to screen 95% of babies by one month of age (corrected for gestational age).
3.2.9 – 3.2.11	Screening providers: 1. have implemented policies and processes for the communication of screening results in accordance with the UNHSEIP screening protocols (refer to Screener manual). Screening results are made available to relevant other parties with prior consent from parents/guardians/whānau

	2. have competent screeners with a good understanding of the specific requirements for communication results as specified in the UNHSEIP protocols and manuals when screening babies. Referrals to audiology are made with prior consent from parents/guardians/whānau**.**
3.2.12	Screening providers: 1. have processes to ensure the most current UNHSEIP resources are made available to parents/guardians/whānau when babies are referred to audiology services.
Screening declines or unscreened babies	
3.2.13 – 3.2.16	1. Screening providers have implemented policies and processes in accordance with the UNHSEIP screening protocols for the management and tracking of babies: a. who are unable to be screened b. who are referred to audiology until the commencement of the audiology appointment c. whose parents/guardians/whānau miss screening appointments. 2. Screening providers: a. have implemented policies and processes in accordance with the UNHSEIP screening protocols to manage and record screening declines b. record declines and the reasons parents/guardians/whānau declined screening in the baby's clinical records and other required documentation c. provide parents/guardians/whānau with information on how to opt back on UNHSEIP (if still eligible) and what to do if there are any concerns about baby's hearing d. submit data to A&CS for parents/guardians/whānau who decline screening as additional consent is **not** required to submit data for monitoring purposes. Refer to legal advice provided to the Antenatal and Newborn Screening Clinical Oversight Group, who have approved the following Sept 2022.

3.3: Diagnostic audiology pathway

I know what it means for me:

The people: I work together with my service providers so they know what matters to me, and we can decide what supports my wellbeing.

Te Tiriti o Waitangi: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.

As service providers: We work in partnership with people and whānau to support their wellbeing and improve health outcomes.

Criteria / Ngā paearu

Diagnostic audiology pathway

3.3.1 Audiology providers shall engage with parents/guardians/whānau to assess and plan their newborn's audiology assessment in a timely manner.

3.3.2 Audiology providers shall ensure all referred babies are offered their first audiology appointment by 44 weeks gestational age to enable the diagnostic testing to be completed by three months corrected gestational age.

3.3.3 Audiology providers shall comply with UNHSEIP DAP.

3.3.4 Audiology providers shall ensure audiology surveillance appointments shall be offered at a clinically appropriate time to parents/guardians/whānau of:

1. babies and children who are referred for hearing surveillance through the UNHSEIP
2. babies and children up to five years for whom risk factors were not identified at the time of screening (for example post-natal risk indicator discovery).

Audiology – Declines, tracking. undiagnosed, Did Not Arrive

3.3.5 Audiology providers shall ensure processes are in place for identifying and tracking parents/guardians/whānau who miss audiology appointments, and these include a minimum of three attempts to contact the parents/guardians/whānau such as by letter, email, text and phone contact, with at least one verbal attempt (spoken or via NZSL interpreter).

Every effort shall be made to ensure parents/guardians/whānau referred from UNHSEIP are aware of the benefits of attending audiology appointments.

Where possible, transport or other support shall be provided to parents/guardians/whānau who require assistance to attend audiology appointments.

3.3.6 Audiology providers shall ensure all audiology assessments shall be completed by the time the newborn is three months old (corrected age), taking into account that full diagnosis may take more than one appointment.

3.3.7 Audiology providers shall ensure that:

1. each offer of an audiology appointment and outcome is clearly documented in the baby's clinical records or electronically in the referral management system
2. the PHCP is advised that the baby has not attended audiology and may be at risk of a delayed confirmation of hearing loss. Where a Well Child Health provider has been

identified, they will also be notified. The B4 School Check (B4SC) programme should also be notified if possible.

3. there are effective processes in place when babies referred to audiology transfer to another district/audiology provider before assessment is completed
4. there is effective liaison with PHCPs, Well Child services and Māori, Pacific and other support services to assist with locating and supporting babies and parents/guardians/whānau to attend audiology appointments.

Diagnostic audiology assessment and results

3.3.8 For babies with no hearing loss, audiologists shall:

1. communicate the audiology results to parents/guardians/whānau at the earliest opportunity.
2. provide the parents/guardians/whānau with relevant information and explain that, if they have concerns about their child's hearing at any time, they should talk to their PHCP, Well Child provider or early childhood or schoolteacher.
3. provide the parents/guardians/whānau with appropriate written UNHSEIP resources that are most current (Refer to DAP)
4. send a written report of the audiologist assessment to the screening coordinator, PHCP and/or Well Child provider, where this is not available on a shared patient information database.

3.3.9 For babies with hearing loss, audiologists shall:

1. communicate the audiology results and next steps to parents/guardians/whānau at the earliest opportunity.
2. provide the parents/guardians/whānau with appropriate written UNHSEIP resources that are most current (refer to DAP).
3. send a written report of the audiologist assessment to the screening coordinator, PHCP and/or Well Child provider
4. send subsequent referrals to the Adviser on Deaf Children (AoDC), ear, nose and throat specialist (ENT/otolaryngologist), or paediatrician with prior consent from parents/guardians/whānau within two weeks of the assessment.

Early intervention

3.3.10 Audiology providers shall ensure that any baby diagnosed with hearing loss receives input from a multidisciplinary team (MDT) that shall develop an action plan for the baby with their parents/guardians/whānau with their prior consent.

3.3.11 The initial MDT should include an audiologist, Adviser on Deaf Children (AoDC), and an ENT/ otolaryngologist.

Depending on the degree, type and cause of hearing loss and the needs of the parents/guardians/whānau, the audiologist or AoDC may recommend requesting support from other care providers.

