Service Specification

Service Specification No.	01
Service	Integrated Hearing Service for Age Related Hearing Loss 50 years + Lancashire and South Cumbria Wide
Commissioner Lead	
Provider Lead	
Period	3 years (1st April 2019 – 31st March 2022) plus an option to extend for a further 2 years
Date of Review	Annually by 31st March of each contract year

1. Population Needs

National/local context and evidence base

The impact of hearing loss in adults can be great both at a personal and a societal level leading to social isolation, depression, loss of independence and employment challenges.

Assessing the hearing needs of patients with hearing loss, developing an individual management plan and providing appropriate interventions can reduce isolation, facilitate continued integration with society and promote independent living.

The ageing population means that demand for both hearing assessment and treatment services is set to rise substantially over the coming years. However, a significant proportion of this client group will have routine problems that do not require referral for an Ear, Nose and Throat (ENT) out-patient appointment prior to assessment. Patients have benefitted from access to adult hearing care services with a referral made directly from their GP enabling timely diagnosis and treatment.

One in six people in the UK have some form of hearing loss. Most are older people who are gradually losing their hearing as part of the ageing process, with more than 70% of over 70 year-olds and 40% of over 50 year-olds having some form of hearing loss.

Around 2 million people currently have a hearing aid, however, approx. 30% of these do not use them regularly, and there are a further 4 million people who do not have hearing aids and would benefit from them.

In addition we are faced with an ageing population, where there will be an estimated 14.5 million people with hearing loss by 2031. The World Health Organisation predicts that by 2030 adult onset hearing loss will be a long term condition ranking in the top ten disease burdens in the UK, on a par or perhaps exceeding those of diabetes and cataracts.

The following CCGs commission and provide a standardised approach to the delivery of hearing services from multiple locations across Lancashire:

- Blackburn with Darwen CCG
- Blackpool CCG
- Greater Preston CCG
- Chorley & South Ribble CCG
- East Lancashire CCG

- Fylde and Wyre CCG
- Morecambe Bay CCG
- West Lancashire CCG

There is a commitment to providing care closer to home by offering services in community settings which embraces the latest technology, maintains quality and strives to improve the patients experience and outcomes.

The vision is aligned with the Everyone Counts Planning for patients 2014/15 to 2018/19 guidance issued by NHS England in December 2013.

Evidence base:

- The Department of Health published Transforming Community Services: Ambition, Action, Achievement Transforming Services for Acute Care Closer to Home (2009) promoted removing services traditionally delivered in secondary care settings by placing them in the community. The aim was to improve access, reduce demand for secondary care services and consequently reduce overall waiting times for outpatient and inpatient hospital care.

- Commissioning Services for People with Hearing Loss: A framework for clinical commissioning groups (July 2016). This commissioning framework provides a clear guide to what good commissioning looks like for hearing loss services and meets one of the key recommendations of the Action Plan on Hearing Loss. This framework will ensure that clinical commissioning groups (CCGs) are properly supported to make informed decisions about what is good value for the populations they serve and provide more consistent, high quality, integrated care to meet the needs of local people with hearing loss across England. In turn, it will help reduce inequalities between access and outcomes from hearing.

- Action Plan on Hearing Loss (March 2015) NHS England and Department of Health report is to encourage action and promote change across all levels of public service. It identifies how hearing needs can be met and improved for children and adults.

- Action on Hearing Loss (2011) Hearing Matters, NHS England outlines the latest evidence and sets out what actions needs to be taken to improve the lives of people with hearing loss and to remove barriers in their way.

- Transforming Integrated Hearing Services for Patients with Hearing Difficulty, Department of Health (June 2007) this document provides good practice and evidence to help commissioners and service providers to make changes to the way that Integrated Hearing Services are delivered, in particular, to reduce waits of patients with the most common hearing difficulties.

The demand for hearing services both nationally and locally is set to increase as the population ages which will result in rising costs and the need for more efficient and effective services to be provided. The Commissioner is committed to the provision of high quality, dedicated and professional hearing services for patients with hearing conditions, centred on clinical assessment and treatment via the most appropriate management pathway.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	N
Domain 2	Enhancing quality of life for people with long-term conditions	Y
Domain 3	Helping people to recover from episodes of ill-health or following injury	N
Domain 4	Ensuring people have a positive experience of care	Y
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	Y

Service overview

The services set out in this specification, its annexes and appendices are commissioned by the following organisations: Blackburn with Darwen CCG, Blackpool CCG, Greater Preston CCG, Chorley & South Ribble CCG, East Lancashire CCG, Fylde and Wyre CCG, Morecambe Bay CCG and West Lancashire CCG.

The service is for the registered population of the NHS commissioning organisations and is open for patients aged 50 years and over. The service will include an assessment, hearing aid fitting (where required), rehabilitative support, follow-up and aftercare services for adults with no contraindications, who have suspected or diagnosed age related hearing loss. The service will be delivered 6 days per week.

Patients are excluded from this specification if they are under 50 years (49 years and 364 days) or require access to specialist services (for patients who meet the contra-indications detailed in Appendix 1). These patients should continue to be accessed by GP referral to the appropriate service. Commissioners reserve the right to review the age threshold for this service and will work collaboratively with all providers and patients affected by this change to agree changes to the service and contract.

Providers need to ensure clear and formal accountability processes and structures are in place to ensure a safe, effective and integrated continuity of clinical care for all patients.

The provider will ensure the following are available and implemented:

- Hearing test and needs assessment including provision for urgent appointments and drop in sessions
- Residual Wax removal-micro-suction (using a vacuum to suck the wax out) not syringing (flushing the wax out using water),
- Development of an Individual Management Plan (IMP) inclusive of a long term conditions management approach
- Provision and fitting of hearing aids and moulds where required in a suitable environment (quiet, confidential, private, and permits the patient to retain dignity) as appropriate
- Appropriate hearing rehabilitation e.g. patient education, self-care and advice on equipment availability and local support groups
- Information on and signposting to any relevant communication/social support services
- Annual follow up appointments initiated by the provider at the end of years 1, 2 and 3 should be made via the patients preferred preference e.g. telephone, electronically or face to face. Should either of these, methods prove unsuccessful then the provider should make a face to

face appointment for the patient should they have any issues. At year 3 all appointments should be face to face to determine whether or not the hearing aids are still providing the outcomes identified within the IMP.

- Working towards direct referral pathways to other appropriate locally determined or specialist services
- All patients referred to the service are eligible for **ONE** single (monaural) or pair (binaural) of hearing aid/s as part of the patients full 3 year pathway delivered by the provider. Any exceptions to this are if there is change in hearing (following assessment, in line with local assessment of change criteria, see section 2.3) when a replacement aid should be provided to the patient.
- During the third year assessment, if the patients' hearing has no significant change and wishes to remain with the current provider, the patient does not require a re-referral and will be provided with on-going aftercare with the same provider. Providers should ensure the patient is aware of choice and should ensure the form within 3.4.2 is completed and stored within the patients' medical records.
- Should the patient wish to change providers at the end of the 3 year the patient must be discharged back to the patients GP with a discharge letter stating reason for discharge.

The overall service will be carried out in accordance with best practice and guidelines listed in Appendix 2. Details of the service model can be found in section 3.4.

See full definition of first, follow up and aftercare available in appendix 6.

2.2 Local defined outcomes

As outlined in the British Society of Audiology, Practice Guidance Common Principles of Rehabilitation for Adults in Audiology Services (Oct 2016) the UK National Health Service embraces a client-centred model of health care (DH 2011). This model is based on the Picker principles of patient-centred care (www.pickereurope.org). In keeping with this, the provider is expected to work within the below guiding principles which should be central to all forms of practice and aligned to the patient being central to the delivery of the integrated hearing service and aligned to outcomes.

1. Identifying individual needs
2. Setting joint goals
3. Making shared, informed decisions
4. Supporting self-management strategies.

The broad service outcomes are specified below:

- Increased choice and control for patients as to where and when their treatment is delivered – providing on-going care closer to home;
- Personalised care for all patients accessing the service;
- Timely access to hearing assessment, and a range of support services including hearing aid fitting, follow-up and on-going aftercare;
- All patients contacted to discuss utilisation and satisfaction of the hearing aids at specified times following first follow up appointment
- Reduced communication difficulties for patients with poor hearing;
- Timely referral or signposting to other local services for support and equipment, including social services and voluntary services;
- Access to clear guidance and information for patients and their families about the important role of hearing in maintaining effective communication and active engagement in a range of social and work settings, including advice on the range of support available;

- High levels of satisfaction from patients accessing the service;
- Improved quality of life for patients, their families/carers and communication partners.

Applicable measures relating to the above outcomes are set out in Quality Schedule 4.

The purpose of the Integrated Hearing Service is to ensure:

- Equitable access to a high and consistent quality care for all patients using the service
- A safe hearing service for patients that conforms to a recognised quality assurance tool e.g. the Improving Quality In Physiological Diagnostic Services - Self Assessment and Improvement Tool (Traffic Light Ready system (TLR)) and is UKAS accreditation
- Assurance to patients that if hospital specialist care/treatment is required that this will be appropriately provided.

The service should also recognise and utilise the most up to date published clinical guidelines/good practice (as set out in Appendix 2).

2.3 Assessment of change criteria

The hearing threshold levels of an individual ear are often described in general terms rather than in terms of the actual numbers at different frequencies on a pure-tone audiogram. Recommendations are made below to associate particular descriptors with bands of average hearing impairment.

Four audiometric descriptors are outlined below:

Mild hearing loss 20-40
Moderate hearing loss 41-70
Severe hearing loss 71-95
Profound hearing loss In excess of 95

These are based on the average of the pure-tone hearing threshold levels at 250, 500, 1000, 2000 and 4000 Hz. Averages do not imply any particular configuration of hearing loss and do not exclude additional terms (e.g. profound high-frequency hearing loss) being used. Descriptor Average hearing threshold levels (dB HL).

All new patients who are supplied with a hearing aid must meet the mild to profound criteria as outlined above and are eligible to be supported by the service and provided with ONE bi/monaural hearing aid/s as required by the patient. The provider is also responsible for understanding the self-perceived activity limitations that may impact on the patient's long term management and these additional factors will be considered.

Patients who are assessed throughout the 3 year pathway who have had a significant change in hearing assessment and where the hearing aid is unable to be tuned to the required dB are eligible to be supplied with a new hearing aid to meet the patients hearing needs.

