

SCHEDULE 2 – THE SERVICES

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 Specification No. | |
| Service | Adult Hearing Service |
| Commissioner Lead | |
| Provider Lead | |
| Period | |
| Date of Review | |

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| 1. Population Needs |
| 1.1 National/local context and evidence base |
| <p>The impact of poor hearing in adults can be great both at a personal and a societal level leading to social isolation, depression, loss of independence and employment challenges.</p> <p>Assessing the hearing needs of adults with hearing loss, developing an individual management plan and providing appropriate interventions can reduce isolation, facilitate continued integration with society and promote independent living.</p> <p>The ageing population means that demand for both hearing assessment and associated interventions is set to rise substantially over the coming years. The vast majority of the ageing population with poor hearing can benefit from direct primary care referral to adult hearing services, often based in the community, and do not require referral to an Ear, Nose and Throat (ENT) out-patient appointment prior to audiological assessment. This facilitates timely diagnosis and access to support for adults with poor hearing.</p> <p>Approximately nine million adults in England have some form of hearing loss - that equates to one in six people. Most are older people who have a progressive hearing loss as part of the ageing process, with more than 70 percent of over 70 year olds and more than 40 percent of over 50 year olds having some form of hearing loss. There are certain groups that have a higher prevalence of noise induced hearing loss such as members of the armed forces. Hearing loss is now one of the most common long-term conditions in older people and the sixth leading cause of years lived with disability in England. In addition we are faced with an ageing population, where there will be an estimated 13 million people in England with hearing loss by 2035. For more information, please see Commissioning Services for People with Hearing Loss: A framework for clinical commissioning groups (2016) at https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf.</p> |

Around two million people currently have a hearing aid and nine out of 10 hearing aid users benefit from them and use them regularly. There are four million people who do not have hearing aids and would benefit from them. There is significant unmet need for hearing aids which needs to be tackled.

The provider is required to undertake an Adult Hearing Service for any service user registered with a GP practice within the area of the CCG, including those of no fixed abode. Referrals to the service will only be from GPs whose practice is a member of the CCGs for whom the service is being delivered.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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|-----------------|---|--|
| 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

The broad outcomes required of the service are specified below:

- Increased choice and control for service users as to where and when their treatment is delivered – providing on-going care closer to home;
- Personalised care for all service users accessing the service;
- Timely access to hearing assessment, and a range of support services including hearing aid fitting, follow-up and on-going aftercare;
- High proportion of service users continuing to benefit from the chosen intervention, including wearing hearing aids when required if they have been provided;
- Reduced communication difficulties for service users with poor hearing;
- Timely referral or signposting to other local services for support and equipment, including social services and voluntary services;
- Access to clear guidance and information for service users and their families about the important role of hearing in maintaining effective communication and active engagement in a range of social and work settings, including advice on the range of support available;
- High levels of satisfaction from service users accessing the service;
- Improved quality of life for service users, their families/carers and communication partners.

Applicable measures relating to these broad outcomes are set out in Schedule 4C (Quality Requirements).

3. Scope

3.1 Aims and objectives of service

The aim is to provide a comprehensive service for adults experiencing hearing and communication difficulties who feel they might benefit from hearing assessment and rehabilitation including the option of trying hearing aids with aftercare and support, in line with the National Commissioning Framework, other national guidance and local requirements.

The vision for people with 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 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 service user and professional education;
- Provide person-centred care, and respond to information and psychosocial needs, including for the effect on partners of living with poor hearing;
- 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;
- Improve the service through research and development and the adoption of new evidence based technologies and practices.

All providers of Adult Hearing Services must ensure that there are local arrangements for referral into more specialist medical services in line with British Academy of Audiology (BAA) Guidelines for *Direct Referral of Adults with Hearing Difficulty to Audiology Services* (2016 – currently in draft) and British Society of Hearing Aid Audiologists (BSHAA) Protocol and Criteria for Referral for Medical or other Specialist Opinion (2011).

The purpose of the Adult Hearing Service is to ensure:

- Equitable access to high and consistent quality care for all people using the service;
- A safe hearing service that conforms to the accreditation standards set out in the Improving Quality In Physiological Diagnostic Services (IQIPS) Accreditation Scheme;
- The service should also recognise published clinical guidelines and good practice (as set out in Section 4 - Applicable Service Standards).

3.2 Service description/care pathway

The service required for the registered population of the NHS commissioning organisation is for a hearing assessment service, including hearing aid fitting (where required), rehabilitative support, follow-up and aftercare services for adults with no contraindications (see 3.4 acceptance and exclusion criteria), who have suspected or diagnosed hearing loss. The service should include some flexibility to provide later evening and/or weekend appointments outside of regular working hours (Mon-Fri, 9am-5pm).

(Local commissioners may wish to vary the age threshold for the service in agreement with local GPs, clinicians and services, where appropriate, to improve access and enable younger adults to access the service as long as they do not meet the contra-indications set out in 3.4 below.)