Requests for support from other providers shall be subject to informed consent obtained from the parents/guardians/whānau and shall always be managed by the audiologist or AoDC.

3.3.12 Service providers shall ensure the initiation of early intervention and other support services for babies identified with hearing loss. These include:

1. babies identified with a permanent congenital hearing loss shall be referred immediately to an ENT/otolaryngologist (or paediatrician, depending on local referral pathways) and offered the services of an AoDC.
2. the AoDC shall contact the parents/guardians/whānau ideally within ten working days of referral, as per UNHSEIP policy.
3. if required, amplification shall normally be provided within four weeks of diagnosis.
4. districts shall have systems and processes in place for minimising loss to follow-up.

3.3.13 Service providers shall ensure the outcome measures and reports from other members of the early intervention multidisciplinary team shall be maintained to ascertain satisfactory progress with amplification.

Guidance 3.3: Diagnostic audiology pathway

Diagnostic audiology pathway

3.3.1 – 3.3.3

Audiology providers:

1. involve a baby's parents/guardians/whānau to obtain consent for diagnostic audiology assessment
2. have an implemented policy describing the UNHSEIP diagnostic audiology pathway in accordance with the UNHSEIP DAP and other relevant UNHSEIP protocols and manuals
3. have implemented strategies and processes to ensure all referred babies are offered their first audiology appointment within the UNHSEIP target timeframes (corrected for gestational age)
4. comply with the UNHSEIP DAP. Any deviation from the DAP (except in special circumstances):
    a. is reported to A&CS
    b. documented in clinical records on the nature and rationale for this.
5. ensure audiologists and other health care and support workers are competent and have good understanding of requirements specified in the UNHSEIP DAP and relevant protocols and manuals for babies attending diagnostic audiology assessments
6. where possible, work in partnership with parents/guardians/whānau, screeners and coordinators, independent LMCs, PHCPs and other health care organisations to provide access to audiology within the UNHSEIP target timeframes
7. provide Māori and Pacific peoples the option to access Māori and Pacific service providers when support is required at any point of the audiology pathway, where this service is available.
8. Audiology providers:
    a. provide audiology clinics with a view to accessibility for parents/guardians/whānau
    b. confirm audiology appointments verbally or via text, email or voice message. Every effort must be made to ensure audiology appointments are accessible to parents/guardians/whānau
    c. have processes for identifying and following parents/guardians/whānau who missed audiology appointments are clearly documented
    d. there are a minimum of three attempts to contact the parents/guardians/whānau which include letter, text and phone contact, with at least one verbal attempt (spoken or via NZSL interpreter)

e. alternative appointment times are offered that, where practicable, are responsive to the needs of the parents/guardians/whānau

f. each offer and outcome is clearly documented in the baby's clinical records.

9. Audiology providers:

a. create a safe and welcoming environment where parents/guardians/whānau feel comfortable to attend audiology appointments

b. have clear processes for gathering feedback through surveys, complaints processes, or informal discussions

c. respond in a timely, respectful, and appropriate way to any issues raised

d. analyse feedback regularly to identify patterns or recurring barriers for parents/guardians/whānau from priority groups

e. address barriers when implementing policies, appointment systems, communication methods, or outreach activities.

3.3.4

Audiology providers:

1. have implemented strategies and processes describing the offer of audiology surveillance appointments for referred babies to ensure they are screened at a clinically appropriate time, in accordance with the UNHSEIP protocols and target timeframes

2. have implemented strategies and processes to manage ongoing audiology services for babies with risk factors up to five years of age.

Audiology – Declines, tracking. undiagnosed, Did Not Arrive

3.3.5 – 3.3.7

1. Audiology providers have implemented policies and processes in accordance with the UNHSEIP audiology protocols for the management and tracking of babies:

a. referred to audiology are assessed before they are three months old (corrected age)

b. whose parents/guardians/whānau miss audiology appointments

c. referred to audiology transfer to another district/audiology provider before assessment is completed.

2. Audiology providers:

a. have processes for identifying and following parents/guardians/whānau who missed audiology appointments are clearly documented. Refer to guidance for 3.3.1 – 3.3.3

b. where possible, transport or other support is provided to parents/guardians/whānau that require assistance to attend audiology appointments

c. notify the PHCP or Well Child Health provider (if appropriate) if babies who have not attended audiology and may be at risk of a delayed confirmation of hearing loss.

3. Audiology providers:

a. where possible, work in partnership with parents/guardians/whānau, screeners and coordinators, PHCPs, Well Child services and Māori, Pacific and other support services to provide support to access to audiology appointments within the UNHSEIP target timeframes

b. provide Māori and Pacific peoples the option to access Māori and Pacific service providers when support is required at any point of the audiology pathway, where this service is available.

Barriers to audiology include:

1. difficulty making appointments

2. location or transport issues

3. language or communication challenges, e.g. lack of translated materials in the preferred language of the parents/guardians/whānau

