

A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement

Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service	Direct Access Adult Hearing Service for Age Related Hearing Loss
Commissioner	NHS Merseyside CCGs
Lead	
Provider Lead	Tom McKnight / Frank Moore
Period	1 st April 2014 – 31 st March 2015
Date of Review	31/03/15

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. 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

2. Scope

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 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 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

2.2 Service description

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 NHS Merseyside.

Complex audiology services (for patients who meet the contra-indications detailed in 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 Appendix 2. Details of the service model can be found in section 2.3.

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.

2.3 Service model

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)

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 2.3.2 and 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)

2.3.2 Fitting

Fitting (if not undertaken at assessment appointment – see section 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. Providers are therefore recommended to use the NHS Supply Chain to obtain all aid(s) and equipment. If NHS Supply Chain is not used, Providers must demonstrate compliance to the minimum technical specification as designated by the NHS. NHS 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, as designated by the NHS.

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.

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

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.

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 2.10) 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.

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.

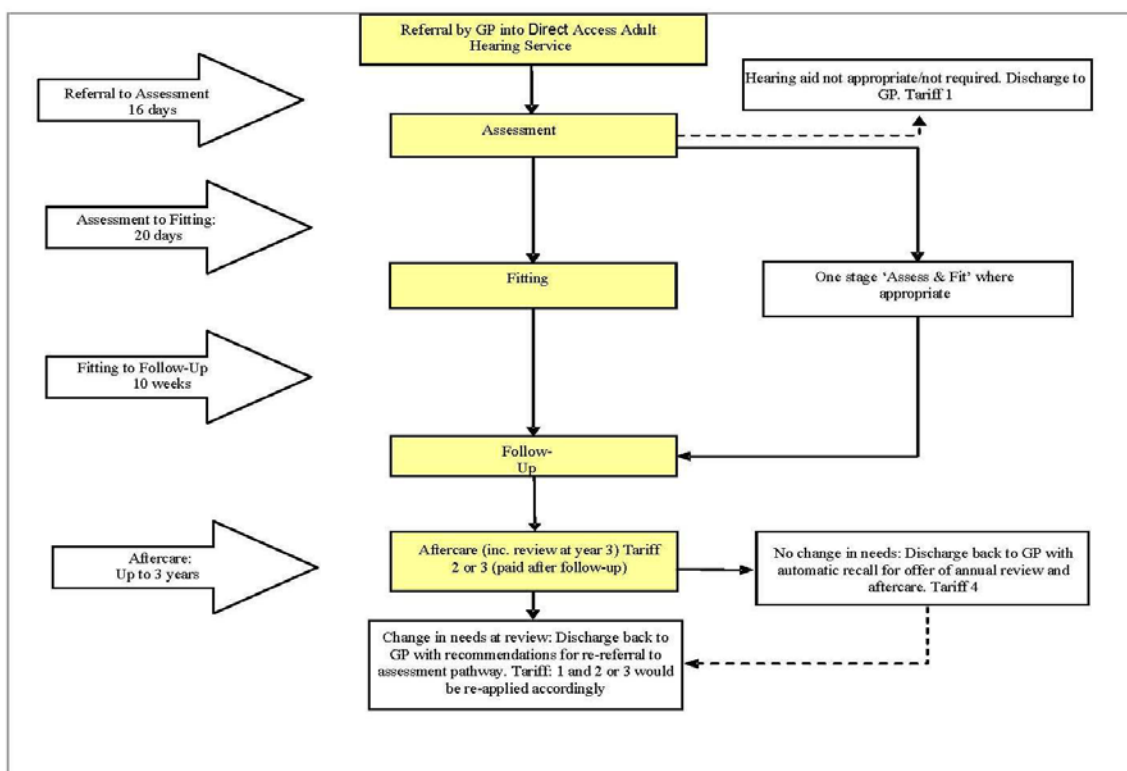
Options for battery replacement include:

- 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.

2.4 Care pathway

The following diagram shows the expected pathway and the expected response times. The response times should negate the need for a prioritisation system.



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 Merseyside area. The expectation is that the service will be provided from appropriate (see section 4.2) accessible, premises within the NHS Merseyside locality, with the service available and accessible to patients throughout the geographic area for the standard days/hours of operation.

2.6 Location(s) of service delivery

The expectation is that the service will be provided from appropriate (see section 4.2) accessible, premises within the NHS Merseyside locality, with the service available and accessible to patients throughout the geographic area for the standard days/hours of operation.

2.7 Days/hours of operation

Operating hours of the service across the geographic area covered by NHS Merseyside, 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.

2.8 Any acceptance and exclusion criteria

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.

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 Appendix 1

2.9 Referral processes

2.9.1 Accepting referrals

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

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 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.

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.

3. Applicable Service Standards

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

Please see Appendix 2 for applicable accreditation standards and guidelines.

4. Other

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 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 Appendix 3.

In terms of training and development:

- All staff should be trained to identify the contra-indications (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

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.

The CCG reserves the right to undertake spot checks or audits as deemed appropriate by the CCG.

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

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.

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

5. 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

80% of the total value is for activity and a further 20% awarded for the achievement of 5 stated Key Service Outcomes. Each outcome will be weighted equally i.e. for each indicator achieved 4% will

be gained to a maximum of 20% where all 5 indicators are met.

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

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.

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).

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 Special Opinion (2011)

Accreditation Standards

Improving Quality In Physiological diagnostic Services (IQIPS) Accreditation Standards and Criteria

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

Published Clinical Guidelines and Best Practice

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

1. NHS Core principles
2. National Institute for Health and Clinical Excellence Guidance/Quality Standards, when available
3. Department of Health: Standards for Better Health
4. Clinical protocols specified by British Society of Audiology and British Academy of Audiology
5. British Society of Audiology guidelines on minimum training standards for otoscopy and impression taking 12
6. 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 aids¹² and ¹³
7. Guidelines on the acoustics of sound field audiometry in clinical audiological applications.
8. Hearing Aid Handbook, Part 512
9. British Society of Audiology Pure Tone air and bone conduction threshold audiometry with and without masking and determination of uncomfortable loudness levels
10. British Society of Audiology recommended procedure for taking an aural impression
11. British Society of Audiology recommended procedure for tympanometry (when undertaken)
12. British Academy of Audiology Guidelines for Referral to Audiology of Adults with Hearing Difficulty (2009)
13. Recommended standards for pre-hearing aid counselling (Best Practice Standards for Adult Audiology, RNID, 2002)
14. Recommended standards for deaf awareness (Best Practice Standards for Adult Audiology, RNID, 2002)
15. Guidance on Professional Practice for Hearing Aid Audiologists (British Society of Hearing Aid Audiologists, 2011)

Suggested 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 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.

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.

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

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).