3.Scope

3.1 Service aims

The aim of the service is to provide a comprehensive patient-centred Integrated Hearing Service which will include the provision of hearing aids for age related hearing loss (non complex) in line with national guidance and local requirements for the registered population of the NHS commissioning organisation aged 50 years and over.

The vision for people with age related hearing problems is for them to receive, high quality, efficient services delivered closer to home, with short waiting times and high responsiveness to the needs of local communities, free at the point of access.

Key principles within which the Integrated Hearing Service operates:

- Contribute to improving public health and occupational health focus on hearing loss
- Contribute to reducing the prevalence of avoidable permanent hearing loss
- Encourage early identification, diagnosis and management of hearing loss through improved patient and professional education
- Provide person-centred care, responding to information and the patient's psychosocial needs
- Support communication needs by providing timely signposting to appropriate services e.g. Assistive technologies.
- Promote inclusion and participation of people who are hard of hearing and to make reasonable adjustments for patients who have learning and development disorders, dementia and mental health conditions.
- Compliance with clinical guidance and good practice
- Ensure services are available to all who are eligible without regard to gender, sexuality, religion, ethnicity, social or cultural determinants. However, where it is deemed clinically appropriate, alternative services may be established that meet the specific needs of one or more groups within a community. Such services will enhance rather than detract from the existing provision.
- Offer developmentally appropriate, co-produced information for those eligible for the services, any carers and referrers about the services provided and how they are accessed and about their care.
- Ensure compliance with locally agreed pathways to other services such as Ear Nose & Throat (ENT) as part of collaborative working as one healthcare system.
- To reduce duplication of services (one individual or set of hearing aids per patient, per provider), re-provision of lost hearing aids and multiple referrals to different providers.

The Integrated Hearing Service is for adults (over the age of 50) experiencing difficulties with their hearing and communication who feel they might benefit from hearing assessment and care, including the option of trying hearing aids to reduce these difficulties. All providers of Integrated Hearing Services must ensure that there are local arrangements for referral into more specialist medical services in line with British Academy of Audiology (BAA) Guidelines for *Direct Referral of Adults with Hearing Difficulty to Audiology Services* (2016) and British Society of Hearing Aid Audiologists (BSHAA) Protocol and Criteria for Referral for Medical or other Specialist Opinion (2011).

3.2 Service Objectives

The objectives are outlined below and linked to the Local Quality Requirements set out in Quality Schedule 4 (appendix 3):

Patient outcome focussed:

- Improving access through locally based services as close to patients' home or work as possible. (KPI number 1.1)
- Co-ordination of care via an integrated service so patients experience appropriate care, seamlessly and in a timely manner. (KPI number 1.2)
- Provision of active support for patients to adjust their condition. (KPI number 1.1 and 1.2)
- Increased patient choice and control as to where and when their treatment is delivered-providing on-going care closer to home. (KPI numbers 1.1)
- Personalised care for all patients accessing the service that is characterised by the co-production of an Individual Management Plan. (KPI number 1.1)
- Increased compliance and proportion of patients continuing to wear hearing aids. (KPI number 1.1. and data captured in Schedule 6)
- Increased reported levels of patients at the first review reporting improved hearing and health and wellbeing outcomes. (KPI number 1.1)
- To support a reduction in social isolation and consequent mental ill health (i.e. depression and onset of dementia). (KPI number 1.1)
- Reported increase in the quality of life for patients, their families/carers and communication partners by completion of either The Glasgow Hearing Aid Benefit Profile (GHABP) or Client-Orientated Scale of Improvement (COSI) or International Outcome Inventory for Hearing Aids (IOI-HA) at regular intervals to show an increase in continuity of care through the 3 year term. (KPI number 1.1)

Evidence based:

- Enhanced outcomes through provision of care that is evidence based and provided according to local and national guidance. (KPI number 1.7)

Efficient:

- Ensuring efficient use of resources and avoidance of unnecessary appointments or services.(KPI number 1.2)
- Ensuring optimum use of available capacity through robust planning of clinics and minimizing of DNA rates.(KPI number 1.2)
- Provision of a high quality workforce with knowledge and skills to manage the care of audiology patients in the community wherever possible. (KPI number 1.4)
- Access to hearing assessment, fitting and follow-up within agreed timeframes with patients remaining with the provider for on-going support and monitoring. (KPI number 1.2)
- Increased reported levels of satisfaction from GPs referring into the service. (KPI number 1.1)

3.3 Service Overview

The service is required for the registered population of the NHS commissioning organisations for a age range of 50 plus years adult hearing assessment service, including hearing aid fitting (where required), rehabilitative support, follow-up and aftercare services for adults with no contraindications, who have suspected or diagnosed hearing loss. The location(s) of the service will be agreed with each CCG via the procurement process.

Operating hours of the service across the geographic area covered by the NHS commissioning organisations, will be 6 days per week within the core hours of 8.00am – 6.00pm. However, the service should have the capacity to flex should the service require it.

Opening the service on statutory public holidays is for the discretion of the provider; however there will be a requirement for providers to ensure patients are notified in advance of closures and have access to an emergency service for the provision of batteries and tubing.

The service is commissioned to provide all GP and community referred patients (50 years plus) with **ONE** single (monaural) or one pair (binaural) of hearing aid/s as part of the patients NHS funded 3 year pathway. All patients should be made aware that should they lose their hearing aid(s) there will be a charge for a replacement of £68 per hearing aid, patients are exempt based on the agreed criteria of having a diagnosis of dementia, learning disabilities or registered blind in which case the cost will be borne by the Commissioner. A further exemption to this is if there is a moderate change in hearing, where further clinical assessment will be required in line with the assessment of change criteria (sec 2.3).

All patients fitted with a hearing aid(s) should have annual reviews to determine how patients are managing with wearing their hearing aids and to discuss any issues. At the start of the patient's pathway patients should be asked what their preferred method of communication is e.g. letter, telephone, electronic, face to face. At years 1 and 2 this should be the way in which their annual review is carried out unless this proves unsuccessful the patient should be offered a face to face appointment. The 3 year review must be a face to face appointment. If after 3 attempts the patient is unable to be contacted for the 3 year review, then the patients GP should be contacted.

For patients who meet the contra-indications detailed in Appendix and services for adults under 50 (49 years and 364 days) are not covered by this specification and should continue to be accessed by GP referral to the appropriate service in each relevant CCG area as they may require more specialist intervention.

Contract monitoring arrangements -

Providers need to ensure clear and formal accountability processes and structures are in place to ensure a safe, effective and integrated continuity of clinical care for all patients. Full service model outlined in section 3.4. The service will be delivered by a number of provider/s in line with local need and as agreed by each individual CCG as part of the procurement process outcome. Each CCG within the Pan Lancashire and South Cumbria area will act as a lead commissioner and will be responsible for managing single or multiple contracts on behalf of all Lancashire and south Cumbria CCG's and will be responsible for updating all relevant CCGs on performance and service delivery to inform a countywide picture of service delivery.

Consistent monitoring reports for both qualitative and quantitative information and data has been developed and implemented for this contract and each CCG will be responsible for managing and distributing this information to all CCGs as well as payment arrangements.

Each CCG will report and update on their lead contract to a Lancashire Audiology Contract Management Board (ACMB) who will be responsible for providing Countywide oversight and management of all Audiology services in the Lancashire Area.

Providers may be invited to attend and present to the ACMB in order to address any questions or queries relating to the delivery of the service.

3.4 Service model

The service will be a community based model and reflect any specific local requirements as set out in appendix 7. All locations should be agreed with commissioners.

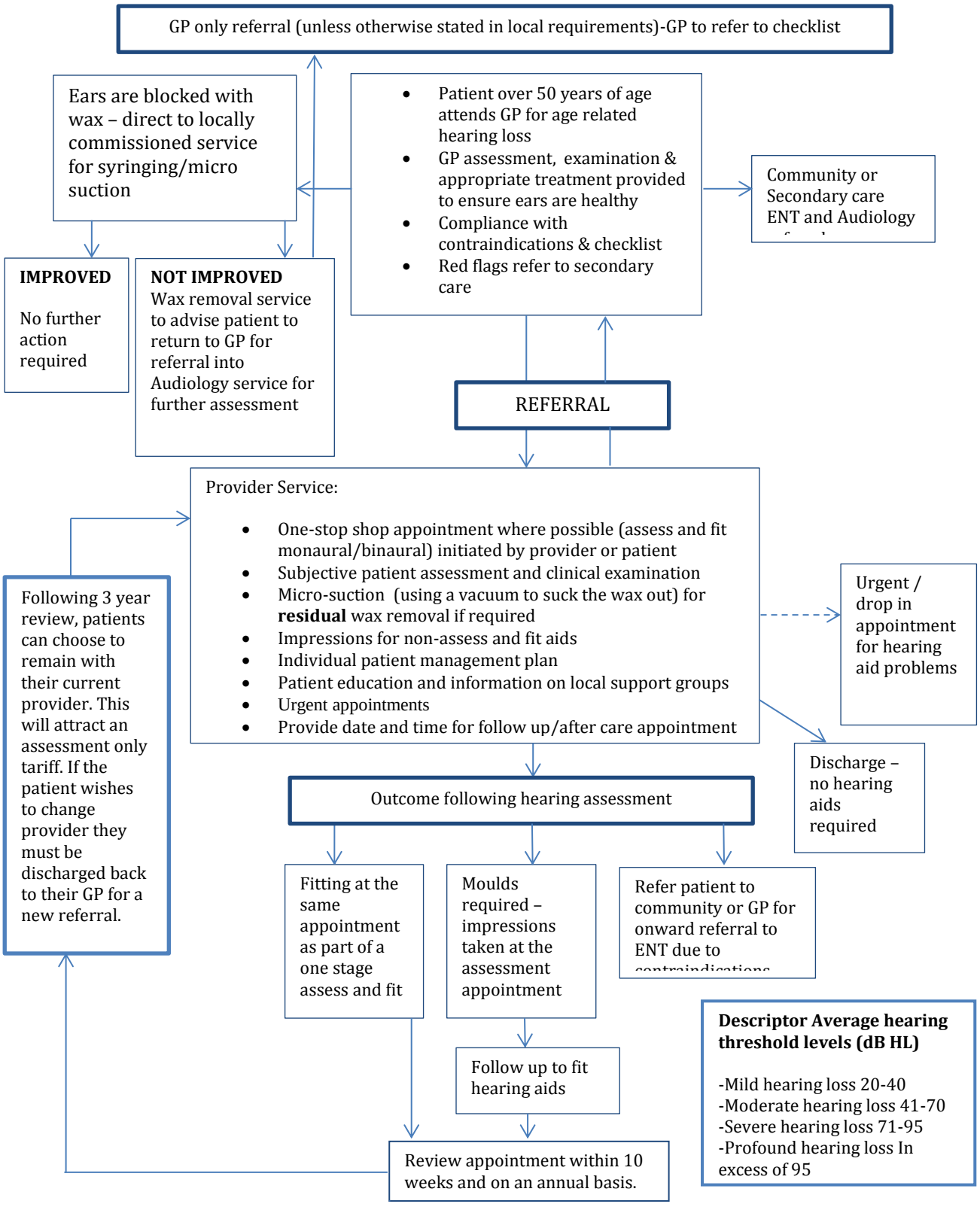
Should the provider wish to mobilise in additional areas outside of the original procurement process; the following criteria must be met prior to service implementation.