	4. cultural needs not being met 5. accessibility issues (physical, sensory, digital) 6. hearing or visual impairments not being accommodated 7. limited health literacy or understanding of audiology processes 8. lack of information about what to expect (e.g., discomfort, purpose of audiology) 9. concerns about cultural safety, e.g., absence of Māori or Pacific staff 10. negative experiences with staff or services 11. fear, anxiety, or past trauma (e.g., survivors of abuse) that makes contact difficult.
Diagnostic audiology assessment and results	
3.3.8 – 3.3.9	Audiology providers: 1. have an implemented policy describing the UNHSEIP diagnostic audiology pathway in accordance with the UNHSEIP protocols for babies: a. with no hearing loss b. with hearing loss. 2. provide accurate documentation in clinical notes 3. send reports to screening coordinator, PHCP and/or Well Child provider 4. send referrals for early intervention as per DAP that meet UNHSEIP target timeframes.
Early intervention	
3.3.10 – 3.3.11	Audiology providers: 1. have implemented policies and processes for the care of any baby diagnosed with hearing loss including input from a multidisciplinary team (MDT) 2. demonstrate action plans for babies with hearing loss in discussion with parents/guardians/whānau 3. communication of audiology results in accordance with the UNHSEIP audiology protocols (refer to DAP). Audiology results are made available to relevant other parties with prior consent from parents/guardians/whānau 4. have competent audiologists with a good understanding of the specific requirements for communication audiology results as specified in the UNHSEIP protocols and manuals when assessing babies referred to audiology 5. referrals to early intervention multidisciplinary team and other support services are made with prior consent from parents/guardians/whānau**.**
3.3.12	1. Service providers have implemented policies that meet UNHSEIP protocols and target timeframes for the initiation of early intervention and other support services for babies identified with hearing loss. This includes systems and processes to track babies so they are not lost to follow up. 2. Parents/guardians/whānau confirm the process when referred for early intervention including contact by AoDC (as per UNHSEIP policy), amplification as required (within four weeks of diagnosis).
3.3.13	Audiology providers: 1. have implemented policies and processes for the receipt of outcome measures and reports for babies referred to the early intervention multidisciplinary team 2. receive outcome measures and reports from the early intervention multidisciplinary team 3. continue to track progress of babies that require amplification services.

3.4: Transition, transfer and discharge

I know what it means for me:

The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the UNHSEIP service.

Te Tiriti o Waitangi: Service providers advocate for Māori to ensure they and whānau receive the necessary support during transition, transfer and discharge.

As service providers: We ensure the people using our UNHSEIP services experience consistency and continuity when exiting our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.

Criteria / Ngā paearu

3.4.1 Service providers shall implement a process to support a safe, timely and seamless transition, transfer or discharge. This shall be documented and discussed with parents/guardians/whānau.

3.4.2 Service providers shall ensure people obtain the support they need, and that it is documented in the transition, transfer or discharge plan.

3.4.3 Service providers shall ensure there are effective processes in place to ensure continuity of service when babies transfer to another district before screening or audiology assessment is completed.

3.4.4 Audiology providers shall ensure that for all audiology assessments undertaken for babies referred through the UNHSEIP:

1. the A&CS is notified when a baby is not assessed due to a transfer to another district.
2. when a baby is referred from another district for audiology, it is the responsibility of the district that undertakes the assessment to send a copy of the UNHSEIP Diagnostic Assessment Data Form to the A&CS on completion of the assessment at the end of each month (with a copy of the district's referral for their records).

Guidance 3.4: Transition, transfer and discharge	
3.4.1 – 3.4.3	1. Service providers have implemented policies that meet UNHSEIP protocols and target timeframe for transitioning, transferring, and discharging babies and parents/guardians/whānau using UNHSEIP services. 2. The process includes transfer of/to screening, audiology, early intervention or specialist care at other districts or providers, if required. 3. Service providers have transition, transfer, and discharge information available in accessible formats and provide it in a timely manner. 4. Where possible, service providers confirm arrangements for transfer from their service. 5. Service providers make reasonable efforts to verify their referral to the receiving service or district is acknowledged. 6. Service providers have processes to: a. transition babies and their parents/guardians/whānau between districts to support them through the change b. provide continuous care following screening and referral to audiology. This process can include parents/guardians/whānau who choose not to complete screening audiology assessment. 7. Service providers shall ensure babies and their parents/guardians/whānau from priority groups (Māori or Pacific peoples) who require transfer obtain the support they need. If required, they shall be referred to Māori and Pacific service providers, and other support services. Support or referrals are documented in the transfer or 'exit' plan. 8. Evidence demonstrates appropriate management of all babies requiring transfer.
3.4.4	Audiology providers have implemented policies that meet UNHSEIP protocols and target timeframes for: 1. transitioning, transferring, and discharging babies and parents/guardians/whānau using audiology services 2. prompt notification to A&CS when a baby is not assessed due to a transfer to another district.

Standard 4: Facilities and equipment

Outcome 4

Screening and audiology services are provided in a safe environment appropriate to the age and needs of the people receiving services, which facilitates independence and meets the needs of people with disabilities.

4.1: The facility

I know what it means for me:

The people: I feel the environment is designed in a way that is safe and sensitive to my needs. I am able to enter, exit and move around the environment freely and safely.

Te Tiriti o Waitangi: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.

As service providers: Our physical environment is safe, well maintained, tidy, comfortable and accessible, and the people we deliver UNHSEIP services to, can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction and function.

Physical environment

Criteria / Ngā paearu

4.1.1 Buildings, plant and equipment shall be fit for purpose and comply with legislation relevant to the screening service being provided. The environment is inclusive of parents/guardians/whānau cultures and supports cultural practices.

4.1.2 The physical environment, internal and external, shall be safe, accessible, minimise risk of harm and promote safe mobility and independence.

4.1.3 Screening providers shall ensure the environmental conditions for newborn hearing screening are optimal, in private and quiet areas, that are sensitive to the parents'/guardians'/whānau and baby's needs.

4.1.4 Audiology providers shall ensure that the audiology room:

1. has an appropriate chair, such as upholstered recliner, so that the parent can hold the baby in comfort, and an alternate arrangement for the baby to sleep (such as a cot)
2. has access to a sink, either in the room or in close proximity
3. meets the maximum sound levels set out in the UNHSEIP DAP.

4.1.5 There shall be adequate numbers of toilets (and any other required facilities for the service) that are accessible, conveniently located, and in close proximity to each service area to meet the needs of newborns and parents/guardians/whānau receiving services.

