**Service Specifications**

|  |  |
| --- | --- |
| **Service Specification No.** | 01 |
| **Service** | Integrated Hearing Service for Age Related Hearing Loss – Lancashire Wide |
| **Commissioner Lead** |  |
| **Provider Lead** |  |
| **Period** | 4 years (1st April 2019 – 31st March 2023) |
| **Date of Review** | Annually by 31st March of each contract year |

|  |
| --- |
| **1.** **Population Needs** |
| **1.1 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 * Preston, 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 technology, maintain quality and strive 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. * Guidance on Identifying Non-Routine Cases of Hearing Loss in Adults ( April 2015) Service Quality Committee of the British Academy of Audiology to enable clinicians to direct hearing impaired adults along the most appropriate treatment pathway and to enable effective discussions between commissioners and Audiology professionals by identifying cases of hearing loss in adults that are likely to be unsuitable for the routine adult care pathway. * 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 |   2.2.1 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 required for the registered population of the NHS commissioning organisations is for over 50 years 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 service will be delivered 7 days per week including Monday to Friday 8am to 6pm with extended opening hours on a weekend/late evening.  Complex audiology services (for patients who meet the contra-indications detailed in Appendix 1) 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.  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 Integrated Hearing Service will consist of:   * Hearing test and needs assessment including provision for urgent appointments and drop in sessions * Residual Wax removal-micro-suction * 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 * Follow up appointments (initiated by patient and provider) via telephone, face to face or electronically to be made with the patient in years 1,2 and 3 as part of an annual aftercare service for up to 4 years, including advice, maintenance and patient review in year 4. * Battery, tips, domes, wax filters and tube replacement service. * GP referral to ENT services and patient choice offered (follow local pathways and protocols). Providers and Commissioners are working towards a direct ENT pathway which will be enacted upon local agreement. * 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 4 year pathway delivered by the provider. A exceptions to this are if there is change in hearing (following assessment) and a replacement aid should be provided to the patient.   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.  2.2 Local defined outcomes  The broad service outcomes are specified below:   |  | | --- | | * Increased choice and control for service users as to where and when their treatment is delivered – providing on-going care closer to home; | | * Personalised care for all service users accessing the service; | | * Timely access to hearing assessment, and a range of support services including hearing aid fitting, follow-up and on-going aftercare; | | * High proportion of service users continuing to benefit from the chosen intervention, including wearing hearing aids when required if they have been provided; | | * Reduced communication difficulties for service users 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 service users 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 service users accessing the service; | | * Improved quality of life for service users, their families/carers and communication partners. |   Applicable measures relating to the above outcomes are set out in Schedule 4.  The purpose of the Integrated Hearing Service is to ensure:   * Equitable access to 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 (IQIPS-SAIT) 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). |
| **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 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 – currently in draft) 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 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 and 1.3) * 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 1.3) * 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 4 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.   **Efficient:**   * Ensuring efficient use of resources and avoidance of unnecessary appointments or services. * Ensuring optimum use of available capacity through robust planning of clinics and minimizing of DNA rates.(KPI number 1.2 and 1.3) * Provision of a high quality workforce with knowledge and skills to manage the care of audiology patients in the community wherever possible. (KPI number 1.5) * Access to hearing assessment, fitting and follow-up within agreed timeframes with patients being referred back to the Integrated Hearing Service for on-going support and monitoring. (KPI number 1.2 and 1.3) * Increased reported levels of satisfaction from GPs referring into the service. (KPI number 1.1)   **3.3 Service description**  **3.3.1 Service overview**  The service 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.  Operating hours of the service across the geographic area covered by the NHS commissioning organisations, will be 7 days per week within the core hours of 8.00am – 6.00pm, Monday to Friday, with extended opening hours on a weekend/late evening.  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 referred patients with **ONE** single (monaural) or one pair (binaural) of hearing aid/s as part of the patients 4 year pathway. Unless there is a change in hearing, where a further clinical assessment will be required to evidence the change.  Complex audiology services (for patients who meet the contra-indications detailed in Appendix 1) 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 as they may require more specialist intervention.  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.  **3.4 Service model**  The service will be a community based Integrated Hearing Service model for patients with non-complex hearing conditions that require hearing aids and which can be treated and managed within the competency of qualified professionals.  Domiciliary provision will be delivered within the patient’s place of permanent residence.  If patient’s circumstances change i.e. because they become housebound during the initial 4 years, the Provider must continue to provide the service until the end of that 4 year period.  