



Adult Hearing AQP Implementation Pack

DH INFORMATION READER BOX

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HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

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For Recipient's Use	

Preface

Introduction

This implementation pack has been designed to support commissioners to deliver Any Qualified Provider in Adult Hearing services locally. It has been developed by NHS commissioners, clinical experts and Department of Health officials, working in partnership. The use of this pack is not mandatory. Commissioners can refine it to meet local needs and, over time, help to improve it. This pack is simply a place to start, avoiding duplicating effort.

This pack should be used for services that are commissioned using the Any Qualified Provider model – where commissioners are aiming to secure innovation or deliver more choice for patients for example. Other forms of procurement are also available, which might suit other circumstances, more details of these can be found in DH procurement guidance.

The AQP impact assessment shows that the cost of procuring services per project under AQP is lower than existing arrangements:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_128457

This pack has been prepared by working with a range of professionals, from both clinical and commissioning backgrounds and we recommend that commissioners using these packs continue to engage with clinicians, professionals and a wide range of providers wherever possible.

Generally we expect there to be consistency across service specifications to sustain quality and help to spread best practice, but where necessary specifications should be amended to reflect local variations in need.

More information and further resources for commissioners can be found here: <http://nww.supply2health.nhs.uk/AQPRESOURCECENTRE/Pages/AQPHome.aspx>, including a pricing principles document that should be read alongside this implementation pack.

If commissioners do come up with innovative new ways to drive up the quality of care by offering choice of provider - please use the AQP resource forum to share your hard work.

Workforce, education and training implications

When commissioning a service under patient choice of AQP, there are some important workforce, education and training considerations, which commissioners must take into consideration. Annex 2 provides some additional details on these issues.

Public Sector Equality Duty

Commissioners should have regard to the Public Sector Equality Duty when commissioning services for patients. Please refer to Annex 3: Public Sector Equality Duty and visit the Department of Health website for more information on 'Equality and Diversity'.

Glossary

A glossary of terms used within this implementation pack is included in Annex 4.

Next Steps

These packs will be used by commissioners undertaking AQP in Adult Hearing through 2012/13. An evaluation of the pack and the AQP process will be undertaken during this period. In the meantime if you have any questions or comments on this pack, please contact AQP.Queries@dh.gsi.gov.uk

Document Management

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Name	Signature	Title	Version	Date of Issue

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		2.3.6 – explained payment point of pathway and introduced tariff 5	NHS Tees
		2.5, 2.6 & 2.7 – removed ref to Tees	NHS Tees
		5 – “working” days	NHS Tees
		Spec Appendix 4 – info requirement table and bullets	NHS Tees
		Currency and price – tariff 5 and financial recovery model	NHS Tees
		Commissioner notes – to reflect currency change	NHS Tees
3	4/12/12	Re-formatting of sections.	Liz Bailey DH
3	4/12/12	Insertion of generic sections on Operating Principles of AQP.	Liz Bailey DH

CONTENTS OF THIS PACK

Section 1

Section B – Service Specification7

Section 2

Currency and Pricing.....38

Section 3

Information Requirements for Patients44

Section 4

Recommendations on qualification requirements for the service.....46

Section 5

Guidance for Commissioners.....47

Annex 1

Details of the delivery team and stakeholders52

Annex 2

Considerations.....54

Annex 3

Public Sector Equality Duty56

Annex 4

Glossary58

Section 1

Section B – Service Specification

Section 1 INDEX

SECTION B PART 1 - SERVICE SPECIFICATION

B1_1.0 Population Needs 10

B1_2.0 Scope 11

B1_3.0 Applicable Service Standards 23

B1_4.0 Other..... 23

B1_5.0 Key Service Outcomes 25

SECTION 1 APPENDIX 1

S1A1.1 History: 27

S1A1.2 Ear examination:..... 27

S1A1.3 Audiometry: 27

SECTION 1 APPENDIX 2

S1A2.1 Improving Quality In Physiological diagnostic Services (IQIPS) 29

S1A2.2 Published Clinical Guidelines and Best Practice 29

SECTION 1 APPENDIX 3

S1A3.1 Professional Head of Service 31

S1A3.2 Audiologists 31

S1A3.3 Registered Hearing Aid Dispensers..... 32

S1A3.4 Assistant/Associate Audiologists 32

SECTION 1 APPENDIX 4

SECTION 1 APPENDIX 5

S1A5.1 Quality Requirements 35

TABLES

Table 1: Patient tracker activity form34

Table 2: Quality requirements.....35

Table 3: Tariffs.....41

Table 4: Finance Recovery Model43

FIGURES

Figure 1: Expected pathway and response times21

SECTION B PART 1 - SERVICE SPECIFICATION

Mandatory headings 1 – 3. Mandatory but detail for local determination and agreement.

Optional headings 4 – 6. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement.

Service Specification No.	Version 2
Service	Direct Access Adult Hearing Service for Age Related Hearing Loss
Commissioner Lead	NHS Tees
Provider Lead	
Period	2012/13
Date of Review	

B1_1.0 Population Needs

B1_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. These patients would benefit from direct access to adult hearing care services with a referral being 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.

B1_2.0 **Scope**

B1_2.1 **Aims and objectives of service**

The aim is to provide a comprehensive patient-centred direct access adult hearing service for age related hearing loss in line with national guidance and local requirements.

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 of an integrated hearing service, within which the Direct Access Adult Hearing Service operates, is to:

- Improve public health and occupational health focus on hearing loss
- Reduce 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, and respond to information and psychosocial needs
- Support communication needs by providing timely signposting to lip reading classes and assistive technologies and other rehabilitation services
- Promote inclusion and participation of people who are deaf or hard of hearing
- Compliance with clinical guidance and good practice

The Direct Access Adult Hearing Service is aimed at adults (over the age of 55) 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.

In line with British Academy of Audiology Guidelines for Referral to Audiology of Adults with Hearing Difficulty (2009) and British Society of Hearing Aid Audiologists Protocol and Criteria for Referral for Medical or other Specialist Opinion (2011), the Direct Access Adult Hearing Service may be provided to patients as long as they do not meet the contra-indications at SECTION 1 APPENDIX 1.

The purpose of the Direct Access Adult 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 working towards IQIPS accreditation (as set out in Section 3 of the implementation pack). The service should also recognise published clinical guidelines/good practice (as set out in SECTION 1 APPENDIX 2).