Equipment

4.1.6 Screening providers shall ensure that all newborn hearing screening equipment used within the UNHSEIP meets the criteria for universal newborn hearing screening equipment in Aotearoa New Zealand. This shall include calibration, software installation/updates and maintenance.

4.1.7 Screening providers shall ensure the use of reusable medical devices, conductive electrode gels and shared equipment adhere to the recommendations of the Screener Manual.

4.1.8 Screening providers shall ensure daily checks are carried out on all screening equipment in use and documented on the UNHSEIP daily equipment checklists.

4.1.9 Newborn hearing screening equipment shall be maintained according to the requirements outlined in the UNHSEIP Screener and Coordinator manuals. Equipment shall be handled and stored according to manufacturers' recommendations.

4.1.10 Audiology providers shall ensure audiology equipment:

1. meets the requirements set out in the current UNHSEIP DAP
2. instruments shall be calibrated as per UNHSEIP and manufacturers' specifications.

Guidance 3.4: Transition, transfer and discharge

Physical environment

4.1.1 – 4.1.5

1. Ensure the facility has considered the use of the environment for various activities and cultural needs. For example, creating/improving culturally appropriate environments for whānau supporting Māori in their service. These environments could take the form of a separate space for whānau to gather, such as whānau rooms.
2. When designing (or redesigning) services, service providers consider:
    a. the impact of the facility design on service delivery models
    b. versatile, flexible spaces
    c. a co-design approach.
3. Service providers consider:
    a. minimising environmental hazards
    b. using amenities, fixtures, equipment, and furniture that meet infection prevention requirements, and are easy to clean and maintain
    c. providing non-slip surfaces or other safe, effective means of minimising slipping in areas frequently exposed to moisture or slippery substances.
4. Gender-neutral toilets are available in shared places.
5. Provide a private space/room for breastfeeding and baby changing facilities where possible.
6. Processes are in place to assure privacy.

Equipment

4.1.6– 4.1.10

1. Screening providers have implemented policies and procedures to ensure all equipment used for UNHSEIP screening services meet the UNHSEIP Service Standards and UNHSEIP Screener and Coordinator manuals.
2. Audiology providers have implemented policies and procedures to ensure all equipment used for UNHSEIP diagnostic audiology assessment services meet the UNHSEIP Service Standards and UNHSEIP DAP.

3. Screening and audiology diagnostic equipment are accessible, stored correctly, maintained, calibrated and tested in accordance with the UNHSEIP manuals and protocols, and stocked to a level appropriate to the service setting.
4. All electrical and acoustic equipment meet current electrical and acoustic safety requirements.
5. Service providers have policies and procedures in place to meet the UNHSEIP criteria when purchasing equipment for universal newborn hearing screening or audiology equipment in Aotearoa New Zealand.

4.2: Security of people and workforce

I know what it means for me:

The people: I trust that if there is an emergency, my UNHSEIP provider will ensure I am safe.

Te Tiriti o Waitangi: Service providers provide quality information on emergency and security arrangements to Māori and whānau.

As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.

Criteria / Ngā paearu

4.2.1 Where required by legislation, there shall be a Fire and Emergency New Zealand approved evacuation plan, implemented fire and emergency management policies and procedures identifying and minimising related risk.

4.2.2 Health care and support workers shall receive appropriate information, training and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

4.2.3 Health care and support workers are able to provide a level of first aid and emergency treatment appropriate for the degree of risk associated with the provision of the service.

4.2.4 An appropriate call system shall be available to summon assistance when required.

4.2.5 Screening providers shall ensure health care and support workers are equipped with a telephone for use in emergency situations.

Guidance 4.2: Security of people and workforce

4.2.1

1. Service providers meet the reporting requirements of the New Zealand Fire Service as specified in the Fire and Emergency New Zealand (Fire Safety, Evacuation Procedures, and Evacuation Schemes) Regulations 2018.
2. Where applicable, service providers have an emergency management plan that links to local Health New Zealand | Te Whatu Ora (Health NZ) and local authority (Civil Defence Emergency Management Act 2002) requirements.
3. Emergency equipment is accessible, stored correctly, maintained, not expired, and stocked to a level appropriate to the service setting.

	4. Service providers have policies and procedures on fire safety and emergency management relevant to the service, including earthquake procedures. This includes specific requirements required for the evacuation of tāngata whaikaha (disabled people). 5. Service providers prominently display evacuation plans or procedures.
4.2.2	1. Service providers have business continuity planning or a disaster recovery plan in place. They have evidence that they have trialled it. 2. Service providers provide induction and training for health care and support workers around responding to emergency and security situations. This includes specific requirements required for the evacuation of tāngata whaikaha (disabled people). 3. Service providers monitor the wellbeing of their health care and support workforce during an emergency. 4. Selected health care and support workers undertake fire warden training. 5. Service providers support people receiving services to maintain their own wellbeing and know what to do in an emergency.
4.2.3 – 4.2.5	1. Relevant health care and support workers have first aid training appropriate to the service. 2. Enough health care and support workers are available at all times to support people receiving services in an emergency or crisis. 3. Service providers monitor their call system's response time and take action to enhance its responsiveness. 4. Health care and support workers have access to emergency escalation processes both on site and via an on-call process. 5. Service providers have a call system for use as required, which health care and support workers understand clearly and use. 6. Service providers equip health care and support workers with a telephone for use in emergency situations.

Standard 5: Infection prevention

Outcome 5

Service provider's infection prevention (IP) strategies are up to date and informed by evidence that seeks to maximise quality of care and minimise risk of infection.