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-**  Figure 3.4 (a) below shows the expected pathway and the expected response times. The response times should negate the need for a prioritisation system. It is recognised that for a small number of patients more serious pathology will be found on examination by the Provider and that the patient will require direct referral to secondary care for specialist opinion.   * Patient over 50 years of age attends GP for age related hearing loss * GP assessment, examination & appropriate treatment provided to ensure ears are healthy * Compliance with contraindications & checklist * Red flags refer to secondary care   Ears are blocked with wax – direct to Treatment room for syringing/micro suction  **NOT IMPROVED**  Refer to GP/ hearing centre for appointment  **IMPROVED**  No further action required  Secondary care ENT and Audiology referrals  Provider Service:   * One-stop shop appointment where possible (assess and fit monaural/binaural) initiated by provider or patient * Subjective patient assessment and clinical examination * Micro-suction for **residual** wax removal if required * Impressions for non-assess and fit aids * Individual patient management plan * Patient education and information on local support groups * Urgent appointments   Discharge –no hearing aids required  Moulds required – impressions taken at the assessment appointment  Refer patient to GP for onward referral to ENT due to contraindications  GP only referral-GP to refer to checklist  REFERRAL  Outcome following hearing assessment  Fitting at the same appointment as part of a one stage assess and fit  Follow up to fit hearing aids  Urgent / drop in appointments for hearing aid problems  Review appointment within 10 weeks and on an annual basis.  Return to the Integrated Hearing Service between following 4 year episode  **3.4.1 Referral processes**  The Provider will have the ability to be able to receive referrals through the national NHS e-referral service (ERS).  **All referrals into the service will be received from the patient’s own GP only. GP to comply with referral checklist - Appendix 5**  The GP assessment must highlight and document on the referral if the service user has additional needs for which the Provider must make reasonable adjustments.  The hearing service is required to be diligent in assessing referrals received to ensure a fast response to:   * The Provider must ensure that any suspected cancer patients should be referred immediately to secondary care in line with 2 week rule requirements. * The Integrated Hearing Service 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 Integrated Hearing Service, once the patient has been signposted as needing an Integrated Hearing Service which cannot be provided by the GP. Operational standards must be applied to mitigate self-presenting patients that do not require the service, are a patient or another service provider and the provider is responsible for checking the patient pathway to reduce duplication between services and the CCGs being charged for unnecessary contacts.  Patient choice must be offered in accordance with local referral arrangements. The patient will be able to select a hearing service of their choice dependant on local CCG framework model and this must be for a duration of 4 years.  **3.4.3 Rejecting referrals**  The Provider must only accept referrals that meet the referral criteria covered by this specification.  The Provider must satisfy the CCG that it maintains robust patient management processes to ensure onward referral to secondary care, where merited, is undertaken in a timely fashion.  The Provider will send a clinical letter to the GP detailing the reason for onward referral. Any onward referral to secondary care SHOULD NOT delay the fitting of hearing aids if it is appropriate to do so. 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 secondary care referral is completed the patient must be accepted back (if appropriate) to the original Provider and continue on their 4 year pathway. This activity will be captured in Schedule 6 to monitor the patients referred back to the Integrated Hearing Service.  **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 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 Do Not Attend (DNA)**  Should a patient not attend for a pre booked appointment then the Provider must contact the patient and be given one further opportunity to attend within 2 calendar days. The Commissioner will not be charged for any non-attendance (DNAs).  **3.4.5 Residual Wax Removal**  Wax removal is provided only to support the fitting of hearing aids only during the 4 year pathway and is undertaken by the provider of choice. The purpose is to ensure any assessment for permanent hearing loss is not affected by wax. All patients should access local wax removal services prior to the referral to the provider. If the patient has residual wax, then the provider may remove residual wax. 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.  All residual Wax removal must be provided within the ‘one stop shop’ service model and be available from the Provider through micro-suction if self-administration of appropriate treatments has failed to remove the wax. This should be made available to patients prior to fitting of hearing aids, and as part of the on-going monitoring and support services available to new and current patients.  This service is only provided to support the fitting of hearing aids and not for general wax removal. If patients have an on-going issue with wax once their aids are fitted they should be directed to the GP based wax removal service for continuing treatment in line with local wax removal pathways and protocols available in each CCG area.  **3.4.6 One stage assessment and fit – Community and Domiciliary**  The Integrated Hearing Service must ensure that two approaches are available to address the assessment and fitting requirements of the pathway following initial GP examination/referral. Wax removal should be available at all appointments and should not be a reason to delay a one stage ‘assess and fit’ model of care.  **Two stage pathway**   * A single ‘assess and fit’ pathway for patients to receive hearing aids at the initial assessment appointment - 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 returns at a later date 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 Domicillary Visits**  GP domiciliary referrals must be made on an individual patient basis following GP examination.  