- Providers to meet with Commissioner/s to outline their service plans which will include :
    - Information on how the provider will meet patient need and local requirements,
    - what the likely demand may be,
    - Agree location and opening times including timescales for implementation,
    - how the provider will comply with local pathway,
    - communication and marketing plan.
- Provider to gain agreement with the Commissioner ***prior*** to implementation and provide as a minimum 8 weeks' notice.

The service will be provided by appropriately qualified professionals in line with the clinical management guidelines published by the British Society of Hearing Aid Audiologists 'Guidance on professional practice for Hearing Aid Audiologists' and locally agreed pathways and protocols approved by the CCGs.

Care Pathway-

Diagram 3.4 below shows the pathway. It is recognised that for a small number of patients more serious pathology may be found on examination by the provider and that the patient will require direct referral to secondary care for specialist opinion. Providers should be willing to work towards developing this referral pathway. Until this is established providers must telephone the GP within the same day to notify them of the findings in order for the GP to refer onto a more specialist service.



3.4.1 Referral processes

The provider must be visible on eRS via a directly or indirectly bookable service.

All referrals into the service will be received from the patient's own GP or community service should this be operational within CCGs area – please check local requirements as outlined in appendix 7. Referrers to comply with referral checklist in Appendix 5

The patient assessment must highlight and document on the referral if the service user has additional needs for which the provider must make reasonable adjustments.

The provider is required to be diligent in assessing referrals received to ensure a fast response:

- The provider must ensure that contact is made the same day with the patients GP if any assessment results in suspected cancer.

- The provider will only offer services to patients where appropriate skills and equipment are available.

3.4.2 Accepting referrals

Appointments will be booked and managed by the provider, once the patient has been referred. Operational standards must be applied to mitigate self-presenting patients that do not require the service. The provider is responsible for checking the patient pathway to reduce duplication between services in and out of CCG commissioned area/s and the CCGs being charged for unnecessary patient contacts.

Once the 3 year care pathway has ended, and the final 3 year assessment has taken place, patients have the right to remain with their current provider by completing the form below. This is applicable for patients that have no significant hearing changes, of which after the 3 year review will attract the aftercare tariff upon the patient receiving aftercare.

For patients that have moderate, severe or profound changes to their hearing (as outlined in sec 2.3) a new patient tariff is acceptable without the need for discharge and re-referral. The form below should be completed with the patient prior to starting the new assessment. This should be recorded as part of the KPIs.

form to continue with current provider 07.1

3.4.3 Rejecting referrals

The Provider must only accept referrals that meet the referral criteria covered by this specification. Should the Audiologist conducting the hearing test and discover any contra indications the patient should be discharged and referred back to either their GP or community service (as stated within local requirement information in appendix 7) for onward referral to specialist service as appropriate following locally agreed pathways, clearly stating reasons why the hearing assessment cannot be fulfilled.

The provider must satisfy the CCG that it maintains robust patient management processes to ensure onward referral to specialist service, in a timely fashion.

The provider will send a clinical letter to the GP detailing the reason for onward referral. If it is clinically appropriate to delay the fitting, the patient should be advised that their pathway has already started as the hearing assessment has already taken place. Once the onward referral is completed the patient must be accepted back (if appropriate) to the original provider and continue on their 3 year pathway. This activity will be captured in Schedule 6 to monitor the patients referred back to the provider.

Prior to referral, an initial assessment should be undertaken by the GP of the patient presenting with hearing difficulties, see appendix 5 for GP Hearing Aid pathway and GP checklist. This is to ensure that they do not fall within the contraindications criteria (see Appendix 1) and that the ear(s) are free from wax (dependent on the local wax removal service arrangements in each CCG area).

Any inappropriate referrals received (e.g. for patients who meet the exclusion criteria) must be rejected and returned back to the GP within 5 working days.

If a referral is received with insufficient information, the provider should liaise with the patient's GP to seek this information so as not to delay the patient's appointment. If it is not possible to get the necessary information then the provider will return the referral to the GP for re-referral once all the missing information is known – providing patients are informed of any cancellations to pre-booked appointments following the return of the referral to the referrer.

3.4.4 Did Not Attend (DNA)

Should a patient not attend for a pre booked appointment then the provider must contact the patient within 2 calendar days and be given one further opportunity to attend. The Commissioner will not be charged for any non-attendance (DNAs).

3.4.5 Residual Wax Removal

Wax removal as part of the service is provided to support the fitting and monitoring of hearing aids and only provided as a means of residual wax removal. The purpose is to ensure any assessment for age related hearing loss is not affected by wax. All patients should have wax removed from their ears prior to the assessment appointment; this service is available from local wax removal services and in line with local agreed CCG pathways which are not part of this specification (but outlined in the local requirements in appendix 7) as per diagram 3.4.

If the patient has residual wax when attending for their hearing assessment then the provider should remove any visible residual wax as part of the 'one stop shop' model. All wax should be carried out through micro-suction (using a vacuum to suck the wax out) unless otherwise agreed with the commissioner. All wax removal should be removed prior to assessment and fitting of hearing aids to ensure patient is suitable for this service and accurate moulds etc. This service will not attract any additional payment but will help to complete the one stage assess and fit process.

This element of the service is only provided to support the fitting and ongoing monitoring and support services of hearing aids and not for general wax removal. If patients have any on-going issues with wax once their aids are fitted they should be directed to the local wax removal service/pathways and protocols available in each CCG area. The provider should liaise with your local CCG who will provide a copy of the local wax removal pathway and service/s.

3.4.6 One stage assessment and fit at the first appointment including Domiciliary
This includes first appointment, assessment, provision of aids and fitting.

The provider must ensure that two approaches are available to address the assessment and fitting requirements of the pathway following initial GP examination/referral.

Two stage pathway

- A single 'assess and fit' pathway for patients to receive hearing aids at the initial assessment appointment (same day)- suitability depends on hearing loss, dexterity, cognitive ability, emotional readiness and patient choice of the most appropriate hearing aids

- A two stage pathway, only where an impression of the ear is taken at the first assessment appointment for an ear mould to be made and the patient return at an agreed date and time for the hearing aid fitting (or bilateral impressions for bilateral fittings). If patients choose to have two stage pathways by choice this is included within the tariff and not chargeable separately.

Pre-appointment information to the patient must mention the two options, to better prepare patients in advance of having to make this decision. To ensure equity of access all information made available should be in a range of formats.

3.4.7 Domiciliary Visits

Domiciliary referrals must be made on an individual patient basis following GP examination and confirmation from the GP that the patient is house bound with confirmation that the patient has capacity and that consent is in place. Assessment by the provider, including domiciliary referrals, should be booked within 5 working days and undertaken within 16 working days of receipt of referral. If family member or responsible adult or guardian is required (due to a patient lacking capacity) or requested by the patient to be present at the assessment, an appointment must be secured within 28 days.

The requirement for a family member or responsible adult or guardian to be present needs to be established prior to making the appointment. This is done on the basis that the patient's mind is impaired and it is thought that a patient is unable to make decision if they cannot:

- Understand or remember the information about the decision
- Use that information to make a decision
- Communicate their decision by talking, using sign language or by any other means

Domiciliary provision will be delivered within the patient's place of permanent residence. This will only be offered to patients who are housebound. Hearing assessments must be conducted in appropriately sound treated rooms where possible, such that ambient noise levels are compliant with the 'BS EN ISO 8253-1:1998 standard. If this is not possible (care home or domiciliary visits, community premises etc.) the 35dBA standard will be required (as a minimum standard) before undertaking testing. This should be done in situ with a portable sound level meter and the evidence of this undertaking documented. If, in exceptional circumstances, the sound levels are over 35dBA but are clinically suitable then the clinician may be allowed to use their clinical judgement to make the decision and proceed to see the patient accordingly.

3.4.8 Patient consent and communication

Consent must be obtained from the patient or obtained in line with the Mental Capacity Act regulations.

If a family member or responsible adult or guardian is required to attend the appointment (due to patient lacking capacity), or requested by the patient to be present at the assessment, the appointment must still take place within agreed timescales.

The provider must ensure patients have an adequate understanding of the hearing assessment process before the appointment by providing information (in a suitable language or format that accommodates those who have learning disabilities) in advance (either via the referrer or to be received by the patient at least 2 working days before the appointment) that explains the purpose of the assessment, what it involves and the possible outcomes e.g. being fit with hearing aids. The content of the letter should include information on how patients can request communication support such as a translator or chaperone for ethnic diverse cultures.

In addition, providers must supply details of which professional (job title and name where possible) will perform the test as well as a choice of when and where it will take place. Patients should be encouraged to bring a relative or significant other to the appointment for support if they wish.