Expected outcomes of the service:

- Increased patient choice and control as to where and when their treatment is delivered – providing on-going care closer to home
- Timely access to hearing assessment, fitting and follow-up
- Personalised care for all patients accessing the service
- High proportion of patients continuing to wear hearing aids
- High levels of satisfaction from patients accessing the service
- High levels of satisfaction from GPs referring into the service
- Reduced social isolation and consequent mental ill health (i.e. depression and onset of dementia)
- Improved quality of life for patients, their families/carers and communication partners

B1_2.2 Service description

B1_2.2.1 Service overview

The service required is for a direct access adult hearing assessment service, including hearing aid fitting (where required), follow-up and aftercare services for adults aged 55 or over, with suspected or diagnosed age related hearing loss for the registered population of the NHS commissioning organisation.

Complex audiology services (for patients who meet the contra-indications detailed in SECTION 1 APPENDIX 1) and services for adults under 55 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 Direct Access Adult Hearing Service will consist of:

- Hearing needs assessment
- Development of an Individual Management Plan (IMP)
- Provision and fitting of hearing aids
- Appropriate hearing rehabilitation e.g. patient education
- Information on and signposting to any relevant communication/social support services
- Follow-up appointment to assess whether needs have been met

- Discharge from hearing assessment and fitting pathway
- Aftercare service for up to 3 years, including advice, maintenance and review at 3rd year
- Battery, tips, domes, wax filters and tube replacement service
- Annual aftercare and review after 3 year pathway, where required

The overall service should be carried out in accordance with best practice and guidelines listed in SECTION 1 APPENDIX 2. Details of the service model can be found in section 2.3.

B1_2.2.2 Interdependencies with other services

The Direct Access Adult Hearing Service should be seen as part of wider integrated adult health and social care hearing services working in partnership with GPs, Primary 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 it will work with these other organisations to support patients to successfully manage their hearing loss and promote independent living. They should as a minimum have a well-developed and audited pathway for communication with GPs and ensure a seamless integration of the Direct Access Adult Hearing Service within the wider health, voluntary and social services environment e.g. lip-reading classes, equipment services etc.

B1_2.3 Service model

B1_2.3.1 Assessment

Assessment should be undertaken within 16 working days of receipt of referral (unless the patient requests for this to be outside of this time e.g. holiday, sickness etc).

The Provider should ensure patients have an adequate understanding of the hearing assessment process before the appointment, by providing information (in a suitable language and format) 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. Providers should make patients aware of their right to communication support, and how to request this if required.

In addition, Providers should provide 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 should ensure that communication with the patient 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 should 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, occluding wax, 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 rebooked or referred back to the GP for treatment as necessary. Such events should be recorded as 'Incomplete Assessments'
- Assessment of current activity restrictions and participatory limitations - using a formal validated self-report instrument - that will enable an outcome measure to be documented for both the individual patient and also the service. The Glasgow Hearing Aid Benefit Profile (GHABP) or Client-Orientated Scale of Improvement (COSI) or International Outcome Inventory for Hearing Aids (IOI-HA) are the preferred outcome measures for this service
- 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)

Where the patient has already had a hearing test performed elsewhere, the provider will still offer an initial assessment to complete a full assessment of the patient. A reduction of x% of the tariff will be agreed by the commissioner for patients who meet the criteria to avoid a double payment where the cost of the tariff is included in the ENT tariff.

Following the assessment, the practitioner should:

- Explain the assessment, including the extent, location, configuration and possible causes of any hearing loss and the impact hearing loss can have on communication e.g. 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
 - Develop a written Individual Management Plan (IMP) with the patient which defines the patients' goals and hearing needs and how they are going to be addressed
 - 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 should be referral back to the GP for onward referral to complex audiology or other support services)
 - The patient declines bilateral aiding where offered as appropriate (this should be confirmed in a signed statement by the patient)
 - Other reason (e.g. manipulative ability, otological)
 - Proceed to fitting (where appropriate – see sections B1_2.3.2 and B1_2.3.3) using open ear technology or take impressions and decide on choice of ear mould type and characteristics
 - Provide patient information (in a suitable language and format) 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.

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

- Providers should issue patients with a maximum of 1 hearing aid for unilateral use or 2 hearing aids for bilateral use. Spare hearing aids are not part of standard NHS provision.
- For patients requiring assessment only (i.e. no fitting of hearing aids) tariff 1 applies (see Currency and Price details on pages 29-30)

B1_2.3.2 Fitting

Fitting (if not undertaken at assessment appointment – see section B1_2.3.1) should be undertaken within 20 working days from assessment (unless the patient requests for this to be outside of this time e.g. holiday, sickness etc). The patient should be made aware of their right to communication support for the fitting appointment; and if this is required the patient should still receive their fitting appointment with 20 working days.

At the fitting appointment (if separate from the assessment) the following should be provided and discussed with the patient:

- Otoscopy
- A review of the patient information and outcome measures (GHABP/COSI/IOI-HA)
- Selection and programming of hearing aids*
- Education of patient in order to reach a shared understanding of the benefits of hearing aid provision
- 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 in the Individual Management Plan
- Modification of ear moulds/venting if necessary and repeat of objective measurements for verification
- Evaluation of subjective sound quality (including own voice) and fine tune if necessary
- With patients own aid(s) worn and switched on, teach the patient (using same model) how to:
 - Change battery – observe insertion and removal and correct processes for maintaining battery life
 - Operate controls
 - Switch between programmes
 - Insert and remove aids
 - Use loop
 - Take care of aids, including cleaning, re-tubing and what to do if the aid is damaged or appears not to be working
- Advise on acclimatising to the use of hearing aids and amplified sound
- Advise on battery warnings, battery supply, repair/maintenance service
- Supply cleaning wires if open ear fit
- Explain the purpose and function of hearing aid data-logging

- Advise on lost/damaged hearing aid charging policy
- Issue a copy of the audiogram, information (in a suitable format) on the aids, ear moulds, local services, and update the IMP and provide a battery issue book if appropriate
- Discuss patient's wider needs and provide signposting to any relevant support services (including lip-reading classes and assistive technologies), as agreed with the patient, in accordance with agreed local protocols
- Arrange a follow-up appointment - the patient should be offered a choice of face to face or non-face to face follow-up and given the option to bring a relative/carer

***Note:** 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.

If the fitting appointment is as a result of a re-assessment of the patient, the reasons for the new fitting and expected benefits of this to the patient should be documented. The provider should record:

- The change in threshold of the audiogram
- Details of both new hearing aid(s) issued and old aid(s) no longer in use. Old aids should be returned to the NHS Supply Chain

The Provider should maintain an adequate stock and range of hearing aids and accessories (such as tubes/domes) to support the ongoing care of patients using this service and keep an up to date stock that meets the minimum specifications, through using the NHS Supply Chain.