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

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 service users.

The Adult Hearing Service will consist of:

- Hearing needs assessment;
- Development of a personalised care plan;
- Provision and fitting of hearing aids, where clinically appropriate and agreed with the service user;
- Appropriate hearing rehabilitation, for example service user information; hearing therapy;
- Information on and signposting to any relevant communication/social support services;
- Follow-up appointment to assess whether needs have been met;
- Aftercare service for up to three years, including advice, maintenance and review at third year;
- Discharge from hearing assessment and fitting pathway;
- Provision for service user complaints and feedback to the Provider.

The overall service should be carried out in accordance with best practice and guidelines listed in this service specification¹.

Assessment

Providers should work with GPs and other health and care services to encourage referrals to the service. Assessment should be undertaken within 16 working days of receipt of referral (unless the service user requests for this to be outside of this time, for example holiday, sickness etc).

The Provider should ensure service users have an adequate understanding of the hearing assessment process before the appointment, by providing information (in a suitable language and format, for example large type) in advance (either via the referrer or to be received by the service user at least two working days before the appointment) that explains the purpose of the assessment, what it involves and the possible outcomes. Providers should make service users aware of their right to communication support and/or accessible information, and how to request this if required, in line with the Accessible Information Standard. Service providers should make provision to encourage and involve service users in the consultation process as this is known to improve realisation of benefits by deepening understanding of and compliance with the advice provided.

In addition, Providers should provide details of which professional (job title and name where possible) will perform the assessment as well as a choice of when and where it will take place.

During the assessment appointment, the practitioner should ensure that communication with the service user is effective enough to be able to work in partnership with them (and partner if present) to reach jointly agreed goals/outcomes, undertaking the following:

¹ Providers should make service users aware of their right to communication support and/or information in an accessible format, and how to request this if required, in line with the Accessible Information Standard

- 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 if they have served in the armed forces, 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 service user must be informed of the reason for not being able to perform the test and rebooked or referred appropriately to the GP or other service 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 service user 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 and will be agreed in discussion with commissioners;
- Assessment of loudness discomfort levels;
- Integration of assessment findings with service user expectations - to enable them 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, for example, poorer speech discrimination and sound localisation and the impact this can have on a personal and societal level.
- Discuss with the service user 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 (for example, audibility of sounds and speech).
- Work collaboratively with the service user 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 service user wishes to accept provision of hearing aids, at the same appointment:
 - Undertake pre-fitting counselling, managing expectations as necessary;
 - Develop and share a written personalised care plan with the service user 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 service user 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 (it is estimated that in people aged 50 and over the bilateral fitting rate might range between 85 percent and 90 percent, it might be lower in younger adults, and higher in older adults because age-related hearing loss is bilateral and slowly progressive).
- Bilateral fittings are not clinically appropriate where:
 - One ear is not sufficiently impaired to merit amplification²

² Service users may benefit from bilateral fitting because of the interaction between the two aids and the important effect this has on discerning directional cues in the sounds, and this should be taken into account

- One ear is so impaired that amplification would not be beneficial (and should be referred back to the GP for onward referral to specialist 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 service user information (in a suitable language, large print and format, for example firm card) and ensure that they have 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. This should include a record of hearing aid settings and details and how to return to the Provider, rather than the GP/referrer, should there be any difficulties with the hearing aid.
- Provide relevant information from the consultation to the GP/referrer as agreed with the service user.
- Electronically record details of the assessment appointment, including any comments by the service user and record if they have served in the armed forces to enable onward referral to any additional services for veterans.
- A full record of the consultation and any decisions/ agreements should be provided to the service user at the end of the consultation. British Society of Hearing Aid Audiologists guidance on record keeping is available at <http://www.bshaa.com/Publications/BSHAA>.

***Note:**

- Where an NHS-qualified provider also provides private hearing aids and a service user 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 them 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 service user booked appointment outside of the NHS-funded service.
- At any private appointment, providers should ensure the service user is provided with details and information regarding the specification of NHS devices and be clear what, if any, are the additional benefits a private hearing aid would bring in order to ensure the service user makes an informed decision about purchasing a private hearing aid.
- Providers must not promote their own private treatment service, or an organisation in which they have a commercial interest.
- Providers must not encourage service users to 'trade up' (i.e. to privately purchase more expensive hearing devices than is necessary).
- Where a service user is actively seeking alternative information about private purchase, providers must not act unprofessionally or make uninformed comments about alternatives, but refer to alternative unbiased sources of information, for example, the BSHAA Find an Audiologist service.
- Where an enquiry is made because the service user 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.
- If the assessment indicates that the service user will benefit from bilateral hearing aids, provision should be made for provision of two hearing aids, and the reason for this, and the expected benefits should be explained.
- Providers should issue service users with a maximum of one hearing aid for unilateral use or two hearing aids for bilateral use. Spare hearing aids are not part of standard NHS provision, except in circumstances where this is justified for example for those who are blind or partially sighted.