During the assessment appointment, the practitioner must ensure that communication with the patient is appropriate with her/his needs and takes into account any additional needs the patient has including learning and communication difficulties and is effective enough to be able to work in partnership with the patient to reach jointly agreed goals/outcomes, undertaking the following:

- A clinical interview to assess hearing and communication needs - this must establish relevant symptoms, co-morbidity, hearing needs, auditory ecology, dexterity, and cognitive ability, significant psycho-social issues, lifestyles (including driving, use of mobile phones, TV, etc.) expectations and motivations
- Full otoscopy
- Measurements of pure-tone air and bone conduction thresholds - if there are contra-indications to performing Pure Tone Audiogram (PTA) - for example, discharging ear, exposure to sustained loud sound in the 24 hours preceding test - the patient must be informed of the reason for non-completion and re-booked to the most appropriate service as part of their episode of care tariff.
- Wax removal (where appropriate) should be undertaken prior to the assessment and fitting process however if residual wax remains and prevents assessment and fitting this should be removed by this service as part of the one stop shop approach.
- Assessment of loudness discomfort levels - where required.
- Integration of assessment findings with patient expectations - to enable patients to decide on appropriate and suitable interventions (i.e. hearing aids, communication support, education etc.)

All patients should be provided with a ‘patient pack’ which includes the following information:

- What service will be provided to them including information on location, frequency of follow ups and after care appointments including confirmation of date and time of next appointment/s and how to access after care appointments if patents are experiencing issues with their hearing aid(s)
- Information on use of the hearing aid including care instructions, battery life information (e.g. warning noises), how the loops works, information on any extra facilities (e.g. volume adjustments) and how to clean the equipment.
- Clarity on replacement hearing aids and costs.

- Any FAQ or do's and don'ts of the practical hearing aid(s).
- Clarity of the patient responsibility for hearing aids (e.g. keeping them clean and dry)
- Information on local hearing loss support/volunteer groups or information for carers/family support groups.
- Information on other useful equipment to aid hearing loss e.g. personalised loop.

3.4.9 Information Technology (IT) System

In order to facilitate streamlined and co-ordination of care for a positive patient experience in a timely manner, providers are required to ensure that their local IT system/s is robust and providers are able to share patient information with GP's (via ERS) and other audiology providers in order to reduce duplication of service. Providers must be compliant with one or more of the below IT systems:

- All clinical systems to be used must be able to integrate with the CCG's preferred system (EMIS Web) which has 100% coverage across all Lancashire practices.
- Use of Lancashire Person Record Exchange System (LPRES) – local integration engine
- Use of NHS mail to transmit Patient Confidential Data
- Use of Medical Integration Gateway (MIG) – Supplied by Healthcare Gateway
- Or various combinations of the above

The provider must be visible on eRS via a directly or indirectly bookable service.

All referrals into the service will be received from the patient's own GP or community service should this be operational within CCGs area – please check local requirements as outlined in appendix 7. Referrers to comply with referral checklist in Appendix 5

The provider will need to provide evidence of their IG Toolkit and obtain access to the secure HSCN Network.

3.4.10 Following the assessment, the practitioner must:

- Explain the assessment, including the extent, location, configuration and possible causes of any hearing loss and the impact hearing loss can have on communication, for example, poorer speech discrimination and sound localisation and the impact this can have on a personal and societal level.
- Discuss with the patient the management options available to address their hearing loss and whether a hearing aid would be beneficial, exploring the psycho-social aspects of the hearing loss, as well as the physical aspects (e.g. audibility of sounds and speech)
- Work collaboratively with the patient to establish realistic expectations for the management suggested providing all relevant literature (in a suitable language and format) to facilitate discussions
- Where hearing aids are expected to be beneficial and the patient wishes to accept provision of hearing aids, at the same appointment:
    - Undertake pre-fitting counselling, managing expectations as necessary
    - Adopting the principles of co-production a written Individual Management Plan (IMP) will be developed with the patient, which defines the patient's goals and hearing needs and how they are going to be addressed.
    - Objective measurements (e.g. Real Ear Measurements (REM)) to verify fitting by agreed protocol (e.g. BAA/BSA recommended procedure and adjustment of hearing aid output to match target exceptions to be reported to the Individual Management Plan.
    - Discuss and document in the patient record the hearing aid options and agree types

and models with the patient based on their suitability to the patients' hearing loss
- Provide the patient with a 'patient pack' (see sec 3.4.8).
- Provide patient information (in a suitable language and format ensuring that reasonable adjustments for those with learning disabilities are applied) and ensure that the patient has understood the major points arising from the assessment including details of the hearing aid(s) which have been, or will be, fitted and any follow-up arrangements.
- Discuss and document whether a unilateral or bilateral fitting is appropriate. Any decision in this respect must be based on clinical need and not financially driven.
- Electronically record details of the assessment appointment, including any comments by the patient.
- Inform patients of replacement hearing aid costs and criteria for exemption if appropriate.

Bilateral fittings are not clinically appropriate where:

- One ear is not sufficiently impaired to merit amplification.
- One ear is so impaired that amplification would not be beneficial and a referral should be made to an appropriate service.
- The patient declines bilateral aiding where offered as appropriate and this should be recorded on the patient records.
- The patient has other reasons (e.g. manipulative ability, otological, change of batteries etc.)
- Agree an appointment time and date for an annual review which must include reminder letter and or call.

The patient is asked to decide on choice of ear mould type and characteristics unless:

- A referral to a more specialist service is required, at which point providers should follow locally agreed pathways which may prevent fitting (exceptional circumstances)
- The patient declines bilateral aiding (2 aids) where offered as clinically appropriate (this must be confirmed in a signed statement by the patient) and is part of their episode of care on where and when they may wish to return for the second fitting.

A full record of the consultation and any decisions/ agreements should be provided to the service user at the end of the consultation. British Society of Hearing Aid Audiologists guidance on record keeping is available at http://www.bshaa.com/Publications/BSHAA

Note:

- Where an NHS-qualified provider also provides private hearing aids and a patient expresses a personal preference around hearing aids that cannot be met by the NHS funded service, or enquires about privately prescribed hearing aids, providers must advise the patient that the appointment is exclusively for NHS services and any further dialogue or information concerning private hearing aids must be dealt with at a separate patient booked appointment outside of the NHS-funded service.

- Provision of NHS-funded hearing aid(s) will be of a minimum technical specification, as designated by the NHS, and obtained through the NHS Supply Chain. Supply Chain instruments/accessories must only be provided to patients seen in the NHS pathway. Should there be instances when Providers have to purchase items from other suppliers the items provided to patients seen in the NHS Pathway MUST meet NHS quality and technical standards as do those brands and models listed in the NHS Supply Chain catalogue. Providers should note they may have obligations under the Public Contracts Regulation 2006 \ EU Procurement Law if they make their own procurement arrangements rather than procure through NHS Supply Chain.

- Providers must not promote their own private treatment service, or an organisation in which they have a commercial interest.

- Providers must not encourage patients to 'trade up' (i.e. to privately purchase more expensive hearing devices than is necessary).

- Where an enquiry is made because the patient is experiencing functional difficulty with an NHS provided device, every effort must be made to address this from within the NHS funded service. Where this is not possible, the Commissioner must be informed, providing details of what action the Provider is proposing to take to resolve the issue. Such notification must be supported with appropriate records

- Providers should issue patients with a maximum of 1 hearing aid for unilateral use or 2 hearing aids for bilateral use for the full 3 year period of this contract. Spare hearing aids are not part of standard NHS provision.

- Any marketing of the service and communication with potential patients must be agreed with the Commissioner in the first instance

All GPs and providers of Adult Hearing Care Services must co-ordinate patients' care and management to ensure that care continues to be provided to patients for a continuous 3 year period.

3.5 Exceptionality to criteria

The reasons for any additional new hearing aids within the 3 year period (**only one individual or set is funded under this contract per patient for the full 3 year pathway**) including expected benefits must be explained to the patient and formally documented and sent to the GP.

- The change in threshold of the audiogram
- Details of both new hearing aid(s) issued and old aid(s) no longer in use.
- The Provider must ensure that hearing aids no longer required are disposed of in a safe and appropriate manner and in accordance with applicable legislation.
- Details of how the old hearing aids cannot meet the clinical needs.
- Details of how the new hearing aids will meet the clinical needs of the patient.

3.6 Review appointment –10 weeks after fitting and annually (included in the fitting tariff)

Patients must be empowered to self-manage their hearing aids supported by receiving appropriate contact and support at every consultation. The communication can be face to face or via telephone, must be undertaken within 10 weeks of fitting (unless there are clear documented, clinical reasons to do otherwise, or if a patient chooses to wait beyond this period), in order to determine whether needs have been met and that continuous usage is evident. All current patients must be informed in writing e.g. patient leaflet that they have access to the Integrated Hearing Service (as part of their on-going treatment via their current provider) for support, advice and help with their aids as and when this is required to ensure there is no duplication of care.

Patients must be offered via face to face or non-face to face 'contacts' during years 1-3 of their care (e.g. electronic, telephone review or postal questionnaire) – the Provider must seek to meet the patient's preference where possible.

If the patient opts for a non-face to face follow up and this proves unsuitable (for either patient or Provider), a face to face appointment should then be undertaken within 7 working days of the non-face to face contact.

A quicker follow-up appointment may be necessary in advance of the patient's pre-booked follow up appointment (e.g. if the patient is experiencing difficulty with their aids) and provision for on the day urgent appointments must be available.

The Provider must:

- Utilising principles of co-production update the IMP in conjunction with the patient to ensure that any residual need has a plan of action
- Maintain confidential electronic records of the follow up appointment including completed copies of the outcome tool, any adjustments made to the aid(s) and comments made by the patient.

The provider must ensure that they offer an annual review appointment/contact to the patient during the 3 years of their episode of care within the service. The annual review must include as a minimum:

- A discussion with the Audiologist on performance and satisfaction of the hearing aid (s)
- Re-programming of the aid(s) if required
- Replacement or modification of ear moulds (if required)
- Repair and modification of faulty hearing aid(s)
- Review of patients hearing - where a patient has significant change in their hearing, replacement hearing aids can be provided should the patient wish to remain with the current provider. The Commissioner to be advised as per section 2.
- Continued usage of the preferred validated outcome measure (GHABP/COSI/IOI-HA) plus any additional measures used to assess the effectiveness of the intervention and respond to result
- To conduct objective measurements e.g. REM (if necessary)
- The provision of information (in language and formats to enable access for all) and sign-posting to any relevant communication/social/rehabilitation support services

3.7 Aftercare – minor maintenance/repair (included in the fitting tariff)

The provider must provide on-going aftercare and equipment maintenance to patients following their fitting. Appointments must not be limited to an annual service and patients must be able to access the service as frequently as required as part of their service delivery, and without additional charge to the Commissioner (including quick access to on the day appointments).