B1_2.3.3 One stage 'Assess & Fit'

The Direct Access Adult Hearing Service should ensure that two approaches are available to address the assessment and fitting requirements of the pathway:

- A single 'assess and fit' pathway where suitable, for patients to receive hearing aids at the initial assessment appointment - suitability depends on hearing loss, dexterity, cognitive ability, emotional readiness and patient choice
- A two stage pathway, 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)

Pre-appointment information should mention the two options, to prepare patients better in advance of having to make this decision.

B1_2.3.4 Follow-Up

A follow-up appointment should be undertaken within 10 weeks of fitting (unless there are clear documented, clinical reasons to do otherwise, or if patient chooses to wait beyond this period), in order to determine whether needs have been met.

Patients should be offered a choice of a face to face or non-face to face follow-up (e.g. telephone review or postal questionnaire) – the Provider should 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 this should be offered within 5 working days of the request from the patient.

Within the follow-up the provider should:

- Discuss with the patient whether the outcomes agreed within the IMP have been met and if not how to resolve residual needs and update the IMP as necessary
- Check on use of hearing aid(s) in terms of comfort, sound quality, adequacy of loudness, loudness discomfort, noise intrusiveness, telephone use, battery life, cleaning, use of loop and different programmes
- Confirm patient's ability to remove and insert aid and provide further help if needed
- Review hearing aid data-logging
- Fine tune hearing aid (if necessary) based on patient's comments
- 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 a suitable language and format) and sign-posting to any relevant communication/social/rehabilitation support services

The Provider should:

- 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

B1_2.3.5 Aftercare

The Provider should provide on-going aftercare and equipment maintenance to patients for 3 years after fitting.

Aftercare services should 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
- Provision of information (in a suitable language and format) about wider support services for hearing loss

Patients should be able to access aftercare services (via face to face or non face to face methods) within 2 working days of the request. A postal repair service must also be available to patients for returns within 7 working days.

Aftercare may be provided by any member of staff or volunteer staff who is suitably trained and qualified for the task at hand e.g. BSHAA-approved Hearcare Assistant, but there must always be an experienced audiologist or hearing aid dispenser available in person or on request to provide further support if required.

B1_2.3.6 Review

Patients should be informed that whilst their current hearing aids are expected to remain appropriate for several years, it is best practice to review their needs 3 years after fitting. The Provider should carry out automatic recall to offer a review appointment as part of the aftercare element of the pathway. The Provider should inform the GP of the outcome of the review or if the patient declined a review.

Patients should be able to directly access a review appointment earlier than 3 years if they fail to continue to manage with their hearing aid(s) or if there is suspected significant changes in their hearing.

It is expected that most patients will be discharged (see section B1_2.1) back to their GP after the 3 year review. Tariffs will be dependent on whether the patient was a unilateral (tariff 2) or a bilateral (tariff 3) hearing aid user. Whilst these tariffs include the 3 year aftercare and 3 year review as described in sections 2.3.5 and this section, tariffs should be paid after the follow-up (2.3.4). A recovery schedule is recommended in the Currency and Price section on pages 29-30 to allow NHS commissioning organisations to then reclaim a percentage of the tariff should any part of the 3 year aftercare and review pathway be undelivered.

Where the review suggests that there are no significant changes, the patient should be discharged back to the GP with the Provider responsible for yearly aftercare and automatic recall to offer patients an annual review. In this instance, tariff 4 will apply.

Where review suggests that there are significant changes to a patient's hearing needs, the patient should be discharged back to the GP with the advice to undergo a full re-assessment and fitting pathway. The GP would be required to re-refer the patient to the service and the pathway described in section 2.3 will start again (and with the associated timescales and tariffs).

Within the annual aftercare and review period (i.e. after the 3rd year review and where a patient's hearing needs have not changed) if a hearing aid stops working due to mechanical failure and requires replacing outside of warranty, tariff 5 will apply. The patient would still remain within this annual aftercare pathway as per above.

B1_2.3.7 Battery Replacement Service

Batteries for hearing aids provided through an NHS qualified provider should be provided free of charge to NHS patients as part of the aftercare service, and should be of a designated specification according to the NHS Supply Chain.

Options for battery replacement include:

- By post (free of charge to the patient) from the Provider
- 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.

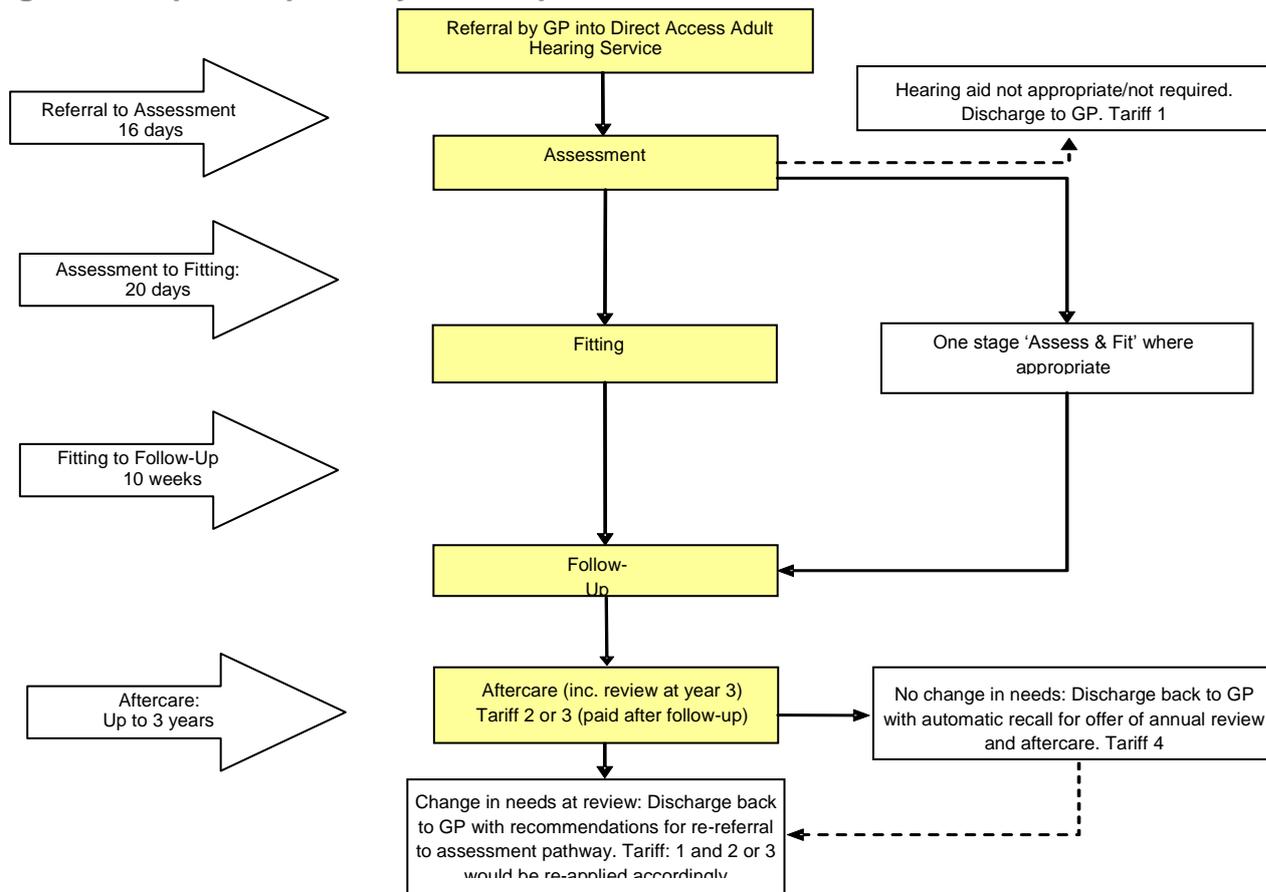
The Provider is responsible for the purchase, provision and replacement of batteries to NHS patients and must supply the brand as designated by NHS Supply Chain.