5.1: Infection prevention programme and implementation

I know what it means for me:

The people: I trust my service provider is committed to implementing policies, systems and processes to manage my risk of infection.

Te Tiriti o Waitangi: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant.

As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size and scope of our services.

Criteria / Ngā paearu

5.1.1 There is an Infection Prevention (IP) role, or IP personnel, as appropriate to the size and setting of the service provider, who shall:

1. be responsible for overseeing and coordinating implementation of the IP programme
2. have clearly defined responsibility for IP decision-making
3. have documented reporting lines to the district leadership or senior management
4. follow a documented mechanism for accessing appropriate multidisciplinary IP expertise and advice when needed
5. receive continuing education in IP
6. have access to shared clinical records and diagnostic tests of babies and parents/guardians.

5.1.2 Service providers shall have a clearly defined and documented IP programme that shall be:

1. developed by those with IP expertise
2. approved by the district leadership
3. linked to the quality improvement programme
4. reviewed and reported on annually.

5.1.3 Service providers shall develop written IP policies with input from suitably qualified personnel, which comply with relevant legislation and accepted best practice. The suite of policies shall include:

1. hand hygiene and standard precautions
2. aseptic technique
3. transmission-based precautions,
4. prevention of sharps injuries
5. prevention and management of communicable infectious diseases in service providers and users
6. decontamination and reprocessing of reusable medical devices and equipment
7. single-use items
8. health care-associated infection (HAI) surveillance
9. the built environment.

5.1.4 Infection prevention education shall be provided to health care and support workers and people receiving services by a person with expertise in IP. The education shall be:

1. included in health care and support workers' orientation, with updates at defined intervals
2. relevant to the service being provided.

5.1.5 Service providers will demonstrate a clear process for early consultation and involvement from the IP personnel or committee during the procurement of equipment and design of any new building or when significant changes are proposed to an existing facility.

5.1.6 Service providers shall ensure that reusable medical devices and shared equipment are appropriately decontaminated and reprocessed based on recommendations from the manufacturer and best practice guidelines. There shall be written policies for both manual and automated decontamination of reusable medical devices.

Refer to AS5369:2023 – Reprocessing of reusable medical devices and other devices in health- and non-health-related facilities.

5.1.7 There shall be evidence of audit and corrective actions, if applicable, of the appropriate decontamination of reusable medical devices based on recommendations from the manufacturer and best practice standards.

5.1.8 Single-use medical devices shall not be reused or remanufactured unless a formal risk assessment process has been followed and documented, and approved by the district leadership.

Guidance 5.1: Infection prevention programme and implementation	
5.1.1	1. Where multidisciplinary IP expertise is not available within a service, the service provider has a defined process for gaining advice and support on infection prevention, infectious disease, or clinical microbiology. 2. A position description, terms of reference, or similar document clearly states the responsibilities, functions, and allocated hours of work of the IP role and personnel. 3. The IP role or personnel have access to the necessary tools (such as standards, guidelines, and evidence-informed literature) to perform their function. 4. Service providers support the IP role or personnel to develop the skills they need to meet the requirements of the role.
5.1.2	Guidance related to the infection prevention plan for an organisation should include: 1. if the plan is developed by IP personnel 2. the plan details a timeframe for annual review against strategic company/hospital/facility objectives 3. links to the quality improvement programme for an organisation.
5.1.3	May also include policies such as: 1. procurement 2. waste management 3. cleaning 4. laundry.
5.1.4	1. Education for health care and support workers: a. is tailored to meet the needs of various roles and responsibilities b. occurs in a manner that recognises and meets their communication method, style, and preference c. is easy for all people to access, understand, and use, enact, or follow d. is based on evidence-informed practice. 2. Service providers assess the IP education and training needs of all health care and support workers through assessment and review processes; for example, via performance management reviews. 3. Service providers evaluate the provision, quality, and uptake of IP education and maintain education records of health care and support workers. 4. All health care and support workers receive education on IP risk assessment and how to apply this to implementation of standard precautions. 5. Service providers have multiple and integrated approaches to deliver IP education across all professions and disciplines. 7. Education for people using the service occurs in a manner that recognises and meets their communication method, style, and preference.
5.1.5	1. Service providers have clear, documented processes for accessing IP advice during procurement. This process includes providing an evaluation of the decontamination and reprocessing requirements for the medical equipment or device. 2. IP-related products, including PPE, are of an acceptable quality and conform to relevant minimum standards. This includes procurement of appropriate and adequate PPE (transparent face masks/shield/visor) which enable communication with Deaf people. 3. IP role and personnel are involved in any new build or renovation from design phase to completion.

	4. The policy on the built environment sets out the process for early consultation.
5.1.6	1. Service providers reprocess medical devices in line with relevant standards; for example, AS 5369:2023.
	2. Where disinfection and sterilisation of reusable medical devices occur, these procedures are appropriately aligned with accepted best practice standards.
	3. Where mechanical equipment is used in these procedures, it complies with relevant standards.
	4. Where sterilisation of reusable medical devices is not applicable, service providers still have appropriate decontamination procedures in place for equipment and devices used in the delivery of care.
5.1.7	1. Where sterilisation of reusable medical devices is not applicable, service providers still have appropriate decontamination procedures in place for equipment and devices used in the delivery of care.
	2. Automated reprocessing has continuous quality monitoring processes in place where possible.
	3. Service providers audit procedures for reprocessing reusable medical devices at least annually.
	4. External audit is recommended for high-risk reprocessing of reusable medical devices (for example, sterile services and endoscope reprocessing) where possible.
	5. The service provider has a process for critical equipment track and trace to the person receiving services, if applicable.
	6. Service providers are able to demonstrate via audit that they have checks in place to verify that they have sterilised equipment before using it.
5.1.8	1. Reprocessing constitutes remanufacturing. Service providers will not reprocess single-use medical devices for which they do not have validated cleaning instructions or procedures, regulatory registrations and associated technical documentation.