Aftercare may be provided by any member of staff who is suitably trained and qualified for the task required e.g. BSHAA-approved Healthcare Assistant however, there must always be an experienced audiologist or hearing aid dispenser available in person or on request to provide further support if required. Part of the aftercare should include the following:

- Cleaning advice and cleaning aids for patients with limited dexterity
- Battery removal devices for those with limited dexterity
- Replacement of batteries, tips, domes, wax filters and tubing, where required
- Replacement or modification of ear moulds
- Repair or replacement of faulty hearing aids on a like for like basis, documented evidence must be provided as to the rationale for any replacements and associated costs be applied in line with the criteria and agreed exemptions.
- Re-programming if required
- Provision of information (in a suitable language and format) about wider support services for hearing loss. This should include all communication methods such as email, text message,

letters and telephone
- Annual appointment to assess any changes in hearing.

Patients must be able to access routine (2-5 days) and urgent (on the day) appointments must be made available within the Integrated Hearing Service. A postal repair service must also be available to patients for returns within 7 working days, at the provider's expense.

Patients must be provided with hard copies of the information on this service detailing the following as a minimum:
- Which provider they are currently with
- Where they can access the service including address and telephone number
- How they can access the service
- What the service provides e.g. replacement tubes, rectifying of certain issues such as whistling etc.
- What they can do if they are not happy with the service

3.8 Battery replacement Service

Batteries for hearing aids provided through an NHS qualified provider must be provided free of charge to NHS patients as part of the aftercare service with the patients current provider, not an alternative provider, and must be of a designated specification according to the NHS Supply Chain.

Options for battery replacement include:
- Collection from the provider's service
- Via local supply points (e.g. a network of GP practices/health centres) supplied with stocks of good quality batteries in all commonly used sizes free of charge by the provider.

The provider is responsible for the purchase, provision and replacement of batteries to NHS patients and must supply the brand as designated by NHS Supply Chain.

4. Population covered

The provider should deliver the service to the registered population within each CCG only. This is determined by patient being registered at a GP practice within the boundaries of the responsible commissioning CCG. Please see appendix 7 for breakdown of each CCG local information/requirements.

5. Location(s) of service delivery

The service will be provided from various community locations or a hospital setting should it serve a locality within a CCG. All venues should be accessible, DDA compliant premises within the responsible commissioning organisations localities and accessible to patients throughout the geographical area for the standard days/hours of operation detailed in section 3.3.1.

6. Any acceptance and exclusion criteria

6.1 Acceptance criteria

The Integrated Hearing Service is for adults over the age of 50 with suspected or diagnosed age related hearing loss. The Integrated Hearing Service is for adults experiencing hearing and communication difficulties who feel they might benefit from a hearing assessment and rehabilitation

including the option of trying hearing aids with onward aftercare and support.

The referral criteria are based on the BAA Guidance for Audiologists: Onward referral of adults with hearing difficulty directly referred to audiology services (Nov 2016) and BSHAA Referral guidelines for HCPC registered hearing aid dispensers (updated September 2017) for the Direct Referral of Adults with Hearing Difficulty to Audiology Services.

Eligible patients must be referred to provider by a **GP or community service only.**

The provider will need to have systems in place to accommodate patients who:

- Have sight loss/dual sensory loss.
- Require translation services including language.
- Have learning disabilities – as special test facilities and techniques are required.
- Have dementia – as additional support arrangements are required
- Require domiciliary care – the Provider should provide all parts of the service at the patient's domicile (including residential or nursing homes) where this is requested in writing by a GP following an initial GP assessment and examination to rule out exclusions in Appendix 1 and accompanied by the required checklist.

Routine adult hearing services for hearing loss may be provided to people as long as they do not meet the contra-indications as detailed in appendix 1.

6.2 Exclusion criteria

The following patients should not be referred to, or received into the Integrated Hearing Service:

- Children and adults under 50 years of age (i.e. 49 and 364 days)
- Patients not registered with a GP within the CCG locality
- If the provider receives a referral for an out of area patient that they are not contracted to deliver activity for.
- Patients with post-operative or post-traumatic complications
- Patients who require a surgical opinion
- Cases where cancer is suspected based on agreed 2 week wait protocol
- Patients who require management or treatment outside the scope of the Integrated Hearing Service.
- For patients who have not already had wax removed at the earliest point of identification.
- Adult patients who meet the contra-indications and exclusions detailed in Appendix 1

The provider is not expected to undertake procedures not commissioned by the CCGs or specialist services already provided by existing acute specialist Providers.

Any of the services listed above (exclusion criteria) must NOT be undertaken by the provider.

6.3 Interdependencies with other services

The provider should be seen as part of the wider integrated adult health and social care hearing services working in partnership with GPs, Primary and Community Health Care teams, Ear Nose & Throat (ENT) departments, Audio-Vestibular Medicine (AVM) Audiology Departments, local authorities, the voluntary & community sector and independent providers.

The provider must demonstrate how collaborative arrangements with these other organisations will operate to support patients in successfully managing their hearing loss and promote independent living. Providers must have as a minimum a well-developed and audited pathway for communication with GPs and ensure seamless integration of the Integrated Hearing Service within the wider health, voluntary and social services environment e.g. equipment services etc.

For the avoidance of doubt services including lip reading, effective hearing programmes, differential diagnostics, hearing therapy, Tinnitus and balance clinics are excluded from this service specification. The provider will be required to provide advice and direct patients to appropriate support services and training as required including but not limited to translation and lip-reading services.

7. Applicable Service Standards

7.1 Applicable national standards e.g. NICE, Royal College

Please see below for applicable accreditation standards and guidelines including working towards IQIPS accreditation.

7.1.1 Facilities

Hearing assessments must be conducted in appropriately sound treated rooms where possible, such that ambient noise levels are compliant with the 'BS EN ISO 8253-1:1998 standard, Acoustics-Audiometric Test Methods – Part 1: basic pure tone air and bone conduction threshold audiometry'. For further information on minimum requirements please refer to BSA guidance below:

BSA_RP_PTA_FINAL
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All provider premises must meet national minimum standards within the 'British Society of Hearing Aid Audiologists (BSHAA) Guidance on professional practice for Hearing Aid Audiologists. All sites will be agreed as acceptable with the Commissioner as part of the mobilisation process.

Provider nominated facilities should be accessible both in terms of public transport links and parking facilities and have access to PTS services (where locally available) and compliant with all relevant local and national laws, regulations and service requirements including:

- The Equality Act 2010
- The Disability Discrimination Act 1995 and 2005
- Buildings must meet all statutory compliance regulations
- If relevant Acts or guidance is updated then Providers would be expected to comply with these updates.

Particular attention should be paid to the accessibility needs of people with sensory, physical and mental impairments, as well as those who may face, for instance, cultural or language barriers. The Provider must make adequate and reasonable provision for interpreters, carers and others from

whom the patient may require assistance, providing information and signage in a range of formats, media and languages, and ensuring service and customer care is delivered in an inclusive manner which respects the diversity of users.

The provider must adhere to all national and local decontamination procedures and guidelines (cleaning and disinfection) to ensure a safe environment for all staff and patients.

In the unlikely event of an emergency, the service provider must have procedures and processes in place to mitigate and reduce risk to the patient

All provider premises must meet the CCGs Infection Prevention and Control Policy.

7.1.2 Improving Quality in Physiological Services (IQIPS) Accreditation Standards
www.ukas.com/services/accreditation-services/physiological-services-accreditation-iqips/

The delivery of all elements of the audiology services must participate in, and maintain accreditation to defined quality standards operating under the umbrella of the UKAS IQIPS Accreditation Scheme. In particular:

- As a minimum, the provider will be expected to have completed the IQIPS Traffic Light Ready system and have registered an application for accreditation with UKAS;
- Any additional sites must have IQIPS accreditation in order to be commissioned
- After the first 12 months of the contract, rolling audits will be carried out on all providers to determine IQIPS accreditation status. Any site found to be without IQIPS accreditation will be decommissioned from the E-Referral system and will be re-commissioned once evidence of accreditation is supplied.

Accessible Information Standard

www.england.nhs.uk/wp-content/uploads/2015/07/access-info-spec-fin.pdf

The provider must implement and demonstrate ongoing compliance with the Accessible Information Standards.

7.1.3 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)
Hearing assessment, fitting, follow-up and aftercare services should follow current best practice standards and recommendations as defined below:

- NHS Core principles
- National Institute for Health and Care Excellence Guidelines (NG98) and Quality Standards: Hearing loss in adults: assessment and management (2018)
- Care Quality Commission Standards
- Clinical protocols specified by British Society of Audiology and British Academy of Audiology and the British Society of Hearing Aid Audiologists
- British Society of Audiology guidelines on minimum training standards for otoscopy and impression taking 12
- British Society of Audiology and British Academy of Audiology guidance on the use of real ear measurement to verify the fitting of digital signal processing hearing aids 12 and 13
- Guidelines on the acoustics of sound field audiometry in clinical audiological applications
- Hearing Aid Handbook, Part 512

- British Society of Audiology Pure Tone air and bone conduction threshold audiometry with and without masking and determination of uncomfortable loudness levels
- British Society of Audiology recommended procedure for taking an aural impression
- British Society of Audiology recommended procedure for tympanometry (when undertaken)
- Recommended standards for pre-hearing aid counselling (Best Practice Standards for Adult Audiology, RNID, 2002)
- Recommended standards for deaf awareness (Best Practice Standards for Adult Audiology, RNID, 2002)
- British Academy of Audiology Guidelines for Referral to Audiology of Adults with Hearing Difficulty (2009)
- Direct Referral of Adults with Hearing Difficulty to Audiology Services (Draft Guidelines 2016)
- Clegg, A. et al, (2010) The safety and effectiveness of different methods of earwax removal: a systematic review and economic evaluation. Health Technology Assessment 2010; Vol. 14: No. 28
- Guidance on Professional Practice for Hearing Aid Audiologists (British Society of Hearing Aid Audiologists, 2011)
- BSHAA Protocol and Criteria for Referral for Medical or other Specialist Opinion (2011)
- BSHAA Practice Manual for the use, supervision, training and approval of Hearing Care
- BSHAA Professional guidance: referral guideline for HCPC registered hearing aid dispensers (2017)
- Assistants, (British Society of Hearing Aid Audiologists 2013)
- Standards of Proficiency: Hearing Aid Audiologists (HCPC 2014)
- Guidance on Record Keeping (British Society of Hearing Aid Audiologists 2016)
- Health and Care Professions Council professional registration and training standards
- NHS England What works: Hearing loss and health ageing (2017)
- British Society of Audiology: Practice guidance Common principles of rehabilitation for adults in Audiology services (2016)

8. Other

8.1 Workforce

The NHS hearing service is a clinically delivered service by qualified audiologists. The provider must ensure that all procedures are completed by a competent clinician and that the procedure is conducted in a way that ensures maximum comfort and minimum risk for the patient. The service will not administer any local/general anaesthesia.