B1_2.4 Care pathway

Figure 1 below shows the expected pathway and the expected response times. The response times should negate the need for a prioritisation system.

Providers which are unable to see urgent and complex patients within the stated time frame will be subject to penalties from the commissioner. These penalties will need to be agreed locally.

Figure 1: Expected pathway and response times



B1_2.5 Population covered

The Direct Access Adult Hearing Service is to be provided to eligible people registered to a GP practice within the NHS commissioning organisation area.

B1_2.6 Location(s) of service delivery

The expectation is that the service will be provided from appropriate (see section B1_4.2) accessible, premises within the NHS commissioning organisation locality, with the service available and accessible to patients throughout the geographic area for the standard days/hours of operation.

B1_2.7 Days/hours of operation

Operating hours of the service across the geographic area covered by the NHS commissioning organisation, should be 8.00am – 6.00pm, Monday to Friday, with an additional minimum of 5 hours regular extended opening hours on a weekend.

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.

B1_2.8 **2.8 Any acceptance and exclusion criteria**

B1_2.8.1 **Acceptance criteria**

The Direct Access Adult Hearing Service is for adults over the age of 55 with suspected or diagnosed age related hearing loss and who do not meet the exclusion criteria detailed in section 2.8.2

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

- Have sight loss/dual sensory loss
- Have learning disabilities – as special test facilities and techniques are needed
- 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

Eligible patients must be referred into the Direct Access Adult Hearing Service by a GP.

B1_2.8.2 **Exclusion criteria**

The following patients should not be referred into the Direct Access Adult Hearing Service:

- Children and adults under 55 years of age (i.e. 54 and 364 days old)
- Complex adult patients who meet the contra-indications as set out in SECTION 1 APPENDIX 1

B1_2.9 **Referral processes**

B1_2.9.1 **Accepting referrals**

The Provider should have the ability to be able to receive referrals through the national NHS Choose & Book electronic referral system (entry level with ability to upgrade). Where a referrer is unable to use or access Choose & Book, an alternative (i.e. paper) referral process should be accepted.

B1_2.9.2 **Rejecting referrals**

The Provider must only accept referrals that meet the referral criteria covered by this specification.

Prior to referral, an initial assessment should be undertaken by the GP of the patient presenting with hearing difficulties to ensure that they do not fall within the exclusion criteria (see section B1_2.8.2).

Any inappropriate referrals received (i.e. for patients who meet the exclusion criteria) should be returned back to the GP within 5 working days for onward referral with sufficient feedback to minimise inappropriate referrals in future. If the Provider thinks

that there is an urgent need and the patient would require to be seen within 2 weeks, the referral should be made directly and the GP must be informed within 2 working days.

If a referral is received with insufficient information, the Provider should liaise with the 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 can 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.

Any referrals received that are not from a GP should be directed back to the referrer before any assessment is undertaken for this service with an explanation of the correct referral path and criteria. If an assessment as part of this service is undertaken in this scenario, the Provider will not be paid for this activity.

B1_2.10 Discharge processes

Any patient discharged (as per section 2.3.6) should be informed of how to get advice and support if they believe their hearing has deteriorated further or if their hearing aids are no longer fit for purpose.

The Provider should provide a discharge report to the GP and complete an Individual Management Plan for the patient.

B1_3.0 Applicable Service Standards

B1_3.1 Applicable national standards eg NICE, Royal College

Please see Annex 2 for applicable accreditation standards and guidelines.

B1_4.0 Other

B1_4.1 Workforce

The Provider should have an appropriate skill mix within their team in keeping with the recommendations set out in 'Transforming Adult Hearing Services for Patients with Hearing Difficulty – A Good Practice Guide', DH, June 2007. Assessment and treatment should always be provided by staff that are either suitably registered or are supervised by a suitably registered practitioner and who are appropriately trained, qualified and experienced (see SECTION 1 APPENDIX 3).

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 SECTION 1 APPENDIX 3.

In terms of training and development:

- All staff should be trained to identify the contra-indications (SECTION 1 APPENDIX 1) 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
- 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

B1_4.2 Facilities

Hearing assessments should 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 should be achieved before undertaking testing. This should be done in situ with a portable sound level meter and the evidence of this undertaking documented.

B1_4.3 Equipment and Software

The provider should provide equipment and software for audiometric assessment and for the fitting & evaluation of hearing aid(s) and the recording and export of patient data including a minimum of:

- Otoscope
- Ear impression taking equipment
- Ear mould modification equipment
- Audiometer, objective measurement (e.g. REM) and 2cc test box systems that store data electronically in a form that can be readily exported and read into compatible NHS provider systems
- Appropriate and updated hearing aid fitting software
- A Patient Management System that stores data, including outcome questionnaire responses (e.g. GHABP/COSI/IOI-HA), electronically, in a form that can be readily exported and read into compatible NHS provider systems
- Computer hardware and software of a sufficiently robust standard to support the above systems, including secure back up facilities of all patient data

In addition:

- All audiometric equipment should be regularly calibrated to relevant national or international guidelines and undergo regular checks (Stage A, Stage B or Stage C checks) in accordance with national recommendations
- Equipment and electrical connections should meet the NHS requirements of safety of equipment used with patients and comply with the relevant NHSE recommendations

B1_4.4 Governance, Accreditation and Quality Assurance

The provider will be expected to undertake a quality audit such as the IQIPS-SAIT before delivering NHS services under the contract and continue using the quality audit on a regular basis. The provider will be expected to be working towards IQIPS accreditation standards and achieving accreditation when it becomes available.