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 the patient is due to go on holiday, or unable to attend the appointment for any length of time the patient and provider should re-book the appointment for a time and date that suits both parties.  **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.)   **3.4.9 Information Technology (IT) System**  In order to facilitate a streamlined and co-ordination of care for a positive patients experience in a seamlessly and 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 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 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 hearing aid options and agree types and models with the patient based on their suitability to the patients’ hearing loss   + 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. 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, ontological, change of batteries etc.)   The patient is asked to decide on choice of ear mould type and characteristics unless:   * + Referral back to GP for onward referral to Ear Nose Throat (secondary care) prevents fitting (exceptional circumstances) and in line with local pathways and policy.   + 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.   + 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.   + 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.   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. * At any private appointment, providers should ensure the service user is provided with details and information regarding the specification of NHS devices and be clear what, if any, are the additional benefits a private hearing aid would bring in order to ensure the service user makes an informed decision about purchasing a private hearing aid. * Providers must not promote their own private treatment service, or an organisation in which they have a commercial interest. * Providers must not encourage service users 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 4 year period of this contract. Spare hearing aids are not part of standard NHS provision. * Any marketing of the service and communication with potential service users 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 4 year period.  **3.5 Exceptionality to criteria**  The reasons for any additional new hearing aids within the 4 year period (**only one individual or set is funded under this contract per patient for the full 4 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 Check in and Review**  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 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 1-4 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.  The provider must ensure that they offer an annual follow up appointment/contact to the patient during the four 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 * 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. Where the review suggests replacement hearing aids may be of significant audiological benefit to the patient, if at 48 months then a replacement can be provided. The Commissioner to be advised as per section 2. * 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   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.   **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 Integrated Hearing 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.   * 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. * Provision of information (in a suitable language and format) about wider support services for hearing loss   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.  **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 Integrated Hearing Service is to be provided to eligible people registered to a GP practice within the CCG area of the responsible commissioning organisations.    **5. Location(s) of service delivery**  The service will be provided from locally dictated locations as outlined per CCG which is within an 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 and who do not meet the contraindications criteria detailed in appendix 1.  Eligible patients must be referred into the Integrated Hearing Service by a **GP 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 ( in line with locally agreed definitions of 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.   **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 Integrated Hearing Patient Centre.  **6.3 Interdependencies with other services**  The Integrated Hearing Service should be seen as part of 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, balance clinics and patient transport services 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’. 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.  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/](file://\\nsomerset.xswhealth.nhs.uk\ccg\Directorate\BNSSG%20Shared%20Area\BNSSG%20–%20Commissioning\Contract%20Commissioning\AQP%20Community%20Contracts\Audiology\Turnaround\Procurement\Specification\www.ukas.com\services\accreditation-services\physiological-services-accreditation-iqips\)  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 Self-Assessment Improvement Tool (SAIT) and have registered an application for accreditation with UKAS; * Any additional sites must have IQIPS accreditation in order to be commissioned * After the first full year 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](https://www.england.nhs.uk/ourwork/accessibleinfo/)  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 and Quality Standards, when available * 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 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 |
| **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-Self Assessment and Improvement Tool 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 IQIOPS-Self Assessment and Improvement Tool and provide a date (within 18months) 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 service users 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. Both the Commissioner and the Provider have 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. * 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 service users an opportunity to opt into receiving marketing information, and not make future contact without the individual’s explicit opt-in consent.   Where a service user 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> |
| **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. |