The provider must have an appropriate skill mix within their team, in keeping with the recommendations set out in 'Transforming Integrated Hearing Services for Patients with Hearing Difficulty – A Good Practice Guide', DH, June 2007. Assessment and treatment must always be provided by members of staff that are either suitably registered or are supervised by a suitably registered practitioner and who are appropriately trained, qualified and experienced.

Audiologists, Registered Hearing Aid Dispensers and assistant/associate audiologists may provide a direct service to patients according to appropriate qualifications, skills and experience which are set out in Appendix 4.

In terms of training and development:

- All staff should be trained to identify the contra-indications detailed and undertake appropriate action according to defined protocols
- In order to work unsupervised, staff need to be able to evidence that they have undertaken a minimum of 50 assessments and fittings in the preceding 12 months with no untoward issues

or substantiated complaints.

- Newly qualified Audiologists need to spend a minimum of 2 weeks observing a qualified audiologist or dispenser, followed by 2 weeks working under the direct, full-time supervision of a senior audiologist Newly qualified staff undertaking this training period should have a portfolio/evidence to demonstrate competence
- Development of a skilled and modern audiology workforce should be supported by offering suitable clinical training placements to postgraduate, undergraduate and foundation degree students
- Evidence of Continuing Professional Development
- Evidence of regular safeguarding training

8.1.1 Consumables

Consumables and operational costs are included within the NHS hearing service.

8.1.2 Governance, Accreditation and Quality Assurance

The provider will undertake a quality audit by completing the IQIPS Traffic Light Ready system for Integrated Hearing Services before delivering NHS services under the contract and continue using quality audit on a regular basis to improve practice.

Providers MUST be registered on the IQIPS-Self Assessment and Improvement Tool and provide a date (within 12 months) by which any provider intends to become fully accredited before commencing the service. The CCG reserves the right to restrict any provider's continuation in the scheme should any provider fail to register or gain accreditation by the defined date.
The CCG reserves the right to retract or implement any quality improvement tools. Dispensation can be requested by a provider from the CCG if circumstances beyond the providers control prevent them from being accredited by the defined date are evidenced. The CCG will then undertake a risk assessment and make a decision regarding the provider being able to continue providing services under this contract, which could result in the provider's contract being terminated.

Once registered, assurance statements for Sections:

- Domain 1 – Patient Experience PE1-5
- Domain 2 – FRW 7 Managing Complaints
- Domain 3 – Safety SA1 Managing the risk of infection
- Domain 4 – Clinical CL7 Managing Clinical Records

Need to be submitted to the CCG for approval prior to the service commencing.

8.1.3 Whole System Relationships

The provider is responsible for ensuring that all service providers' work together to ensure that the care provided to the patients is well coordinated, high quality and safe and that the system as a whole is efficient and effective. This will involve:

- Agreeing and implementing integrated pathways and protocols
- Identifying boundaries of care between providers and accountabilities
- Developing and maintaining a directory of resources and capabilities provided by any choice of provider organisations
- Developing and implementing shared information/communication systems at the appropriate time (including the use of E-Referral Service ERS).

- Develop and maintain a directory of services for all elements of the service and include a full list of conditions treated, procedures performed and service exclusions
- Developing and implementing systems for measuring outcomes
- Sharing outcomes data with Commissioners and all Providers involved in the pathway
- Sharing learning and proposing future developments
- Providing clinical leadership
- Linking with stakeholders including patients and the public, the voluntary sector, pharmacists, GPs, acute hospitals, local authority.
- Patients referred to the service who do not fulfill the criteria will be re-directed back to the referrer with an indication of the appropriate service.

The provider will ensure that a seamless service is offered and provided to patients at all times.

8.1.4 Marketing and Promotion of Services

Providers marketing and promoting their NHS services should adhere to the NHS Identity Guidelines: http://www.england.nhs.uk/nhsidentity/

The provider will:

- Undertake communication activity and marketing campaigns in order to promote the NHS funded service. This will include producing marketing materials, information and literature relating to the service on a bi-annual basis. Both the Commissioner and the Provider has the right to approve content of such materials. Materials may include posters, information sheets or electronic media on accessing the service.
- Comply with NHS branding guidelines when producing communication, marketing and patient promotion literature.
- All providers must provide their appointment availability via the E-referral System.
- Any communication, marketing and promotional activity must be separate from other non-NHS funded services marketing and promotion activities.
- Not pro-actively promote non NHS-funded services, activities or products which could be considered to be an alternative option to NHS provision to NHS patients using the Integrated Hearing Service.
- Not market NHS products and services as inferior to other products or services they or any organisation in which they have an interest provide.
- Not use the term “Free” in relation to services. The term “NHS-funded” is permitted.
- Offer patients an opportunity to opt in and out of receiving marketing information, and not make future contact without the individual’s explicit opt-in consent.
- Provide each patient with a ‘patient pack’ as outlined in section 3.4.8.

Where a patient is actively seeking alternative information about private purchase, providers must not act unprofessionally or make uninformed comments about alternatives, but refer to alternative unbiased sources of information, for example, the BSHAA find an Audiologist service: http://www.bshaa.com/Find-an-Audiologist. Where a patient may have to attend the provider for another health related issue, the provider is responsible for signposting the patient back to the GP or community service without marketing or providing referral forms for the Integrated Hearing Service.

8.1.5. Exit Planning

Unless otherwise stated, the definitions that shall apply in this Schedule are those set out in the General Conditions.

1. Provision of Information by the Provider

i) In addition to its obligations set out in General Conditions (GC)18 and GC5, in the event of the expiry or termination or the pending expiry of the Contract or any Service or upon any notice of termination, having been served, pursuant to GC17, the Provider agrees that it shall supply to the Commissioner, within 20 Operational Days of receipt of a written request from the Commissioner, such details of the Staff, Provider's Premises, Services Environment, Equipment and the Provider's costs actually incurred in delivering the relevant Services in such format as the Commissioner shall request.

ii) The Provider agrees in relation to the information that it is required to provide, pursuant to paragraph 1(i) of Section 8.1.5 above, that:

a) where required to do so by the Commissioner, it will provide the required information on an anonymous basis, directly to any provider who is identified by the Commissioner as a potential new provider of the Services;

b) the Commissioner may share the information it receives, on an anonymous basis, with any potential new provider of the Services;

c) should the details of any information already provided by the Provider, subsequently change, the Provider will update the Commissioner and/or new or potential new providers to whom it has provided that information, as soon as possible.

iii) The Provider acknowledges that the Commissioner is relying on the accuracy and completeness of the information to be provided pursuant to paragraph 1(i) above in connection with any re-procurement or re-commissioning process it may carry out in respect of the Services and that the information will be required in order to enable any potential new providers of the Services to assess the likelihood of TUPE applying on a transfer of the Services, and more generally, in order to enable any potential provider to undertake an adequate pricing exercise in relation to its proposed assumption of provision of the Services.

2. Staff Information

The Provider shall provide the following information:

i) The organisational and management structure of the Services (including details of how the Services are provided and managed by the Staff and details of any vacant posts).

ii) Whether the Services have dedicated employees (that is they **only** work on the Services) and if so:

- How many of those employees are so dedicated (not whole time equivalents, actual numbers); and

- Each job role/title.

iii) If employees undertake any or any part of provision of the Services, but are not dedicated to the Services, estimate for each individual, the percentage of their working time spent on the Services over the preceding 12 months and for each of these details of what other work they do.

iv) For all employees identified at paragraphs 2ii) and 2iii), details of the following:

- Payment method for wages
- Pay day/date
- Pay band and increment date
- Pay and other remuneration along with any non-cash benefits
- Pension scheme details
- Normal hours of work
- Overtime: whether undertaken, by which employees and whether compulsory or voluntary
- Working time flexi scheme
- Annual Leave entitlements
- How annual leave pay is calculated
- Whether any of the employees are mobile employees (a mobile employee means any employee who is not required to attend a particular dedicated place of work each day)
- How mileage claims are calculated for mobile employees
- For non-mobile employees their normal place of work
- Whether there is in place a contractual mobility clause
- Whether all required pre-employment checks (including DBS, entitlement to work in the UK etc.) have been undertaken/completed.
- Whether there are any existing or contingent liabilities towards any of the employees, for example, but not limited to awards of damages or compensation for, or existing claims in respect of unfair dismissal, personal injury, discrimination, breach of contract, unlawful deductions, whistle-blowing.
- Any outstanding HR issues e.g. discipline, grievance, capability, ill-Health etc.
- Numbers of employees not currently working and why, for example, but not limited to maternity leave, ill health, study leave, career break.

v) In addition to those employees identified at paragraphs 2ii) and 2iii), state what other Staff provide any of the Services and the basis upon which they do that, including bank staff, non-employed consultants, agency workers. Details of how much use has been made of those Staff over the previous 12 months.

3. Costs, Provider's Premises, Services Environment and Equipment

The Provider shall provide the following information:

ii) Details of how the Services are funded by the Provider and the actual costs incurred by the Provider in providing the Services over the 12 months immediately preceding receipt by the Provider of the written information request from the Commissioner made pursuant to paragraph 1(i) of this Schedule 2I;

iii) Details of and a description of any Equipment which is dedicated for use or partially dedicated for use in connection with the Services;

iv) A description of all Provider's Premises utilised in connection with the Services, together with details of the basis on which the Provider owns or occupies those premises;

v) A description of all of the Services Environment and an explanation of any relationship which those have to the Provider's Premises

4. Purchase of Services Equipment

In this paragraph 4 of Schedule 2I, the following definitions shall apply in addition to those set out in the General Conditions:

"**Equipment Agreements**" means any third-party contracts or leases entered into by the Provider or a Sub-contractor which relate specifically to any Services Equipment that is to be sold or transferred to the Commissioner (or a third party nominated by the Commissioner).