B1_4.5 Marketing and Promotion of Services

Providers marketing and promoting their NHS services should adhere to the 'Code of Practice For The Promotion of NHS-Funded Services'.

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 Direct Access Adult 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
- Offer patients an opportunity to opt into receiving marketing information, and not make future contact without the patient's explicit opt-in consent

B1_5.0 Key Service Outcomes

- 90% of patients referred to the service should be assessed within 16 working days of receipt of referral
- 90% of patients requiring hearing aid fitting should be seen within 20 working days of the assessment

- 90% of follow-up appointments should be within 10 weeks of fitting
- 90% of patients should be able to access aftercare within 2 working days of a request
- 95% of responses received from patients sampled via a service user survey should report overall satisfaction with the service

20% of the total value for annual delivered activity will be subject to the achievement of the above key service outcomes. Each outcome will be weighted equally. Penalty will be applied on the individual indicator failed in accordance with weighting i.e. 1 indicator failed is a penalty of 4% reduction; 5 indicators failed is a penalty of 20% reduction.

Further information can be found on the [Quality requirements](#) on page 35

Please see Error! Reference source not found. for additional commissioner notes

SECTION 1 APPENDIX 1

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

S1A1.1 History:

- Persistent pain affecting either ear (defined as earache lasting more than 7 days in the past 90 days before appointment);
- History of discharge other than wax from either ear within the last 90 days
- Sudden loss or sudden deterioration of hearing (sudden=within 1 week, in which case send to A&E or Urgent Care ENT clinic)
- 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 (dysacusis)
- Vertigo (Vertigo is classically described hallucination of movement, but here includes dizziness, swaying or floating sensations that may indicate otological, neurological or medical conditions)
- Normal peripheral hearing but with abnormal difficulty hearing in noisy backgrounds; possibly having problems with sound localization, or difficulty following complex auditory directions.

S1A1.2 Ear examination:

- Complete or partial obstruction of the external auditory canal preventing proper examination of the eardrum and/or proper taking of an aural impression.
- Abnormal appearance of the outer ear and/or the eardrum (e.g., inflammation of the external auditory canal, perforated eardrum, active discharge).

S1A1.3 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:

British Academy of Audiology Guidelines for Referral to Audiology of Adults with Hearing Difficulty (2009)

BSHAA Protocol and Criteria for Referral for Medical or other Specialist Opinion (2011)

SECTION 1 APPENDIX 2

Accreditation Standards

S1A2.1 Improving Quality In Physiological diagnostic Services (IQIPS)

Accreditation Standards and Criteria

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

S1A2.2 Published Clinical Guidelines and Best Practice

Hearing assessment, fitting, follow-up and aftercare services should follow best practice standards and recommendations as defined below:

- NHS Core principles
- National Institute for Health and Clinical Excellence Guidance/Quality Standards, when available
- Department of Health: Standards for Better Health
- Clinical protocols specified by British Society of Audiology and British Academy of Audiology
- 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)
- British Academy of Audiology Guidelines for Referral to Audiology of Adults with Hearing Difficulty (2009)
- 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)

- Guidance on Professional Practice for Hearing Aid Audiologists (British Society of Hearing Aid Audiologists, 2011)

SECTION 1 APPENDIX 3

Suggested Minimum Qualifications and Skills of Clinical Staff

S1A3.1 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 Professions Council (HPC) 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.

S1A3.2 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 HPC 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.

S1A3.3 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 HPC as a Hearing Aid Dispenser

S1A3.4 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).

SECTION 1 APPENDIX 4

Information Management

The Provider shall provide a full patient minimum data set on a monthly basis detailing all activity for the previous month and associated charges (i.e. backup data to support an invoice).

The Provider shall also submit a referral data set detailing who has been referred to them each month.

All data must be provided to the commissioner within 10 working days following month end. The exact contents of each data set should be agreed with the commissioner to meet local requirements.

In addition, the Provider will be expected to provide the information on a monthly basis the following activity information which forms a patient tracker (Table 1 below):

Table 1: Patient tracker activity form

NHS Number	Age	Male/ Female	Ethnic Origin	PCT	Location	Referral Date	New or Re-referral	Assessment Date	Incomplete Assessment Returned	Bilateral, Unilateral, None	Fitting Date	Follow-Up Date	Face to Face or Non-Face to Face	Quicker Follow-up Request Date	Quicker Follow-Up Date	Additional Follow-Up date (if required)	Aftercare Request Date	Aftercare Date	3yr Review Date	Annual Aftercare Accessed (after yr 3)	Annual Review Date 9after yr3		

- Number and type of incidents and complaints received
- Number of referrals not received through Choose and Book
- Number of 'rejected' referrals
- Number of patients accessing the service in extended opening hours
- Number of training assessments undertaken by postgraduate, undergraduate and foundation degree students
- Number of requests to transfer provider (patient choice or clinical consideration) and action taken
- Number of lost/damaged hearing aids
- Number of aids replaced due to mechanical failure after 3rd year review

SECTION 1 APPENDIX 5

S1A5.1 Quality Requirements

Table 2: Quality requirements

Technical Guidance Ref	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Referral to assessment time	Assessments to be completed within 16 working days following receipt of referral, unless patient requests otherwise	90%	Monthly performance reports	Financial penalty*
Assessment to fitting time	Hearing aids to be fitted within 20 working days following assessment, unless patient requests otherwise	90%	Monthly performance reports	Financial penalty*
Fitting to follow-up time	Appointments are offered within 10 weeks from fitting, unless there are clear, documented, clinical reasons to do otherwise, or the patient chooses to wait beyond this period	90%	Monthly performance reports	Financial penalty*
Quicker follow-up	Where patients request this, a quicker follow-up is offered within 5 working days	90%	Monthly performance reports	
Objective measurements (e.g. REM)	Patients undergo objective measurement at first fitting where clinically appropriate (exceptions reported in IMP)	95%	Monthly performance reports	
Additional follow-up	Where required, additional face to face follow-ups are offered within 7 working days of non-face to face follow-up	90%	Monthly performance reports	
Aftercare	Aftercare is available (face to face or non-face to face) within 2 working days of patient request	90%	Monthly performance reports	Financial penalty*
Information sharing	Patient records and associated letters/reports completed and sent to GP within 5 working days of hearing assessment/ fitting/	95%	Monthly performance reports	