**Service Specification APPENDIX 1**

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

**This is criteria for onward referral by the Audiologist \*\*\*\*\***

**History:**

* **Sudden loss or sudden deterioration of hearing** (sudden = within 72 hours), unilateral or bilateral, should be sent to A&E or Urgent Care ENT clinic within 24 hours. 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.
* **Altered sensation or numbness in the face** or observed facial droop. Urgent medical advice should be sought if these symptoms have not previously been investigated.
* **Persistent pain** affecting either ear, which is intrusive and which has not resolved as a result of prescribed treatment. (As a general guideline, this includes pain in or around the ear, lasting a week or more in recent months).
* **History of discharge** (other than wax) from either ear within the last 90 days, which has not resolved or responded to prescribed treatment, or which is recurrent.
* **Rapid loss** or rapid deterioration of hearing (rapid = 90 days or less)14.
* **Fluctuating hearing loss**, other than associated with colds.
* **Hyperacusis** (An intolerance to everyday sounds that causes significant distress and impairment in social, occupational recreational and other day to day activities).
* **Tinnitus**, which is persistent and which:
  + - is unilateral
    - is pulsatile
    - has significantly changed in nature
* is leading to sleep disturbance or is associated with symptoms of anxiety or depression
* **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 ontological, neurological or medical conditions. Examples include headaches with associated dizziness, spinning, swaying or floating sensations and veering to the side when walking. For further guidance on vertigo, see www.vestibular.org).
* **Normal peripheral hearing, but with altered auditory perceptions** or abnormal difficulty hearing in noisy backgrounds. This may include having problems with sound localisation, the perception of pitch and loudness or difficulty following complex auditory directions.

Ear examination:

**Complete or partial obstruction of the external auditory canal** preventing full examination of the eardrum and/or proper taking of an aural impression. If wax is obscuring the eardrum or there is a current infection, local wax care or treatment procedures should be followed.

**Abnormal appearance of the outer ear and/or the eardrum** (Examples include: inflammation of the external auditory canal, perforated eardrum, active discharge, eardrum retraction, abnormal bony or skin growths, swelling of the outer ear or blood in the ear canal).

**Tympanometry (performed if there is any indication of middle ear effusion):**

**Unilateral flat tympanogram**, regardless of the associated level of hearing loss

**THE BELOW GUIDANCE IS FOR AUDIOLOGISTS ONLY:**

**Audiometry:**

**Conductive hearing loss**, defined as 20 dB or greater average air-bone gap over three of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz24,25. A lesser conductive hearing loss in the presence of bilateral middle ear effusion may be referred at the discretion of the Audiologist.

**Unilateral or asymmetrical sensorineural hearing loss**, defined as a difference between the left and right bone conduction thresholds (masked as appropriate) of 20 dB or greater at two or more adjacent frequencies: 500, 1000, 2000, 4000 or 8000Hz. (Other frequencies may be included at the discretion of the Audiologist)27,28,29. In the absence of recordable bone conduction thresholds, air conduction thresholds should be considered instead.

**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 bone conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz. In the absence of recordable bone conduction thresholds, air conduction thresholds should be considered instead.