5.2: Environment

I know what it means for me:

The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment.

Te Tiriti o Waitangi: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible.

As service providers: We deliver UNHSEIP services in a clean, hygienic environment that facilitates the prevention of infection mitigation of and transmission of antimicrobial-resistant organisms.

Criteria / Ngā paearu

5.2.1 Service providers shall ensure safe and appropriate storage and disposal of waste and infectious or hazardous substances that complies with current legislation and local authority requirements.

5.2.2 Service providers shall ensure that people, visitors and the workforce are protected from harm while handling waste or hazardous substances.

5.2.3 Service providers shall ensure that the environment is clean and there are safe and effective cleaning processes appropriate to the size and scope of the service that shall include:

1. methods, frequency and materials used for cleaning processes
2. cleaning processes that are monitored for effectiveness and audit, and feedback on performance is provided to the cleaning team
3. access to designated areas for the safe and hygienic storage of cleaning equipment and chemicals.

5.2.4 Service providers shall ensure there are safe and effective laundry services appropriate to the size and scope of the service that include:

1. methods, frequency and materials used for laundry processes
2. laundry processes being monitored for effectiveness
3. a clear separation between handling and storage of clean and dirty laundry
4. access to designated areas for the safe and hygienic storage of laundry equipment and chemicals.

Guidance 5.2: Environment	
5.2.1 – 5.2.2	1. Safe and appropriate storage and disposal of waste may include prevention strategies, prompt action, and management in line with relevant waste standards. 2. Service providers meet their contractual requirements. 3. Service providers provide suitable PPE appropriate to the risks involved for those handling waste or hazardous substances.
5.2.3	1. Service providers provide suitable PPE for those who are performing the cleaning. 2. A procurement and contract (where used) review process is in place to check that cleaning and disinfection products are fit for purpose.

	3. Cleaning contractors and their employees understand and follow recognised guidelines.
5.2.4	1. Service providers may meet relevant laundry standards that apply to the service they are providing. 2. Service providers have an implemented process for transporting/moving dirty linen within the facility which demonstrate a commitment to cultural safety. 3. Service providers demonstrate a commitment to cultural safety by separating items that are returned from the laundry and stored separately at all sites to uphold tikanga. 4. Single, remote, or rural service providers show evidence that they have taken measures to meet the intent of the standard.

Appendix 1: Legislation and standards

It is a requirement of the NZ Health and Disability Act (2000) that all health care services are delivered in accordance with any approved quality standards.

The following policy and quality standards have been approved by the UNHSEIP Advisory Group, with the audiology standards also being endorsed by the New Zealand Audiological Society (NZAS). All providers of UNHSEIP newborn hearing screening and audiology services must comply with these standards. As well as meeting these standards, all services must meet their obligations in relation to the following legislation and standards:

1. Care of Children Act 2004
2. Health Act 1956, and any subsequent amendments to the Act
3. Health and Disability Commissioner Act 1994, and any subsequent amendments to that Act
4. Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
5. Health and Safety in Employment Act 1992
6. Health Information Privacy Code 2020
7. Health Information Security Framework 2015
8. Health Practitioners Competency Assurance Act 2003
9. Health (Retention of Health Information) Regulations 1996
10. Human Rights Act 1993
11. New Zealand Bill of Rights 1990
12. New Zealand Public Health and Disability Act 2000
13. Pae Ora Healthy Futures Act 2022
14. Privacy Act 2020
15. Public Records Act 2005
16. Reprocessing of reusable medical devices and other devices in health- and non-health-related facilities (AS5369:2023)
17. Vulnerable Children Act 2014 (updated 2015).
18. Acoustic equipment standards:
    a. Electroacoustics - Audiometric equipment, IEC 60645
    b. Acoustics – Reference zero for the calibration of audiometric equipment, ISO 389
    c. Acoustics – Audiometric test methods, ISO 8253
    d. Electroacoustics - hearing aids: Measurement of the performance characteristic of hearing aids for production, supply and delivery quality assurance purposes, IEC 60118
    e. Electroacoustics – Equipment for the measurement of real-ear acoustical characteristics of hearing aids, IEC 616698
    f. Acoustics – Procedures for the measurement of real-ear acoustical characteristics of hearing aids, ISO 12124
    g. Management programs for medical equipment, AS/NS 3551

Appendix 2: Te Tiriti o Waitangi Implementation

	How does/can this programme/ways of working devolve power and resources to Māori communities?	Have Māori been involved in the programme/ways of working development process from the outset?	Are Māori involved in decision-making?	How will this programme/ways of working be accountable and responsive to Māori wellbeing needs and aspirations?
Tino rangatiratanga This principle provides for Māori self-determination and mana motuhake in the design, delivery and monitoring of health and disability services.	**What this looks like:** • Whānau/Māori are at the table informing and self-determining their expectations of the screening provider/ways of working, and we as the Crown recognise this and respond accordingly • When we enable Māori communities to be well resourced to deliver to communities	**What this looks like:** • Whānau/Māori are a part of the screening provider/ways of working design development from the start • Careful consideration with key Māori counterparts is a part of the development of the screening provider/ways of working and have a shared decision-making • Māori are involved in setting the scope/priority/problem definition for the screening provider/ways of working that sets its direction moving forward	**What this looks like:** • There is shared decision-making with Whānau/Māori from the planning, design, development, and working groups • When Māori worldviews, Māori models and Mātauranga Māori are given the same level of influence and decision-making power as western ways of working	**What this looks like:** • Whānau/Māori have a lead role in the design, delivery and monitoring of health and disability services • When Māori wellbeing, needs and aspirations are imbedded into the screening provider/ways of working • There are specific provisions in the screening provider/ways of working to support devolving power and resources to Māori communities, for example, funding allocated to Hauora Māori Partners, Māori represented in and leading governance and accountability measures
	What this does not look like: • When we as the Crown are determining what is right for Māori without Māori being at the table • Our Māori partners are not at the table; pathways that are not pragmatic to supporting Māori communities • Developing the programme/ways of working in-house and then taking it to Māori for consultation once it has already been developed	**What this does not look like:** • Māori NOT being a part of the development and only considered when concerns occur • When Māori are only involved on a need-to-be-included basis and not in the framing and design	**What this does not look like:** • Not having Māori involved in decisions being made at all levels and stages of a screening provider/ways of working • Placing Māori decision-making power only within the realm of "Māori issues" rather than recognising that all aspects of the screening provider/ways of working have the potential to impact on Māori and should therefore have Māori decision-making input	**What this does not look like:** • Compromising Māori needs, aspirations and wellbeing for the sake of the screening provider/ways of working • When Māori are not a part of the delivery and monitoring of the screening provider/ways of working design and regulating processes