Technical Guidance Ref	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	follow-up			
Service user experience	Standardised patient questionnaire to be issued at discharge points. 95% of responses received from service users sampled should report overall satisfaction with service.	95%	Quarterly and accumulative annual report to include an analysis of number of patients discharged and surveyed, number of responses received, % of those satisfied or very satisfied with service.	Financial penalty*
Peer satisfaction of service	A minimum of one GP satisfaction survey will be designed and sent to all referring GP's. 95% of GPs sampled should report overall satisfaction with service	95%	Quarterly and accumulative annual report to include an analysis of completed user questionnaires, demonstrating % of those satisfied or very satisfied with service.	
Service improvement	Service user questionnaires and peer satisfaction surveys to capture areas for improvements. 100% of recommendations made and agreed with Commissioners are addressed	100%	Annual report to demonstrate recommendations and actions taken to address areas of service improvement	
Reducing Inequalities	Patient questionnaire demonstrates a high satisfaction rate from all protected characteristic groups (PCGs)	95%	Accumulative annual service user questionnaire report analysis to include number of patients	

Ref: Adult Hearing Implementation Pack

Technical Guidance Ref	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
			surveyed, number of these in PCGs, response rates, response rates for PCGs, % of these specifying overall satisfaction	
Reducing Barriers	An integrated patient pathway, which facilitates signposting to wider communication/social support services (where appropriate)	100%	Provider provides demonstrable evidence of % patients who receive information about these support services	
Personalised Care Planning	All patients have an Individual Management Plan	100%	Quarterly and accumulative annual report to include a review of audit data to demonstrate that all patients have a completed IMP	
Increased choice and control of when and where treatment is delivered (time and place)	Patient questionnaire to monitor satisfaction with amount of choice and control offered. 95% of service users sampled should report satisfaction with amount of choice and control	95%	Monthly performance report for activity and quarterly report for survey	
Increased uptake of hearing aids and proportion of patients continuing	Percentage of patients still wearing hearing aids at review stage. 90% of patients fitted with a hearing aid should be continuing to wear the aid(s) at review	90%	Monthly performance report	

Ref: Adult Hearing Implementation Pack

Technical Guidance Ref	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
to wear hearing aids				
Reduced social isolation and consequent mental health	Improvement in GHABP/COSI/IOI-HA outcome measures after hearing aid fitted	90%	Monthly performance reports	
Improved quality of life	Improvement in GHABP/COSI/IOI-HA outcome measures after hearing aid fitted	90%	Monthly performance reports	

*20% of the total value for annual delivered activity will be subject to the achievement of the above key service outcomes. Each outcome will be weighted equally. Penalty will be applied on the individual indicator failed in accordance with weighting i.e. 1 indicator failed is a penalty of 4% reduction; 5 indicators failed is a penalty of 20% reduction.

Section 2

Currency and Pricing

S2 1.0 Our Aim

This paper has been developed to inform commissioners and providers on the types of currency and price that could be used locally to set up Adult Hearing services.

A price/cost has not been provided, as per the AQP Implementation pack guidance, price/cost is to be set locally. It is suggested that local commissioners set the same price/cost for all providers of that service – therefore providers compete on quality by using innovation. Commissioners will need to consider the application of a market forces factor for some regions to cover increased costs of provision

S2 1.1 Currency Development

The term currency refers to the units of healthcare for which a payment is made and can take a variety of forms. Currency is different from cost or price. A currency is the unit of healthcare that will be paid for. The four principles of a good currency are:

The currency must be clinically meaningful – that is as a grouping of patients/service users it is accepted by clinicians. Involvement of clinicians in designing the currency packages will help ensure that they are clinically meaningful.

- The currency should have as much resource homogeneity as possible (“iso-resource”) – that is individuals within a proposed currency group should require a similar type and amount of resource. Considering the variables of patient need (and resource usage) will help you to define iso-resource.
- The currency should incentivise the provision of improved care. The group will have to consider the incentives and the outcomes that they developed for patients with a hearing loss. The group will have to be mindful of creating perverse incentives.
- The currency should be workable – this means that they should be supported by underlying information flows (available or attainable). The cost-benefit of granularity should be considered and data burdens should be kept to the minimum necessary for ease of implementation.

S2 1.2 Potential currency models

The currency model is broadly based on the 2011/12 non-mandatory tariff model, with some additional component inclusions as per the pathway in the specification. A 10% reduction has been applied to the 2011/12 non-mandatory tariffs, as existing providers (locally and elsewhere) are either currently delivering the service to reduced costs from the non-mandatory tariff or have agreed that it is achievable.

20% of the total value for annual delivered activity will be subject to the achievement of the above key service outcomes. Each outcome will be weighted equally. Penalty will be applied on the individual indicator failed in accordance with weighting i.e. 1 indicator failed is a penalty of 4% reduction; 5 indicators failed is a penalty of 20% reduction.

The prices in the model are exclusive of CQUIN. Local commissioners will need to determine which goals/indicators to include under a CQUIN scheme. Suggestions include moving one or more of the quality requirement indicators into CQUIN (e.g. service improvement) or using CQUIN to enhance the thresholds of one or more quality requirement indicators (e.g. aim for 100%).

Whilst the tariffs (2 and 3) include the 3 year aftercare and 3rd year review as described in sections B1_2.3.5 and B1_2.3.6, tariffs should be paid after the follow-up (B1_2.3.4). A recovery schedule is recommended in the Currency and Price section on page **Error! Bookmark not defined.** to allow NHS commissioning organisations to then reclaim a percentage of the tariff should any part of the 3 year aftercare and review pathway be undelivered.

The draft currency model and prices are based on the 2011/12 non-mandatory tariff.

Table 3: Tariffs

Tariff	Basis of Contract	Price
1	Assessment only	£49
2	Assessment, fitting of 1 aid, cost of 1 aid, follow-up, 3 years aftercare and 3 rd year review	£294
3	Assessment, fitting of 2 aids, cost of 2 aids, follow-up, 3 years aftercare and 3 rd year review	£388
4	Annual aftercare and review (after 3 rd year review, where hearing needs have not changed and re-assessment into the pathway is not required)	£23

Tariff	Basis of Contract	Price
5	Replacement hearing aid (due to mechanical failure outside of warranty during a period of annual aftercare following the 3 rd year review)	£68

- Provision of batteries is included within the above tariffs
- Prices are exclusive of CQUIN.
- 20% of the total value for annual delivered activity will be subject to the achievement of the above key service outcomes. Each outcome will be weighted equally. Penalty will be applied on the individual indicator failed in accordance with weighting i.e. 1 indicator failed is a penalty of 4% reduction; 5 indicators failed is a penalty of 20% reduction.