- For service users requiring assessment only (i.e. no fitting of hearing aids) – the relevant tariff applies (see Currency and Price details in Schedule 3A).

Fitting of Hearing Aid as Preferred Intervention

Fitting (if not undertaken at the assessment appointment) should be undertaken within 20 working days from assessment (unless the service user requests for this to be outside of this time, for example holiday, sickness etc). The service user should be made aware of their right to communication support for the fitting appointment; and if this is required they should still receive their fitting appointment with 20 working days.

At the fitting appointment (regardless of same day or separate from the assessment) the following should be provided and discussed with the service user:

- Otoscopy;
- A review of the service user information and outcome measures (GHABP/COSI/IOI-HA);
- Selection and programming of hearing aids*;
- Education of the service user in order to reach a shared understanding of the benefits of hearing aid provision;
- The choice of appropriate objective measurements, including REM, together with details of the relevant adjustment, should 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 service user's own aid(s) worn and switched on, teach them (and where appropriate, their partner) (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 personalised care plan and provide a battery issue book if appropriate;
- Discuss service user's wider needs and provide signposting to any relevant support services (including lip-reading classes, support services and assistive technologies), as agreed with the service user, in accordance with agreed local protocols;
- Arrange a follow-up appointment - the service user 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;
- The service user should be provided with full written instructions regarding all of the above points including links to relevant websites.

***Note:** Provision of NHS-funded hearing aid(s) will be of a minimum technical specification as designated by the NHS. Commissioners 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 service user, the reasons for the new fitting and expected benefits of this to the service user should be documented.

The provider should record:

- Any significant changes 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 Provider for appropriate decontamination/refurbishment or disposal.

The Provider should maintain an adequate stock and range of hearing aids and accessories (such as tubes/domes) to support the ongoing care of service users 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 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 service users to receive hearing aids at the initial assessment appointment (an open fitting is carried out) - suitability depends on hearing loss, dexterity, cognitive ability, emotional readiness and individual 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 service user returns at a later date for the hearing aid fitting (or bilateral impressions for bilateral fittings).

Pre-appointment information should mention the two options as well as highlight other interventions available, to prepare service users 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 the service user chooses to wait beyond this period), in order to determine whether needs have been met.

Service users should be offered a choice of a face to face or non-face to face follow-up (using a variety of mediums, for example, telephone, internet or written review) – the Provider should seek to meet the service users' preference where possible.

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

A quicker follow-up appointment may be necessary in advance of the service user's pre-booked follow-up appointment (for example, if the service user is experiencing difficulty with their aids) and this should be offered within five working days of the request from the service user.

Within the follow-up the provider should:

- Discuss with the service user whether the outcomes agreed within the personalised care plan have been met and if not how to resolve residual needs and update the plan 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 the service user's ability to remove and insert aid and provide further help if needed;
- 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;
- Provide information (in a suitable language and format) and sign-posting to any relevant communication/social/rehabilitation support services including hearing therapy if indicated.
- If face to face follow up is required, then review hearing aid data-logging;
- Fine tune hearing aid (if necessary) based on service user's comments;
- If necessary conduct objective measurements including REM.

The Provider should:

- Update the personalised care plan in conjunction with the service user 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 service user.

Aftercare

The Provider must provide on-going aftercare, support and equipment maintenance on an annual basis as required by the service user after the service user's follow up appointment. Appointments must not be limited to an annual check-up and service users must be able to access this service directly, as frequently as required.

Aftercare services covered by the tariff price must include:

- Cleaning advice and cleaning aids for service users 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;
- Review of service users where they are having problems managing their hearing aid and / or where the provider or the service user considers that there has been a significant change in their hearing. Where the review suggests replacement hearing aids may be of significant audiological benefit to the service user, the service user must be discharged back to the GP with the advice to undergo a full re-assessment and fitting pathway. The commissioner will not pay for a new / upgraded hearing aid unless the provider can demonstrate that the service user's hearing loss cannot be sustained with the existing equipment which should be reprogrammed. This would also apply to service users attending a new provider that has been discharged from another NHS qualified provider.
- For service users on the Aftercare pathway, these will continue for the duration of the contract and not represent for a new hearing aid unless previously described.

Service users should be able to access aftercare services (face to face or non-face to face methods) within two working days of the request. A postal repair service must also be available to service users for returns within seven working days at the provider's expense.

Aftercare may be provided by any member of staff or volunteer staff who is suitably trained and qualified for the task at hand, for example BSHAA-approved Hearcare Assistant or assistant audiologist, and there must always be an experienced audiologist or

hearing aid dispenser available in person or on request to provide further support if required. Further information is available in the 2016 BAA Scope of Practice.

Review

Service users 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 three 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/referrer of the outcome of the review or if the service user declined a review.

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

Tariffs will be dependent on whether the service user is a unilateral or a bilateral hearing aid user. See Schedule 3A.

