SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	1
Service	Direct Access Adult Hearing Service for Age Related Hearing Loss
Commissioner Lead	
Provider Lead	
Period	1st April 2013 - 31st March 2016 (36 months)
Date of Review	Annual Review

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. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	

Domain 4	**Ensuring people have a positive experience of care**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2 Local defined outcomes

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

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.

3. Scope

3.1 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 50) experiencing difficulties with their hearing and communication who feel they might benefit from hearing assessment and care, including the option of trying hearing aids to reduce these difficulties.

Exceptions to the age criteria of 50 years of age and older for this service is for patients:

- With an established hearing loss that is likely to be occupational (eg music industry) and can be managed within the scope of the AQP specification i.e. require only standard hearing testing and provision of hearing aids. Patients who require more complex care should not be referred into or treated by the Direct Access Adult Hearing Service.
- From 20 years of age where there is a family history of Otosclerosis.

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 S1A1.1 – S1A1.3.

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.

3.2 Service description/care pathway

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 50 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 S1A1.1 – S1A1.3)**Error! Reference source not found.** and services for adults under 50 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 under Section 4, Applicable Quality Standards. Details of the service model can be found in section 2.3.

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' and will incur no charge to the Commissioners
- 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) 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.

Fitting

Fitting (if not undertaken at assessment appointment) 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. Commissioners would recommend the use of NHS Supply Chain to obtain aid(s) and equipment to demonstrate compliance - http://www.supplychain.nhs.uk/product-areas/audiology/contract-categories/hearing-aids/

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.

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.

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

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
- Provision of a 36 month review assessment for all patients fitted with hearing aids

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.

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 shall offer a review assessment to all hearing aid patients at 36 months, as part of the provision of aftercare for patients. 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 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. A recovery schedule is recommended in the Currency and Price section 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.

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).

Where a patient's hearing aid malfunctions outside the manufacturer's warranty, or is damaged or lost during the period of aftercare, the Provider shall be responsible to ensure the hearing aid is replaced. Tariff 4 shall apply in these circumstances.

Battery Replacement Service

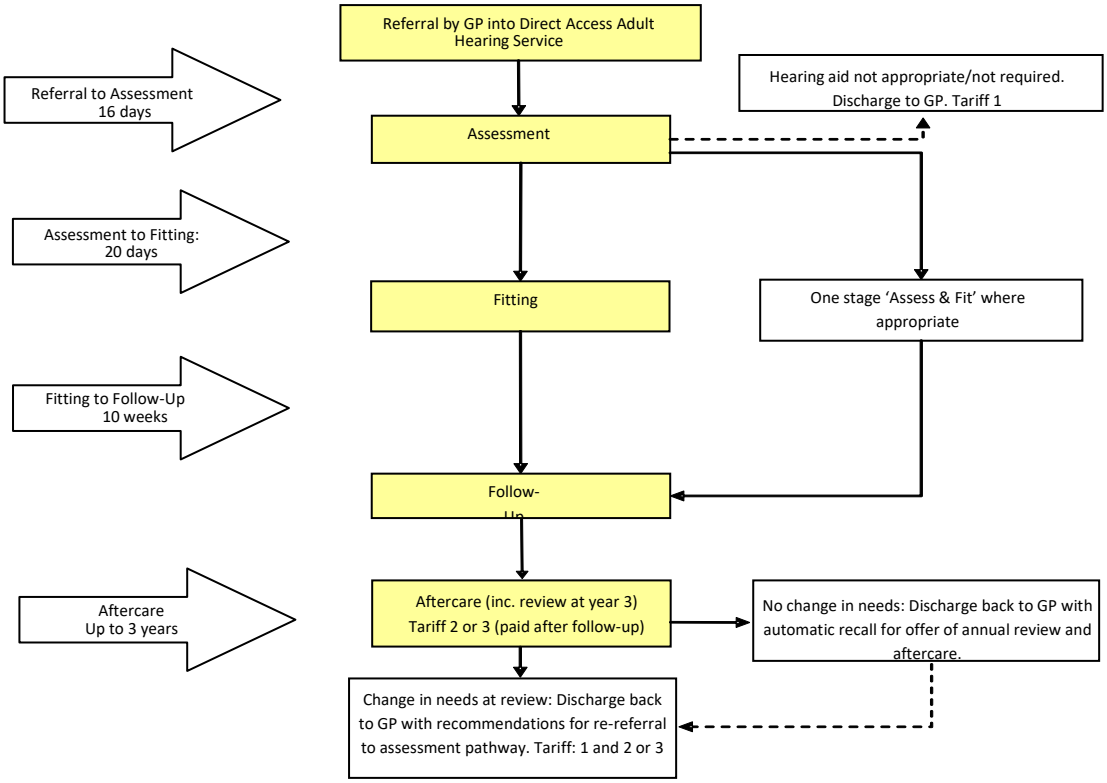
Batteries for hearing aids provided through an NHS qualified provider should be provided free of charge to NHS patients as part of the aftercare service, and should be of a designated specification according to the NHS Supply Chain.

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

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



3.3 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.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance criteria

The Direct Access Adult Hearing Service is for adults over the age of 50 with suspected or diagnosed age related hearing loss and who do not meet the exclusion criteria detailed in section 2.8.2. In addition those patients under the age of 50 who fall into the categories outlined in B1_2.1 Aims and Objectives of Service.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.

Exclusion criteria

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

- Children and adults under 50 years of age (i.e. 49 and 364 days old)
- Complex adult patients who meet the contra-indications as set out below;

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 (dysacuses)
- 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)

Referral Process

The Provider will only accept referrals under this Agreement from the Commissioner's Referral Management Service (RMS).

Where a referral is made directly from a GP, the Provider will return the referral to the appropriate RMS.

If in the event that a referral is received via the RMS, and such referral is outside the scope of the service acceptance criteria, the Provider will return the referral to the RMS, setting out the reasons for return of the referral.

The Commissioner will endeavor to ensure that all referrals made by the RMS are appropriate.

The Provider will produce a quarterly report detailing the number of inappropriate referrals made to it by either the RMS and/or directly by GPs.

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. secure email or,as a final option, paper) referral process should be accepted.

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. It is also expected that referring GPs will have already assured themselves that an assessment can take place and any ear wax removed. If this is not the case the patient should be sent back to the referring practice for this to happen.

The usual position is that where a referral is not suitable for the service but the patient needs an onward referral for another condition, then the patient will usually be referred back to the GP, with the appropriate level of urgency in that referral to GP to match the presenting condition. However, in some local areas the pathway will be different and this will be negotiated with the provider, as part of the deployment of the service.

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.

3.5 Interdependence with other services/providers

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.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Please see link below for applicable accreditation standards and guidelines

http://www.supply2health.nhs.uk/AQPResourceCentre/Pages/Annex2.aspx

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:
The expectation is that the service will be provided from appropriate 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

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.

7. Individual Service User Placement