"**Equipment Transfer Date**" means the date agreed by the Parties on which the Commissioner (or any third party nominated by the Commissioner), acquires any Services Equipment from the Provider.

"**Net Book Value**" means:

(a) in respect of Provider Equipment which is shown in the Provider's accounts, the net book value at the time in question;

(b) in respect of Provider Equipment which is available for use but which has been written off in the Provider's accounts, the net book value which the Provider Equipment would have had if the Provider Equipment had been capitalised which, for the avoidance of doubt, shall be calculated by applying the depreciation rate which the Provider Equipment would have had in the event that it had been capitalised on acquisition; and

(c) in respect of consumables, the acquisition cost in respect of such consumables;

in each case, such amounts to be calculated in accordance with usual and consistent accounting principles.

"**Services Equipment**" means all that Equipment used predominantly in connection with the Services.

i) The Provider agrees that in the event of the expiry or termination of this Contract or any Service, howsoever arising, the Commissioner shall have the first option (but not the obligation) to acquire the Services Equipment or any part thereof (or to facilitate that acquisition by a nominated third party) in accordance with the terms set out in this paragraph 4 of Schedule 2I.

ii) No later than 3 months prior to the Expiry Date (or if the amount of notice of termination is less than 3 months, within a reasonable period of time following receipt of notice of termination), or in the event of the Contract or any Service being terminated under more immediate circumstances, as soon as reasonably practicable, the Provider shall provide to the Commissioner a list of the relevant Services Equipment, giving the Net Book Value of each item.

iii) The Commissioner shall confirm in writing to the Provider as soon as reasonably practicable and in any event no later than 5 Operational Days following receipt of the Provider's list of Services Equipment, which items if any the Commissioner (or any nominated third party) is interested in acquiring and its agreement or otherwise to the Services Equipment valuations.

iv) Where the Parties are unable to agree the Services Equipment valuations, either Party shall be entitled to refer the matter for resolution by an accountant (either jointly appointed by the Commissioner and the Provider or, if the Parties cannot agree a joint appointment, appointed by the President of the Institute of Chartered Accountants on the application of the Commissioner or the Provider) who shall act as an expert in determining both the relevant Net Book Values and how the expert's costs shall be allocated between the Parties.

v) No later than 5 Operational Days following:

a) agreement by the Parties of the amounts due in respect of the Services Equipment to be acquired; or

b) in the event that an expert is appointed pursuant to the provisions of paragraph 6(iv) above, determination of the amounts due;

the Provider shall issue an invoice to the Commissioner (or any third party nominated by the Commissioner) for the amount payable in respect of the Services Equipment, such invoice to be payable by the Commissioner (or any third party nominated by the Commissioner) by bank transfer in cleared funds within 30 days of the date of the invoice or, if agreed otherwise by the Parties, on a later date agreed between them.

Completion of Services Equipment Sale

vi) Where the Commissioner (or any third party nominated by the Commissioner) is acquiring Services Equipment pursuant to this paragraph 4 of Schedule 2H, the Provider shall use all reasonable endeavours to either:

(a) secure the novation to the Commissioner (or such other person as the Commissioner shall direct in writing) of the Equipment Agreements by the Equipment Transfer Date or as soon as possible thereafter (provided that the Provider shall not be required to bear any additional costs or fees in securing any such novation to the Commissioner); or

(b) where it is not appropriate to secure a novation of an Equipment Agreement, so far as it is reasonably practicable, assist the Commissioner (or such other person as the Commissioner shall direct in writing) to enter into a new agreement for the relevant Services Equipment on terms similar to those of the relevant Equipment Agreement (provided that the Provider shall not be required to bear any additional costs or fees in securing any such new agreement for the Commissioner).

vii) Subject to payment having been made in accordance with sub-paragraph 4(v) above, title to the Services Equipment shall pass to the Commissioner (or such other person as the Commissioner may direct in writing) from the Provider, and deemed delivery of the Services Equipment shall occur on the Equipment Transfer Date.

viii) In the event that an item of the Services Equipment shall have been in good working order but ceases to be in good working order as at the Equipment Transfer Date it shall (unless the Commissioner informs the Provider to the

contrary) be deemed to be excluded from the sale of Services Equipment and the amount payable by the Commissioner (or such other person as the Commissioner shall direct in writing) in respect of the Services Equipment shall be reduced by the Net Book Value of the relevant item and the Provider shall remove the relevant Services Equipment from the Services Environment forthwith. Any necessary adjustment to the Services Equipment sale price shall be made by the Parties and settled accordingly.

viiii) The Provider shall indemnify and keep the Commissioner (or any person to whom the Equipment Agreements may be transferred) indemnified in full against all Losses relating to and payable in respect of the Equipment Agreements which are attributable to the period before the Equipment Transfer Date.

x) If any of the Equipment Agreements are not novated by the date on which the Contract or Services terminates or expires (which may be because third-party consent to the novation of any of the Equipment Agreements is refused or otherwise not obtained, or where any of the Equipment Agreements are incapable of transfer to the Commissioner or such person as the Commissioner may direct by novation or other means):

(a) unless and until any such Equipment Agreement is novated, the Provider shall hold such Equipment Agreement and any monies, goods or other benefits received thereunder as trustee for the Commissioner and its successors in title absolutely;

(b) the Commissioner shall (or shall procure that such person as the Commissioner shall have directed to take the transfer or novation of the relevant agreement shall) (if such sub-contracting is permissible and lawful under the Equipment Agreement in question), as the Provider's sub-contractor(s), perform all the obligations of the Provider under such Equipment Agreement and, where sub-contracting is not permissible, the Commissioner shall perform such obligations as agents for the Provider;

(c) the Commissioner shall indemnify the Provider and keep it so indemnified in full and on demand from and against all demands of whatsoever nature relating to and payable in respect of the Equipment Agreements which are attributable to the period from and including the Equipment Transfer Date (except where the demand arose from any breach by the Provider of any Equipment Agreement which occurred without the authority or approval of the Commissioner); and

(d) unless and until any such Equipment Agreement is novated, the Provider shall (so far as it lawfully may) at the Commissioner's reasonable cost give all such assistance as the Commissioner may reasonably require to enable the Commissioner to enforce its rights under such Equipment Agreements and (without limitation) shall provide access to all relevant books, documents and other information in relation to such Equipment Agreement as the Commissioner may reasonably require from time to time.

General

1. In the below provisions of this Schedule 2I Exit Arrangements, the following definitions apply:

"**Actual Termination Date**" means the date on which the Contract terminates or expires howsoever arising;

"**Employed Staff**" means any Staff wholly or mainly employed in the provision of the Services;

"**Breakage Costs**" means amount(s) the Provider is required to pay to terminate (or, where commercially necessary, continue with until the Provider is reasonably able to novate to the New Provider or the Expiry Date is reached) any agreement(s) with premises provider(s), subcontractor(s) or supplier(s) engaged in connection with the Provider's provision of the Services;

"**Commissioner Termination Event**" means termination by the Commissioner of the whole or any part(s) of this Contract in accordance with General Condition 17.2;

"**Contingency Costs**" means such profits as set out in the Provider's Financial Mechanism Template for the 12 month period commencing on the Actual Termination Date; (such templates being embedded in Schedule 5A of this contract)

"**Expiry Date**" means the date on which the Contract is due to expire (including any extension period, where notice to extend has been served in accordance with Schedule 1C) without the operation of a provision to terminate the Contract;

"**Investment Expenses**" means such out of pocket expenses as the Provider has incurred through investment, exclusively in connection with its delivery of the Services, between the Effective Date and the Actual Termination Date;

"**New Provider**" means any individual or organisation (or where there is more than one, all of those individuals and organisations) that replace the Provider in the provision of the whole or part(s) of the Service (or equivalent service(s));

"**Procurement Losses**" means the reasonable costs and expenses of the Commissioner in procuring a New Provider (in addition to the costs and expenses to which the Commissioner is entitled, pursuant to General Condition 18.2);

"**Provider Termination Event**" means termination by the Provider of the whole or any part(s) of this Contract in accordance with General Conditions 17.3 or a termination by the Commissioner in accordance with General Conditions 17.8 which results in an Actual Termination Date being on or before the date which is 36 months after the Service Commencement Date;

"**Termination Losses**" means in respect of any part or parts of the Services under the Contract:

a) Contingency Costs;
b) Investment Expenses;
c) Breakage Costs;
d) any costs reasonably and properly payable by the Provider in writing off equipment or items used exclusively in providing the Services including committed lease obligations up to the Expiry Date which shall not be greater than net book value less the actual realised value for such items; and
e) any additional costs actually incurred in relation to the NHS Pension Scheme, the Local

Government Pension Scheme and/or the NEST scheme, including but not limited to any exit payments.

"**TUPE Transfer Event**" means the transfer of all Employed Staff from the Provider to any New Provider in accordance with the provisions of TUPE upon or immediately following the Actual Termination Date.

The provisions of this Schedule 2I Exit Arrangements shall survive termination of the Contract in accordance with GC19.

Provider Termination Event

- Upon termination of the Contract due to a Provider Termination Event the Commissioner may invoice the Provider for the Procurement Losses (including any reasonable supporting documentation requested by the Provider) and the Provider shall pay to the Commissioner the amount(s) set out in that invoice (subject to the Commissioner Costs Cap below).
- The Commissioner shall use its reasonable endeavours to mitigate any effects of termination in respect of a Provider Termination Event.
- The maximum aggregate amount of Procurement Losses payable by the Provider to the Commissioner is £250,000 (the "**Commissioner Costs Cap**").

9. Key Service Outputs and Outcomes

The Integrated Hearing Service will deliver the below Quality Key Performance Indicators as outlined in Schedule 4 (see embedded in appendix 3).

Any breaches of thresholds in respect of Operational Standards, National or Local Quality requirements which result in withholding of payment or repayment of sums paid and will be in line with the guidance in the NHS standard contract.

Contraindications - APPENDIX 1

This specification does not cover services for people with these contraindications who should continue to be referred by GP referral to the appropriate service as they may require more specialist intervention.