**Other findings:**

**Any other unusual presenting features** at the discretion of the Audiologist or according to the requirements of the service to which the adult is being referred. Audiologists are expected to use their professional judgement and relevant guidance to make appropriate onward referrals for adults requiring Audiology services beyond their own scope of practice (for example, due to hearing loss complexity or co-existing conditions). Such referrals may be made in addition to a referral for a medical opinion.

**Adults with sensorineural hearing loss which does not appear to be age related** should, where appropriate, be offered a referral for aetiological investigation.

**References:**

British Academy of Audiology Guidance for Audiologists:

Onward Referral of Adults with Hearing Difficulty Directly Referred to Audiology Services (2016)

**Appendix 2**

**Outcome Measures**

Glasgow Hearing Aid Benefit Profile:

[http://studentacademyofaudiology.com/sites/default/files/journal](http://studentacademyofaudiology.com/sites/default/files/journal/JAAA_10_02_03.pdf)

Improving Quality in Physiological diagnostic Services (IQIPS):

[http://www.rcplondon.ac.uk/projects/iqips](http://www.rcplondon.ac.uk/sites/default/files/iqips-standards-and-criteria-03-06-11.pdf)

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.**

****

****

**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

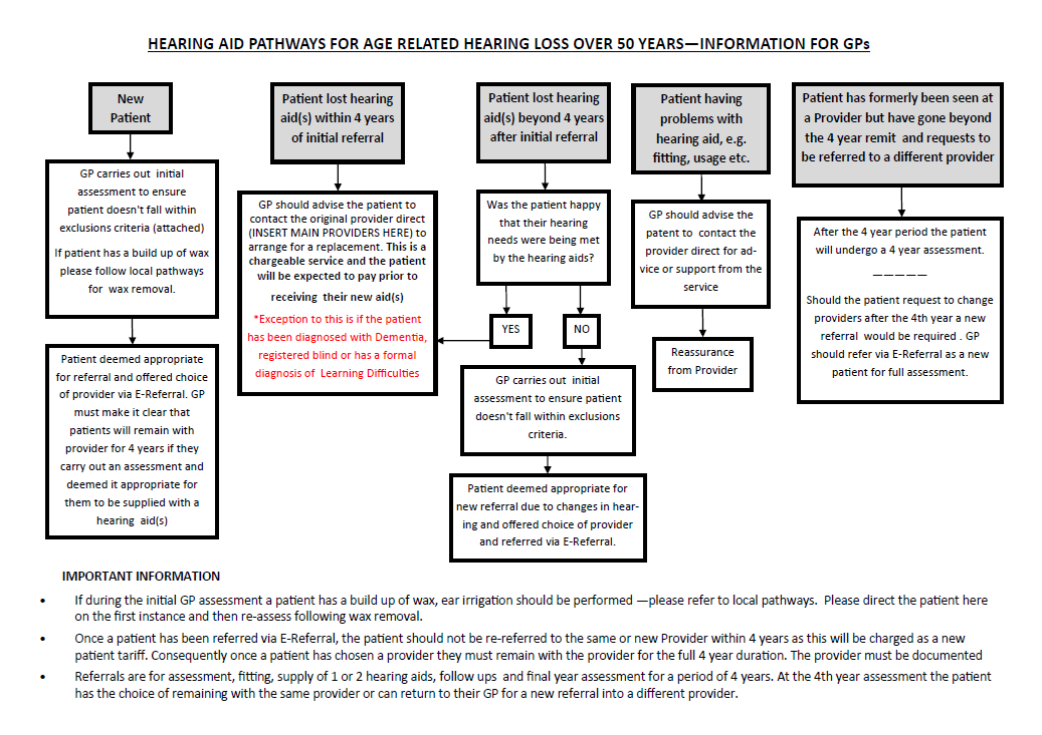
Assistant/Associate Audiologists

* 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:

****

**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

1. 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.

1. Has the tympanic membrane been examined for evidence of:
2. Perforation Yes/No
3. Previous mastoid surgery Yes/No

If the answer to either of the above is Yes, please refer to ENT before considering referral for a hearing test.

1. Is there unilateral hearing loss? Yes/No

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

1. 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.

1. 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