Where the review suggests that there are no significant changes, the service user should be discharged back to the GP/referrer with the Provider responsible for yearly aftercare and automatic recall to offer service users an annual review.

Where review suggests that there are significant changes to an individual's hearing needs, the service user should be discharged back to the GP/referrer with the advice to undergo a full re-assessment and fitting pathway. The GP/referrer would be required to re-refer the individual to the service and the pathway described in Figure 1 below will start again with the associated timescales and tariffs.

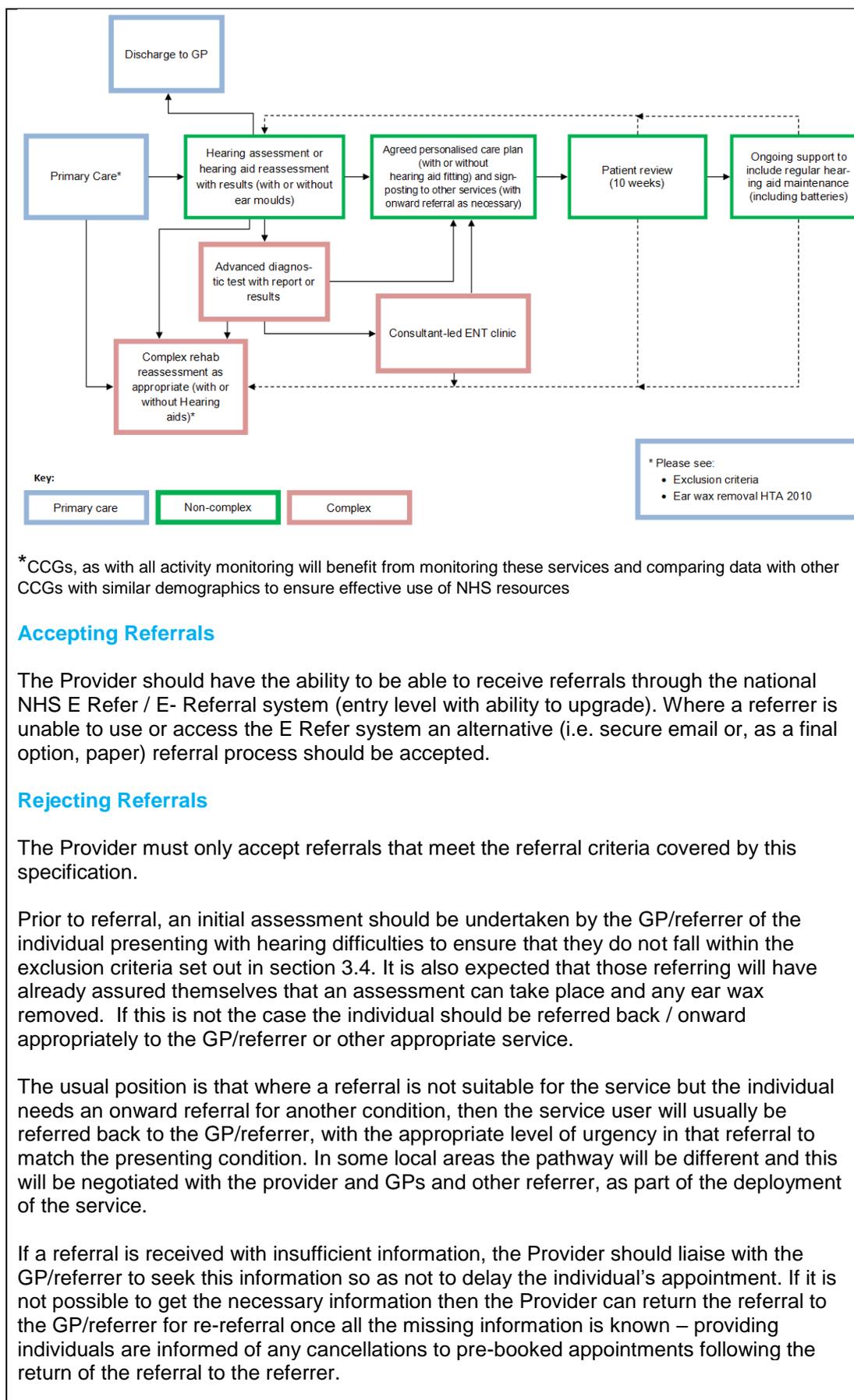
Where a service user's hearing aid malfunctions outside the manufacturer's warranty, or is lost during the period of aftercare, the Provider shall be responsible to ensure the hearing aid is replaced. The relevant tariff shall apply in these circumstances.

The Provider is responsible for the purchase, provision and replacement of batteries to NHS service users and must supply NHS funded hearing aids that are of a minimum technical specification as designated by the NHS.

The commissioner will not pay for a new / upgraded hearing aid unless the provider can demonstrate that the service user's hearing loss cannot be sustained with the existing equipment which should be reprogrammed. This would also apply to service providers attending a new provider that has been discharged from a previous NHS qualified provider.