The service is commissioned by the NHS commissioning organisation and no charge should be made to any individual and/or group for services covered by this service specification.

High powered hearing aids will be considered for existing users who may not be complex, but whose hearing levels have dropped. However, these will not be included in the current tariff and will therefore be costed separately.

Where the patient has already had a hearing test performed elsewhere, the provider will still offer an initial assessment to complete a full assessment of the patient. A reduction of x% of the tariff will be agreed by the commissioner for patients who meet the criteria to avoid a double payment where the cost of the tariff is included in the ENT tariff.

The Commissioner will use the information included in the monthly activity report to calculate payment. Payment will be made on a monthly basis. Payment will be made within 30 days of receipt of the monthly report.

The high cost of rental and staff (London weighting for NHS providers) needs to be reflected in the tariff.

Table 4: Finance Recovery Model

Basis of Contract	Proposed Tariff Excluding CQUIN @ 2.5%	% Tariff recovery for incomplete pathway during 1st year of care following the fitting and follow-up (2.3.4)	% Tariff recovery for incomplete pathway during 2nd year of care following the fitting and follow-up (2.3.4)	% Tariff recovery for incomplete pathway during 3rd year of care following the fitting and follow-up (2.3.4)	Value of tariff recovery for incomplete pathway during 1st year of care following the fitting and follow-up (2.3.4)	Value of tariff recovery for incomplete pathway during 2nd year of care following the fitting and follow-up (2.3.4)	Value of tariff recovery for incomplete pathway during 3rd year of care following the fitting and follow-up (2.3.4)
Assessment only	£49.00	N/A	N/A	N/A	N/A	N/A	N/A
Assessment, fitting of 1 aid, cost of 1 aid, 1 st follow-up, 3 years aftercare and review	£294.00	20.00%	13.00%	6.50%	£58.80	£38.22	£19.11
Assessment, fitting of 2 aids, cost of 2 aids, 1 st follow-up, 3 years aftercare and review	£388.00	15.00%	10.00%	5.00%	£58.20	£38.80	£19.40
Annual aftercare and review (after 3 years)	£23.00	N/A	N/A	N/A	N/A	N/A	N/A

Incomplete pathway is defined as the aftercare and 3rd year review following assessment, supply, fitting and follow-up of the appliance/s.

Funding for replacement/lost aids will be built into the agreement between commissioner and provider.

Please see Error! Reference source not found. for additional commissioner notes

Section 3

**Information Requirements for
Patients**

Section 3 – Information Requirement for Patients

The following guidance is provided to Commissioners about what specific information patients will need in order to make an informed choice of which qualified provider to access should they need a referral to this service. This guidance has been developed by NHS Tees and Local Improvement Networks in the area.

S1.2 What information would you, as a patient, want at the point of referral to the adult hearing service (from your GP)?

- Where it is
- Who is providing it
- Waiting times
- What exactly is provided
- Would some things be referred elsewhere? If so what? If needed onward referral would this take longer cumulatively

S1.3 What information would you want about providers to enable you to make a choice?

- Who are they? Private company – local or national?
- How to complain and to whom
- What happens to complaints?
- Quality ratings
- Independent views of service including survey of patients.

S1.4 When would you want this information, and where would you want to be able to obtain it from?

- Combination of GP, leaflets (providing they are kept up-to-date) and online documents.

S1.5 If you were a patient, how would you want to be able to contact the service, and how should the service contact you?

- Letter
- Text
- Email

S1.6 Is there anything else we need to consider to ensure that patients are able to make an informed choice of provider, or to ensure that the service is accessible for patients?

- Travelling times

Section 4

Recommendations on qualification requirements for the service

04 – Recommendations on qualification requirements for the service

CQC registration is not a requirement for the provision of AQP routine adult hearing services. Complex services and services for children could be regulated by CQC. For more information please refer to CQC.

We would wish to include additional qualification questions around quality assurance and accreditation for adult hearing services. Our recommendation is that a provider needs to:

- Have submitted an application for IQIPS accreditation using the relevant website (www.rcplondon.ac.uk/projects/iqips) is now live.
- Have completed the IQIPS Self-Assessment & Improvement Tool for adult hearing services.
- Be IQIPS adult hearing service accredited.
- AQP qualification will be conditional on achieving accreditation and any provider that is not accredited by this date will be removed from the AQP national qualification register. Any new provider seeking AQP status will need to be accredited.

Section 5

**Guidance for
Commissioners**

Section 5 – Guidance for Commissioners

S5 1.0 Any Qualified Provider

The 2010 health white paper 'Equity and Excellence: Liberating the NHS' and supporting document 'Liberating the NHS: Greater choice and control' clearly signalled the intention to provide greater choice for patients in delivery of healthcare. In July 2011, the Department of Health published 'Operational Guidance to the NHS on Extending Patient Choice of Provider' setting out guidance regarding implementing 'Any Qualified Provider' including musculoskeletal service for back and neck pain as one of the initial service lines to be offered through AQP.

The goal is to enable patients to choose any qualified provider. Choice of provider is expected to drive up quality, empower patients and enable innovation to support the delivery of QIPP. Importantly, extending choice of AQP provides a vehicle to improve access, address gaps and inequalities and improve quality of services where patients have identified variable quality in the past.

S5 1.2 Operating Principles of care delivery

Key overarching principles for Any Qualified Provider that underpinned the development of this pack:

- **Choice:** Extending patient choice of provider is intended to empower patients and carers, improve their outcomes and experience, enable service innovation and free up clinicians to drive change and improve practice. Patients should expect to play a central role in decisions about their condition and treatment and should benefit from high quality and accessible information to inform their decisions.
- **Working in Partnership:** Commissioners undertake to develop and maintain constructive working relationships with service providers and service users, carers, families, colleagues, lay people and wider community networks and working positively with any tensions created by conflicts of interest that may arise between the partners in care through the AQP model.
- **Service Pathway Design:** AQP provides the opportunity to review care pathways, improve access, address gaps and inequalities and improve the quality of services available.
- **Acknowledging the Challenges:** Introducing an extension to choice of provider for community services is inherently complex in the NHS system. Care in the planning and strong engagement throughout the process is key to successful implementation.