	How does the programme/ways of working address inequities for Māori?	What relevant social or wider demographic inequities need to be considered and accounted for?	What specific actions will be undertaken to ensure health outcomes are equitable?	Is the programme/ways of working clear about what is inequitable?
Equity This principle requires the Crown to commit to achieving equitable health outcomes for Māori. That there is an absence of avoidable or remediable differences among groups of people. Equity recognises different people with different levels of advantage require different approaches and resources to achieve equitable health outcomes.	**What this looks like:** • This screening provider/ways of working has constructive writing that identifies what inequity is for Māori and how to approach equitable opportunities • This screening provider/ways of working outlines what the barriers are to achieving equity for Māori and includes pragmatic approaches to addressing the barriers	**What this looks like:** • When the social or wider demographic inequities that may impact Māori are identified within this screening provider/ways of working • This screening provider/ways of working identifies the social, economic and demographic inequities that impact Māori health outcomes and provides considerations to addressing these equity barriers for Māori and Māori communities	**What this looks like:** • This programme/ways of working outlines actions to achieve equitable and accountable outcomes for Māori • The approaches are action-focused to reduce inequity for Māori	**What this looks like:** • This screening provider/ways of working plan outlines and is clear about what is currently inequitable • This screening provider/ways of working clearly articulates how (with key actions) it will address the inequities identified and how to achieve equity for Māori
	What this does not look like: • This screening provider/ways of working does not identify what equity is in the approach. • Maintaining the status quo regarding resourcing or addressing barriers for Māori where this has not previously addressed inequities • No practical solutions over and above what is currently being delivered are provided for Māori, and Māori are grouped with the wider population rather than being recognised as a population requiring additional support to achieve equity.	**What this does not look like:** • No consideration of wider social and demographic inequities specifically for Māori • No practical considerations of other inequities that may impact on health outcomes for Māori are made	**What this does not look like:** • The screening provider/ways of working does not include specific actions that will be taken to address inequities for Māori but rather makes general statements about equity being a priority/what will be achieved by the screening provider/ways of working • The actions are not equitable for Māori to achieve more equitable outcomes	**What this does not look like:** • The screening provider/ways of working is not clear about what inequity is • The screening provider/ways of working does not outline how to achieve equity for Māori

	How will this programme/ways of working be accountable to Māori?	How does this programme/ways of working support Māori providers/organisations and communities?	Does this programme/ways of working embed Māori health values and principles into the system? If so, how will it protect these? How is their authenticity maintained?	How will this programme/ways of working ensure the voice, needs and aspirations of Māori are both actively protected and responded to at all levels of the system?
Active protection This principle requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.	**What this looks like:** • This screening provider/ways of working has Māori at the table holding the screening provider/ways of working team accountable for delivery for Māori at an operational level, implementation, management, and governance • That Māori are involved in monitoring and regulating the screening provider/ways of working that is being delivered	**What this looks like:** • This screening provider/ways of working supports the health/hauora aspirations of Māori and their communities • The screening provider/ways of working ensures that Māori providers and communities have the resources they need to achieve their aspirations	**What this looks like:** • Māori health principles and values are embedded into the screening provider/ways of working • Māori values, tikanga, and ways of working are built into how the programme operates every day. This is supported by working alongside Māori health teams and Māori subject matter experts, and by ensuring Māori perspectives are part of decision-making and service delivery. These approaches are protected by ongoing relationships, regular feedback from Māori stakeholders, and a shared commitment across the programme to achieving equitable outcomes for Māori.	**What this looks like:** • Whānau voice and Māori aspirations are embedded into the implementation, design, and delivery of the screening provider/ways of working plan • When Māori are at the table at all aspects of the screening provider/ways of working governance, delivery, design, and implementation.
	What this does not look like: • Māori are not at the table and there is no mechanism in place to enable Māori involvement at all levels from governance, design, strategy, implementation, and delivery.	**What this does not look like:** • A broad population-based screening provider/ways of working that does not consider Māori aspirations or the unique needs of Māori communities	**What this does not look like:** • When no Māori models of care are displayed throughout the screening provider/ways of working plans	**What this does not look like:** • When Māori are not given a voice throughout all aspects of the screening provider/ways of working.
		• The screening provider/ways of working has had no input from lived experience teams, Hauora Māori partners or Māori communities	• When Māori worldviews, Mātauranga Māori and tikanga are not considered, and not evident in the screening provider/ways of working	• If it's about us without us