Illustrative Care Pathway

Figure 1 shows the expected care pathway for adults with suspected hearing loss:



Any referrals received that are not agreed in the local pathway 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.

Discharge Process

Any service user discharged (as per the discharge criteria) 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/referrer and complete an Individual Management Plan for the service user. In the event that the service user requires urgent onward management the discharge report and any other relevant clinical information will be provided to the GP/referrer, or onward referral the same day. In the case of non-urgent onward referral this will be completed within 48 hours.

Where the service user has changed Provider during the expected three year pathway the commissioners will seek to recover the applicable monies in accordance with Schedule 3A.

3.3 Population covered

The Adult Hearing Service is to be provided to eligible people registered to a GP practice within the NHS commissioning organisation area. The provider is required to undertake an Adult Hearing Service for any service user registered with a GP practice within the area of the CCG, including those of no fixed abode. Referrals to the service will only be from GPs/referrer whose practice/organisation is a member of the CCGs for whom the service is being delivered. Where other local referral arrangements have been agreed, for example, open access or self – referral these should apply.

3.4 Any acceptance and exclusion criteria and thresholds

The Adult Hearing Service is for adults experiencing hearing and communication difficulties who feel they might benefit from a hearing assessment and rehabilitation including the option of trying hearing aids with onward aftercare and support. Local commissioners may wish to vary this in agreement with local clinicians and services, where appropriate, to enable younger adults to access the service.

The referral criteria are based on the BAA 2016 draft guidelines for the Direct Referral of Adults with Hearing Difficulty to Audiology Services which are out for consultation at the time of writing and BSHAA Protocol and Criteria for Referral for Medical or other Specialist Opinion (2011). The BAA and BSHAA are jointly developing updated illustrative contraindications. This guidance will be included as soon as it is available.

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

- Have sight loss/dual sensory loss;
- Have learning disabilities;
- 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.

People with learning disabilities and some requiring domiciliary care may require special test facilities and techniques. It should be the responsibility of the referring clinician and provider to manage between them the appropriateness of referral/treatment according to a person's needs and not automatically exclude them from this service because they have a degree of learning disability or require domiciliary care.

Commissioners should seek assurance that providers have the necessary qualifications, skills and equipment to accommodate these client groups.

Routine adult hearing services for hearing loss may be provided to people as long as they do not meet the contra-indications as detailed below:

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

Children under the age of 18 years;

History:

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

Ear examination:

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

Audiometry:

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

References:

Draft Guidelines for the Direct Referral of Adults with Hearing Difficulty to Audiology Services, British Academy of Audiology (2016)
 BSHAA Protocol and Criteria for Referral for Medical or other Specialist Opinion (2011)

3.5 Interdependence with other services/providers

The 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 authority social services, the voluntary & community sector and independent providers.

The Provider must demonstrate how it will work with these other organisations to support people 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 Adult Hearing Service within the wider health, voluntary, other community, mental health and secondary care services and social services environment e.g. lip-reading classes, equipment services etc.

4. Applicable Service Standards**4.1 Applicable national standards (eg NICE)****Improving Quality in Physiological Services (IQIPS) Accreditation Standards**

www.ukas.com/services/accreditation-services/physiological-services-accreditation-iqips/

Commissioners should ensure that audiology services participate in, and maintain accreditation to defined quality standards operating under the umbrella of the UKAS IQIPS Accreditation Scheme. In particular:

- The provider will be expected to have completed the IQIPS Self-Assessment Improvement Tool (SAIT) and have registered an application for accreditation with UKAS; and
- Accreditation status should be achieved within the duration of the contract term.

Accessible Information Specification

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

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

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

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

- NHS Core principles
- National Institute for Health and Care Excellence Guidelines and Quality Standards, when available
- Care Quality Commission Standards
- Clinical protocols specified by British Society of Audiology and British Academy of Audiology and the British Society of Hearing Aid Audiologists
- British Society of Audiology guidelines on minimum training standards for otoscopy and impression taking 12

- British Society of Audiology and British Academy of Audiology guidance on the use of real ear measurement to verify the fitting of digital signal processing hearing aids 12 and 13
- Guidelines on the acoustics of sound field audiometry in clinical audiological applications
- Hearing Aid Handbook, Part 512
- British Society of Audiology Pure Tone air and bone conduction threshold audiometry with and without masking and determination of uncomfortable loudness levels
- British Society of Audiology recommended procedure for taking an aural impression
- British Society of Audiology recommended procedure for tympanometry (when undertaken)
- Recommended standards for pre-hearing aid counselling (Best Practice Standards for Adult Audiology, RNID, 2002)
- Recommended standards for deaf awareness (Best Practice Standards for Adult Audiology, RNID, 2002)
- British Academy of Audiology Guidelines for Referral to Audiology of Adults with Hearing Difficulty (2009)
- Direct Referral of Adults with Hearing Difficulty to Audiology Services (Draft Guidelines 2016)
- Clegg, A. et al, (2010) The safety and effectiveness of different methods of earwax removal: a systematic review and economic evaluation. Health Technology Assessment 2010; Vol. 14: No. 28
- Guidance on Professional Practice for Hearing Aid Audiologists (British Society of Hearing Aid Audiologists, 2011)
- BSHAA Protocol and Criteria for Referral for Medical or other Specialist Opinion (2011)
- BSHAA Practice Manual for the use, supervision, training and approval of Hearing Care Assistants, (British Society of Hearing Aid Audiologists 2013)
- Standards of Proficiency: Hearing Aid Audiologists (HCPC 2014)
- Guidance on Record Keeping (British Society of Hearing Aid Audiologists 2016)
- Health and Care Professions Council professional registration and training standards