Contra-indications which should not be referred into or treated by the Integrated Hearing Service

History:

- Persistent pain affecting either ear (defined as pain in or around the ear lasting more than 7 days in the last 90 days and which has not resolved as a result of prescribed treatment);
- History of discharge (other than wax) from either ear within the last 90 days, which has not responded to prescribed treatment, or which is recurrent;
- Sudden loss or sudden deterioration of hearing (sudden=within 72 hours in which case refer via locally agreed urgent care pathways). Due to the variety of causes of sudden hearing loss, the treatment timescale should be decided locally by the medical team. Prompt treatment may increase the likelihood of recovery;
- Rapid loss or rapid deterioration of hearing (rapid=90 days or less);
- Fluctuating hearing loss, other than associated with colds;
- Unilateral or asymmetrical, or pulsatile or distressing tinnitus lasting more than 5 minutes at a time;
- Troublesome, tinnitus which may lead to sleep disturbance or be associated with symptoms of anxiety or depression;
- Abnormal auditory perceptions (dysacuses);
- Vertigo which has not fully resolved or which is recurrent. (Vertigo is classically described as a hallucination of movement, but here includes any dizziness or imbalance that may indicate otological, neurological or medical conditions. Examples include spinning, swaying or floating sensations and veering to the side when walking)
- .Normal peripheral hearing but with abnormal difficulty hearing in noisy backgrounds; possibly having problems with sound localization, or difficulty following complex auditory directions;
- Altered sensation or numbness in the face or observed facial droop

Ear examination:

- Complete or partial obstruction of the external auditory canal preventing full examination of the eardrum. If any wax is obscuring the view of the eardrum, the GP surgery should arrange wax removal before referring the patient to Audiology
- Abnormal appearance of the outer ear and/or the eardrum (examples include: inflammation of the external auditory canal, perforated eardrum, active discharge, eardrum retraction, growths, swelling of the outer ear or blood in the ear canal).

Audiometry:

- Conductive hearing loss, defined as 25 dB or greater air-bone gap present at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz;
- Unilateral or asymmetrical sensorineural hearing loss, defined as a difference between the left and right bone conduction thresholds of 20 dB or greater at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz;
- Evidence of deterioration of hearing by comparison with an audiogram taken in the last 24 months, defined as a deterioration of 15 dB or more in air conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.

References:

Draft Guidelines for the Direct Referral of Adults with Hearing Difficulty to Audiology Services, British Academy of Audiology (2016)
BSHAA Protocol and Criteria for Referral for Medical or other Specialist Opinion (2011
BSHAA Referral Guidelines for HCPC registered Hearing Aid Dispensers (updated September 2017).

Appendix 2

Outcome Measures

Glasgow Hearing Aid Benefit Profile:

http://studentacademyofaudiology.com/sites/default/files/journal

Improving Quality in Physiological diagnostic Services (IQIPS):

http://www.rcplondon.ac.uk/projects/iqips

Client Orientated Scale of Improvement (COSI):

http://www.nal.gov.au/outcome-measures_tab_cosi.shtml

International Outcome Inventory for Hearing Aids (IOI-HA)

http://www.harlmemphis.org/index.php/clinical-applications/ioi-ha/

Service Specification Appendix 3

Data Return

All communications must be undertaken via nhs secure e-mail and in line with schedule 4 and 6.

Audiology Schedule 4 FINAL.docx

Audiology_Service_Sch_6_v10 FINAL.xlsx

Service Specification APPENDIX 4

Minimum Qualifications and Skills of Clinical Staff

Professional Head of Service

They must have as a minimum the following qualifications and skills (or equivalent):

- BSc Audiology (or equivalent e.g. Hearing Aid Council examination or Foundation Degree in Audiology) level of expertise in audiology, with a Certificate of Audiological Competence (or equivalent)
- Registered with the Health & Care Professions Council (HCPC) as a Clinical Scientist in Audiology or registered with the Registration Council for Clinical Physiologists (RCCP) voluntary register as an Audiologist.
- Where the Government's Modernising Scientific Careers (MSC) programme brings about changes to registration requirements, senior audiologists must be registered accordingly.
- Appropriate training, skills and experience in testing, assessing, prescribing, fitting digital hearing aids and providing aftercare.
- Relevant experience at a senior managerial level, including experience of team management in adult audiology and evidence of CPD including the provision of patient education related to hearing loss and hearing aids.

Audiologists

They must have as a minimum the following qualifications and skills (or equivalent):

- BSc Audiology or Post Graduate Diploma in Audiology or pre 2004, Medical Physics and Physiological Measurement (MPPM) B-TEC and British Association of Audiological Technicians (BAAT) parts I & II, with training in Clinical Certificate of Competency.
- Registered with the HCPC as a Clinical Scientist in Audiology or a Registered Hearing Aid Dispenser, or with the RCCP voluntary register. Where the Government's MSC programme brings about changes to registration requirements, audiologists must be registered accordingly.
- Evidence of appropriate and recognised training (including CPD) to conduct hearing assessments and rehabilitation, including the provision of patient education related to hearing loss and hearing aids.
- Appropriate training, skills and experience in objective measurements (e.g. REM) of digital signal processing (DSP) hearing aids.

Registered Hearing Aid Dispensers

They must have as a minimum the following qualifications and skills (or equivalent):

- Hearing Aid Council qualification or Foundation Degree in Hearing Aid Audiology
- Registered with the HCPC as a Hearing Aid Dispenser

Assistant/Associate Audiologists

- Assistant/associate audiologists must be trained to perform the functions for which they are employed

- Such training maybe provided by BAA accredited training centres or national training courses for assistant audiologists, or specific topics such as the BSA course in otoscopy and impression taking or audiometry.
- Associate audiologists would be expected to have completed the Foundation Degree in Hearing Aid Audiology (or equivalent).

Appendix 5

GP Hearing Aid pathways

The below pathways will be promoted and implemented across all GP Practices:

Hearing aid pathways new spec 1

GP checklist

The below checklist will complement the pathway as a checklist for GP's to complete prior to referral to audiology services**:**

Age related adult hearing GP referral checklist

1. Ear examination has been undertaken to rule out wax? Yes/No

   If the answer is No, then the examination to be undertaken using an otoscope

2. If wax was present on otoscopy and examination has this been successfully removed? Yes/No

   If the answer is No, then referral should not be made until the wax has been successfully removed. Please follow local pathways.

3. Has the tympanic membrane been examined for evidence of:

   a. Perforation Yes/No
   b. Previous mastoid surgery Yes/No

   If the answer to either of the above is Yes and there is any sign of either condition, please refer to ENT or community service.

4. Is there unilateral hearing loss? Yes/No

   If the answer to the above question is Yes, then refer to secondary care ENT.

5. Has the patient been asked whether the hearing loss is significant and what impact this is having on the patients day to day activities? Yes/ No

   If the answer is No, then this information should be asked and documented.

6. Has the patient been asked whether they are ready to consider wearing hearing aid(s) regularly? Yes/No

   If the answer to the above question is No, then the reason for referral should be documented

Appendix 6 –

Type	Definition
New/ First appointment	New patient – assessment and fitting, residual wax removal. A new tariff is applicable should an existing patient at the end of the 3 year pathway have significant hearing changes, in accordance with Assessment of Change Criteria.
Follow up	Patient appointment/ communication can be face to face or via telephone, must be undertaken within 10 weeks of initial fitting. All current patients must be informed in writing and provided with a patient pack which will include patient leaflet that they have access to the service (as part of their on-going treatment via their current provider) for support, advice and help with their aids as and when this is required to ensure there is no duplication of care. A full breakdown of the content of the pack is available in section 3.4.8.
	Current patients on 3 year pathway: All patients fitted with a hearing aid are required to be offered an annual follow up appointment as per the patients preferred method, with the exception of the third year which must be face to face. During the appointment they will discuss their hearing needs with the Audiologist on the performance and satisfaction of the hearing aid (s) which can include: • Re-programming of the aid(s) if required • Replacement or modification of ear moulds (if required) • Repair and modification of faulty hearing aid(s) • Review of patients where a patient is having problems managing their hearing aid(s)/or whether the provider or the patient considers that there has been a significant change in the patients hearing. • Continue usage of the preferred validated outcome measure (GHABP/COSI/IOI-HA) plus any additional measures used to assess the effectiveness of the intervention and respond to result • Conduct objective measurements e.g. REM (if necessary) • Provide information (in language and formats to enable access for all) and sign-posting to any relevant communication/social/rehabilitation support services • advice, maintenance (Battery, tips, domes, wax filters and tube replacement service) • Re-assessment for hearing change (if required) and in line with the assessment for change criteria in section 2.3 of this specification.
Aftercare (after 3 years)	The Provider must provide on-going aftercare and equipment maintenance to patients who do not require a re-assessment for a change in their hearing loss. Appointments must not be limited to an annual service and patients must be able to access the Integrated

	Hearing Service as frequently as required as part of their service delivery. This can include • Cleaning advice and cleaning aids for patients with limited dexterity • Battery removal devices for those with limited dexterity • Replacement of batteries, tips, domes, wax filters and tubing, where required • Replacement or modification of ear moulds • Repair or replacement of faulty hearing aids on a like for like basis, documented evidence must be provided as to the rationale for any replacements and associated costs be applied in line with the criteria and agreed exemptions. • Re-programming if required • Provision of information (in a suitable language and format) about wider support services for hearing loss. This should include all communication methods such as email, text message, letters and telephone Annual appointment which is face to face to assess any changes in hearing. For patients who have a change in their hearing needs should be assessed in line with the assessment for change criteria in section 2.3 of this specification to confirm whether they require a new hearing aid. Should a new hearing aid be required, the provider should submit a claim for a new patient tariff.

Appendix 7 – Local requirements

18.09.18 - Morecambe Audio Lot

Morecambe Bay CCG

Audio Lot ELCCG 06.06.18.docx

East Lancashire CCG

Audio Lot template - BwD.docx

Blackburn with Darwen CCG

Blackpool Audio Lot template.docx

Blackpool CCG

CSRGPCCG Audio lot template v4 2409201

Chorley South Ribble CCG
Greater Preston CCG

Fylde and Wyre Audio Lot template.dc

Fylde and Wyre CCG

WLCCG Audio Lot template (2).docx

West Lancashire CCG

No local requirements