The following principles govern an AQP approach to contracting for services:

- Providers qualify and register to provide services via an assurance process that tests providers' fitness to offer NHS funded services. The governing principle of qualification¹ is that a provider should be qualified if they:
 - Are registered with CQC and licensed by Monitor (from 2013) where required, or meet equivalent assurance requirements;
 - Will meet the terms and conditions of the NHS standard Contract which includes a requirement to have regard to the NHS Constitution, relevant guidance and law;
 - Accept the NHS prices;
 - Can provide assurances that they are capable of delivering the agreed service requirements and comply with referral protocols; and
 - Reach agreement with local commissioners on supporting schedules to the NHS standard contract including any local referral thresholds or patient protocols.
- Commissioners set local pathways and referral protocols which providers must accept
- Referring clinicians offer patients a choice of qualified providers for the service being referred to
- Competition is based on quality, not price. Providers are paid a fixed price determined by a national or local tariff.

S5 1.3 Service Specification

This model service specification is for a patient-centred direct access adult hearing service for age related hearing loss and sets out the advised minimum requirements for procuring such services under Any Qualified Provider (AQP).

The specification is largely based on the draft SHA Clinical Leads Audiology Network (CLaN) specification, is in line with national guidance, and has been developed with involvement from a range of stakeholders (see Annex 1 for details).

Whilst the service specification has been developed as a national generic model for AQP, some areas can be adapted, in consultation with local user groups and existing service providers, to take into account local circumstances and reflect the breadth of needs of local patients.

It is however recommended that in order to reduce variation across the country, adaptations are kept to a minimum. The areas detailed below could be adapted by commissioners according to local need. We would recommend that areas around outcomes, quality requirements, information requirements and accreditation are not altered.

¹ Department of Health; 2011; Operating Guidance to the NHS: Extending Patient Choice of Provider.

S5 1.4 Areas that could be considered locally by commissioners

- Inclusion/exclusion criteria: the service is for age related hearing loss for 'non-complex' patients (complex services would be required for patients meeting the contra-indications set out in SECTION 1 APPENDIX 1) and for this reason, it was agreed that the age of inclusion for this service would be 55 plus. Local commissioners may wish to vary this, where appropriate, to enable younger adults to access the service.
- Several stakeholders wished us to remove people with learning disabilities from the inclusion criteria and exclude them from this service due to complexity of needs. Adults with learning disabilities may require a different approach to that offered on the specification, often requiring specialist expertise and equipment for assessment and management. As this is a service for individuals aged over 55, patients with a learning disability are very likely to be known to their GP. It was felt it should be the responsibility of the referring clinician and provider to manage between them the appropriateness of referral/treatment according to a patients needs and not automatically exclude them from this service because they have a degree of learning disability.
- Self-referral: the overall consensus was to not include self-referral to this service due to the pre-referral checks required (e.g. ear canal clear from wax) and to ensure the patient does not require complex audiology services. However some commissioners may wish to include self-referral where appropriate in local services or referral by clinicians other than GPs (e.g. nurse practitioners).
- Onward referral: from both a patient choice and commissioning perspective, onward referrals (or 'consultant-to-consultant' referrals) are not included in this service specification and are directed back to the GP for onward referral as appropriate, in collaboration with the patient to exercise choice. Commissioners may wish to allow some onward referrals according to local need and local protocols.

Annex 1

Details of the delivery team and stakeholders

Annex 1: Acknowledgments

NHS Tees would like to acknowledge the involvement of the following organisations/individuals in the development of this implementation pack:

- British Academy of Audiology
- British Society of Hearing Aid Audiologists
- Action on Hearing Loss
- Hearing Link
- Office of the Chief Scientific Officer, DH
- DH Advisor on Audiology
- National Clinical Lead for Audiology
- NHS Durham
- NHS Berkshire
- NHS West Midlands
- NHS South Central
- NHS Solihull
- NHS North of England
- The Royal College of Nursing (RCN)

Annex 2

Considerations

Annex 2: (Considerations)

Please note Annex 2 is being updated - the following links will take you to the latest versions of current guidance and policy.

Annex 3

Public Sector Equality Duty

Annex 3: Public Sector Equality Duty

The Equality Act 2010 replaces the previous anti-discrimination laws with a single Act making it easier for people to understand. It also strengthens the law in important ways, to help tackle discrimination and inequality. The Public Sector Equality Duty, which came into effect on 5 April 2011, sets out the responsibilities a public authority must undertake in order to ensure an environment that fosters good relations between persons of differing protected characteristics. Protected characteristics under the Equalities Act 2010 are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation. The Equality Duty has three aims. it requires public bodies to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- foster good relations between people who share a protected characteristic and people who do not share it.

Commissioners should have regard to the Public Sector Equality Duty when commissioning services for patients. For more information please visit the Department of Health website and search for 'Equality and Diversity'.

Annex 4

Glossary

Annex 4 – Glossary

Age-related hearing loss:	The slow loss of hearing that occurs as people get older.
Audiogram:	Graph used to record the hearing responses of an individual at different frequencies and intensities.
Audiology:	The study of hearing, which involves identification, evaluation, habilitation, and rehabilitation of hearing loss.
Audiometry:	Any kind of testing that involves hearing.
Auditory Ecology:	People's hearing and listening environments.
Bilateral Hearing Loss:	Hearing loss in both ears.
Bone Conduction:	Passing of sound to the inner ear through vibration applied to the bones in the skull, instead of through the outer and middle ear.
Communication Support:	Includes British Sign Language (BSL) interpreters, deafblind interpreters, lipspeakers, notetakers and speech-to-text reporters (palantypists).
Community Based:	Services provided from a community setting (as supposed to a secondary care or primary care setting).
Direct Access:	Referral straight from GP to the service without the need for secondary care triage (e.g. ENT).
Discrimination of Sounds:	Ability to tell the difference between sounds and to respond appropriately.
Earmold:	Plastic fitting that fits into the canal or ear flap of the ear to conduct sound directly into an individual's hearing system from a hearing aid. Earmolds are also intended to remove the possibility of feedback or squealing.
Hearing Aid:	Device with a sound receiver and an earmold that fits into the ear; amplifies speech and environmental sounds.
Loudness Discomfort Levels:	A clinical procedure for hearing aid evaluations.
Noise Intrusiveness:	A feature of sound which determines a high degree of annoyance in spite of the low value of noise rating.
Otology:	The branch of medicine that deals with the structure, function, and pathology of the ear.
Otoscopy:	Examination of the ear.
Pure Tone:	Simple sound wave used in testing hearing.

Pure Tone Audiometry:	Hearing test. Tones at specific test frequencies are presented through earphones. The individual's response to these sounds is recorded on an audiogram.
Sound Localisation:	a listener's ability to identify the location or origin of a detected sound in direction and distance.
Threshold:	Softest level of intensity at which a person hears a particular sound.
Unilateral Hearing Loss:	A hearing loss occurring in one ear.
Venting:	This is a hole drilled into the shell of the aid and is a route for sound to come back from the speaker.