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 and the BAA Scope of Practice (2016).

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.

The Professional Head of Service must be registered with the Health and Care Professions

Council or the Registration Council for Clinical Physiologists. Other team roles may include:

Audiologists, Hearing Aid Dispensers and assistant/associate audiologists who are suitably qualified. Where the Government's Modernising Scientific Careers (MSC) programme brings about changes to registration requirements, audiologists must be registered accordingly and arrangements should be in place to support MSC training placements.

All staff should be trained to identify the contra-indications set out in 3.4 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 two weeks observing a qualified audiologist or dispenser, followed by two weeks working under the direct, fulltime supervision of a senior audiologist. Newly qualified staff undertaking this training period should have a portfolio/evidence to demonstrate competence.

Achievement of the IQIPS accreditation provides some level of assurance that staff are fully trained and competent to deliver the service as there are standards and criteria specifically focused on this area.

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 8253-1:2010 standard, Acoustics- Audiometric Test Methods – Part 1: basic pure tone air and bone conduction threshold audiometry'. If this is not possible because domiciliary visits are required, or where only preliminary hearing assessment is performed before full hearing assessment, the 35 dBA (maximum background noise level) 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.'

Equipment and Software

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

- Otoscope;
- Ear impression taking equipment;
- Ear mould modification equipment;
- Audiometer, objective measurement (for example, . 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 (for example, 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.

Other Recommended Equipment:

- Tympanometer to evaluate eardrum mobility and middle ear function as required

In addition:

- All audiometric equipment should be regularly calibrated and checked to relevant national or international guidelines including 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 NHS England recommendations.

4.3 Applicable local standards

Insert relevant local standards as applicable

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 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 service users an opportunity to opt into receiving marketing information, and not make future contact without the individual's explicit opt-in consent.

Where a service user is actively seeking alternative information about private purchase, providers must not act unprofessionally or make uninformed comments about alternatives, but refer to alternative unbiased sources of information, for example, the BSHAA Find an Audiologist service

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4C)

5.2 Applicable CQUIN goals (See Schedule 4D)

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 service users throughout the geographic area for the standard days/hours of operation.

Operating hours of the service across the geographic area covered by the NHS commissioning organisation, **should be specified by each individual commissioner**, (for example. 8.00am – 6.00pm, Monday to Friday, with an additional minimum of five 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 service users 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



SCHEDULE 3 – PAYMENT

A. Local Prices

Enter text below which, for each separately priced Service:

- *identifies the Service;*
- *describes any agreement to depart from an applicable national currency (in respect of which the appropriate summary template (available at: <http://www.monitor.gov.uk/locallydeterminedprices>) should be copied or attached)*
- *describes any currencies (including national currencies) to be used to measure activity*
- *describes the basis on which payment is to be made (that is, whether dependent on activity, quality or outcomes (and if so how), a block payment, or made on any other basis)*
- *sets out any agreed regime for adjustment of prices for the second and any subsequent Contract Year(s).*

Insert template in respect of any departure from an applicable national currency; insert text and/or attach spreadsheets or documents locally – or state Not Applicable

There is no nationally mandated currency or price for hearing services, but the 2016 /17 National Tariff Payment System (NTPS) sets out principles and rules which govern the agreement of local prices, including:

- The approach must be in the best interests of patients;
- The approach must promote transparency to improve accountability and encourage the sharing of best practice, and
- The provider and commissioner(s) must engage constructively with each other when trying to agree local payment approaches.

Within these principles and rules, CCGs are able to determine how they wish to structure payments to providers for hearing loss services, setting this out as part of their procurement process.

CCGs should use the best possible information to arrive at a price for hearing services. Useful sources of information include:

- Section 8.4 of the Commissioning Framework for People with Hearing Loss
- Non-mandatory prices for adult hearing services set out for reference in the NTPS 2016/17 and below for information;
- 2012 AQP pricing guidance (see Appendix 9 of the Commissioning Framework);
- Other CCGs.

Adult hearing services

| Description | Tariff (£) |
|---|------------|
| Audiology hearing aid assessment only | 53 |
| Pathway for hearing aid assessment, fitting of one hearing aid device, cost of one device & first follow up | 268 |
| Pathway for hearing aid assessment, fitting of two hearing aid devices, cost of two devices & first follow up | 370 |
| Hearing aid aftercare (repairs) | 25 |

It is important to note that the non-mandatory tariff and the 2012 AQP pricing guidance reflect different packages of care. In particular, the 2012 AQP price included a full three years of aftercare following fitting of a device.