	What te ao Māori models of care/cultural safety or standards are in place?	Does the programme/ways of working allow for te ao Māori models of care? Why or why not?	How well are Māori world views and values, including wairuatanga, reflected?	Is there ample choice and opportunity to overcome social and economic disadvantage faced by Māori?
Options The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.	**What this looks like:** • When te ao Māori models of care are shown in the screening provider/ways of working plan with clear guidance of what is expected • When te ao Māori models of care and cultural safety standards are imbedded into the screening provider/ways of working plan	**What this looks like:** • Māori models of care are included in the screening provider/ways of working • The screening provider/ways of working includes te ao Māori in models of care, and approaches that utilise Māori models of care are used to operationalise recommendations. • Inputs and outputs are determined in line with Māori models of care	**What this looks like:** • When Mātauranga Māori pathways are present in the design and implementation of screening provider/ways of working • When wairuatanga, cultural safety, and Māori worldviews are imbedded into the screening provider/ways of working as part of implementation plans • Mātauranga Māori is given the same validity as western worldviews when developing screening provider/ways of working	**What this looks like:** • When the screening provider/ways of working is designed in a way that there are multiple options available for Māori/whānau • Social and economic factors are taken into consideration and there is an action plan in place to support access and options to service delivery
	What this does not look like: • Te ao Māori models are not referenced, shown, displayed, considered or provided a space within the screening provider/ways of working • Cultural safety and cultural competency are not shown or expected within the implementation, design, delivery, leadership and/or governance	**What this does not look like:** • Māori models of care are not in the screening provider/ways of working • Te ao Māori models of care, methodologies or ways of working are not in the plan • Inputs/outputs do not take Māori models of care into consideration at all	**What this does not look like:** • No Māori pathways are provided at all • Wairuatanga, Māori models of care and Māori worldviews are not imbedded at all • Mātauranga Māori is not given any validity within the screening provider/ways of working	**What this does not look like:** • Whānau only have one option which is the same as the general population • Social and economic factors that inequitably impact Māori are not taken into consideration to support access and options for service delivery and implementation

	How are Māori involved in planning, governance, implementation, and how are community organisations being thought of or included in design and delivery?	How well are hapū/Māori aspirations reflected?	Does this programme/ways of working provide sufficient resource and opportunity for Māori to fulfil a partnership role?	
Partnership The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the primary health system for Māori.	**What this looks like:** • When Māori are empowered and given leadership through all aspects of the screening provider/ways of working • When Māori communities and organisations are involved and champion the mahi	**What this looks like:** • When Iwi and Hapū aspirations are heard, understood and acknowledged and their aspirations are imbedded into the screening provider/ways of working	**What this looks like:** • When Māori are resourced sufficiently to deliver • When Māori are at the table to partner and provide robust recommendations to achieve equity for their communities	
	What this does not look like: • Māori are not empowered • Māori are not involved at any stage of the planning, governance and implementation, and have no influence in the screening provider/ways of working process or are only included at the end of the development and implementation process • When Māori organisations do not champion the mahi	**What this does not look like:** • When we do not listen or acknowledge the health needs of hapū and these are not evident in screening provider/ways of working	**What this does not look like:** • When we do not provide Māori with adequate resourcing (human/people resources, data, funding, learning and feedback opportunities etc.) • We do not offer a space to partner	

Appendix 3: References and Links

Māori

1. Māori health models | Ministry of Health NZ: Māori health models | Ministry of Health NZ
2. Te Tiriti o Waitangi framework: Te Tiriti o Waitangi framework | Ministry of Health NZ
3. Te Whare Tapa Whā: Te Whare Tapa Whā model of Māori health | Ministry of Health NZ.
4. Tikanga guidelines examples:
   - Capital & Coast District (2009): Tikanga Māori: A guide for healthcare workers
   - Auckland and Waitematā Districts: Āke Āke phone app
   - Bay of Plenty District, Māori Health Services (ed. 6, 2013): Te Pou Whatukura - Cultural Practice Manual: A Guide for clinicians and staff

Pacific peoples

1. Ministry for Pacific Peoples: Yavu Engagement Framework: Ministry for Pacific Peoples — Yavu - Foundations of Pacific Engagement Tool
2. Pacific Peoples language: Pacific Peoples and their language | NZ Digital government
3. Te Mana Ola (Ministry of Health): Te Mana Ola: The Pacific Health Strategy | Ministry of Health NZ
4. Yavu booklet when caring for Pacific families for regions/districts with high concentration of Pacific population: **Yavu-Booklet.pdf**

Language

Language guides for the following:

- disabled people: Disability language | NZ Digital government
- New Zealand sign language dictionary**:** https://www.nzsl.nz/
- Learn NZSL: https://learn.nzsl.nz/#/id/co-01
- rainbow community: Rainbow inclusive language guide - Te Kawa Mataaho Public Service Commission

Other Ministry of Health or governmental sites:

1. Equity of health care of Māori, Ministry of Health (2014): Equity of Health Care for Māori: A framework | Ministry of Health NZ
2. Disability Support Services Strategic Plan and Ministry of Health (2018) Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan | Ministry of Health NZ
3. Health & Disability Commissioner, Online training on the Code of Health and Disability Services Consumers' Rights
4. Health Quality & Safety Commission's Clinical governance framework (November 2024): Clinical governance framework | Te Tāhū Hauora Health Quality & Safety Commission
5. Health Quality & Safety Commission (most up to date) National Adverse Events Reporting Policy
6. National Screening Unit: National Screening Unit Policy Framework: Open Communication Policy (NSU 03) – Health New Zealand | Te Whatu Ora
7. Primary Maternity Services Notice 2021: https://www.health.govt.nz/publications/primary-maternity-services-notice-2021
8. Te Kāhui Tika Tangata Human Rights Commission website: Rights of Disabled People