SCHEDULE 3 – PAYMENT

B. Local Variations

For each Local Variation which has been agreed for this Contract, copy or attach the completed publication template required by Monitor (available at: <http://www.monitor.gov.uk/locallydeterminedprices>) – or state Not Applicable. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.

Insert template; insert any additional text and/or attach spreadsheets or documents locally – or state Not Applicable

SCHEDULE 3 – PAYMENT

C. Local Modifications

For each Local Modification Agreement (as defined in the National Tariff) which applies to this Contract, copy or attach the completed submission template required by Monitor (available at: <http://www.monitor.gov.uk/locallydeterminedprices>). For each Local Modification application granted by Monitor, copy or attach the decision notice published by Monitor. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.

Insert template; insert any additional text and/or attach spreadsheets or documents locally – or state Not Applicable

SCHEDULE 3 – PAYMENT

D. Marginal Rate Emergency Rule: Agreed Baseline Value

In line with the requirements set out in the National Tariff, insert text and/or attach spreadsheets or documents locally – or state Not Applicable

SCHEDULE 3 – PAYMENT

E. Expected Annual Contract Values

| Commissioner | Expected Annual Contract Value <i>(Exclude any expected CQUIN payments. CQUIN on account payments are set out separately in Table 2 of Schedule 4D, as required under SC38.3.)</i> |
|--|--|
| Insert text and/or attach spreadsheets or documents locally | |
| | |
| | |
| | |
| | |
| | |
| Total | |

SCHEDULE 3 – PAYMENT

F. Timing and Amounts of Payments in First and/or Final Contract Year

Insert text and/or attach spreadsheets or documents locally – or state Not Applicable

SCHEDULE 4 – QUALITY REQUIREMENTS

C Local Quality Requirements

| Quality Requirement | Threshold | Method of Measurement | Consequence of breach | Timing of application of consequence | Applicable Service Specification |
|---|------------|--|-----------------------|--------------------------------------|----------------------------------|
| Recommended Outcomes: | | | | | |
| Outcome 1 Improvement in service user disability, and/or difficulty in communication (reduced communication difficulties) | 90 percent | Validated service user reported outcome tools such as Glasgow Hearing Aid Benefit Profile (GHABP)/ Client Oriented Scale of Improvement (COSI) and International Outcome Inventory for Hearing Aids (IOI-HA) | To be defined locally | Monthly Performance Report | Adult Hearing Service |
| Outcome 2 Improvement in service user reported quality of life | 90 percent | Validated service user reported outcome tools such as Glasgow Hearing Aid Benefit Profile (GHABP)/ Client Oriented Scale of Improvement (COSI) and International Outcome Inventory for Hearing Aids (IOI-HA) | To be defined locally | Monthly Performance Report | Adult Hearing Service |
| Outcome 3 Percentage of service users reporting continued use of their choice of hearing aid and or other intervention(s). | 90 percent | Review of Service Quality Performance Reports | To be defined locally | Monthly Performance Report | Adult Hearing Service |
| Outcome 4 | 90 percent | Validated service user reported outcome tools such as Glasgow Hearing Aid | To be defined locally | Monthly Performance Report | Adult Hearing Service |

| Quality Requirement | Threshold | Method of Measurement | Consequence of breach | Timing of application of consequence | Applicable Service Specification |
|---|-------------------------------------|--|-----------------------|---|----------------------------------|
| Percentage of service users reporting benefits from their choice of intervention | | Benefit Profile (GHABP)/ Client Oriented Scale of Improvement (COSI) and International Outcome Inventory for Hearing Aids (IOI-HA) | | | |
| Outcome 5 Percentage of service users reporting satisfaction with their choice of intervention | 90 percent | Validated service user reported outcome tools such as Glasgow Hearing Aid Benefit Profile (GHABP)/ Client Oriented Scale of Improvement (COSI) and International Outcome Inventory for Hearing Aids (IOI-HA) | To be defined locally | 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. | Adult Hearing Service |
| Recommended KPIs (incorporating key outcomes above) | | | | | |
| Referral to Assessment Time Assessments to be completed within 16 working days following receipt of referral, unless patient requests otherwise | (90 – 98 percent) | Review of Service Quality Performance Reports | Sanction | Monthly | Adult Hearing Service |
| Assessment to Fitting Time Hearing aids to be fitted within 20 working days following assessment, unless patient requests otherwise | (90 – 98 percent) 85 percent | Review of Service Quality Performance Reports | Sanction | Monthly | Adult Hearing Service |

| Quality Requirement | Threshold | Method of Measurement | Consequence of breach | Timing of application of consequence | Applicable Service Specification |
|---|-------------------|---|------------------------------|---|---|
| Note: Some CCGs are specifying outcomes for one stop assess and fit services | | | | | |
| <p>Fitting to Follow Up Time</p> <p>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</p> | (90-98 percent) | Review of Service Quality Performance Reports | Sanction | Monthly | Adult Hearing Service |
| <p>Quicker Follow Up</p> <p>Where patients request this, a quicker follow-up is offered within 5 working days</p> | 90 percent | Review of Service Quality Performance Reports | To be defined locally | Monthly | Adult Hearing Service |
| <p>Objective Measurements</p> <p>(e.g. REM) - Patients undergo objective measurement at first fitting where clinically appropriate (exceptions reported in IMP)</p> | 95 percent | Review of Service Quality Performance Reports | To be defined locally | Monthly | Adult Hearing Service |
| <p>Additional Follow Up</p> <p>Where required, additional face to face follow-ups are offered within 7 working days of non-face to face follow-up</p> | 90 per cent | Review of Service Quality Performance Reports | To be defined locally | Monthly | Adult Hearing Service |
| <p>AfterCare</p> | (90 – 98 percent) | Review of Service Quality Performance Reports | Sanction | Monthly | Adult Hearing Service |

| Quality Requirement | Threshold | Method of Measurement | Consequence of breach | Timing of application of consequence | Applicable Service Specification |
|---|-----------------------------|---|------------------------------|---|---|
| Aftercare is available (face to face or non-face to face) within 2 working days of patient request | | | | | |
| Information Sharing Patient records and associated letters/reports completed and sent to GP within 5 working days of hearing assessment/ fitting/ follow-up | 95 percent | Review of Service Quality Performance Reports | To be defined locally | Monthly | Adult Hearing Service |
| 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 percent | Review of Service Quality Performance Reports | Sanction | 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. | Adult Hearing Service |
| Peer Satisfaction of Service Percentage of GPs satisfied with service (A minimum of one GP satisfaction survey will be designed and sent to all referring GPs) | 95 percent | GP questionnaires | To be defined locally | Quarterly and accumulative report to include an analysis of completed user questionnaires, demonstrating % of those satisfied or very satisfied with service. | Adult Hearing Service |
| Service Improvement | 100 percent of recommendati | Service User Questionnaires | To be defined locally | Annual report to demonstrate | Adult Hearing Service |

| Quality Requirement | Threshold | Method of Measurement | Consequence of breach | Timing of application of consequence | Applicable Service Specification |
|--|--|--|-----------------------|---|----------------------------------|
| Service user questionnaires and peer satisfaction surveys to capture areas for improvements. | ons made and agreed with Commissioners are addressed | | | 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 percent | Service User Questionnaires | To be defined locally | Accumulative annual service user questionnaire report analysis to include number of patients surveyed, number of these in PCGs, response rates, response rates for PCGs, % of these specifying overall satisfaction | Adult Hearing Service |
| Reducing Barriers* An integrated patient pathway, which facilitates signposting to wider communication/social support services (where appropriate) | 100 percent | Provider provides demonstrable evidence of % patients who receive information about these support services validated through service user questionnaires | To be defined locally | Provider provides demonstrable evidence of % patients who receive information about these support services | Adult Hearing Service |
| Personalised Care Planning All service users have a personalized care plan produced jointly with users, their family and carers | 100 percent | Review of audit data to demonstrate that all service users have a completed IMP and service user satisfaction survey | To be defined locally | Quarterly | Adult Hearing Service |

| Quality Requirement | Threshold | Method of Measurement | Consequence of breach | Timing of application of consequence | Applicable Service Specification |
|--|--|---|-----------------------|---|----------------------------------|
| <p>Increased choice and control of when and where treatment is delivered (time and place)</p> <p>95% of service users sampled should report satisfaction with amount of choice and control</p> | 95 percent | Patient questionnaire to monitor satisfaction with amount of choice and control offered | To be defined locally | Monthly performance report for activity and quarterly report for survey | Adult Hearing Service |
| <p>Increased uptake of hearing aids and proportion of patients continuing to wear hearing aids</p> <p>Percentage of patients still wearing hearing aids at review stage ((after first follow up, 12, and 24 months)</p> | 90 percent of patients fitted with a hearing aid should be continuing to wear the aid(s) at review | As above | To be defined locally | Monthly Performance Report | Adult Hearing Service |
| <p>Reduced social isolation and consequent mental health</p> <p>Measure of improvement in outcome measure after hearing aid fitted</p> | 90 percent | Use of validated tool (to be defined by profession) | To be defined locally | Monthly Performance Report | Adult Hearing Service |
| <p>Improved quality of life</p> | 90 percent | Validated service user reported outcome tools such as Glasgow Hearing Aid Benefit Profile (GHABP)/ Client Oriented Scale of Improvement (COSI) and International Outcome Inventory for Hearing Aids (IOI-HA | To be defined locally | Monthly Performance Report | Adult Hearing Service |

SCHEDULE 4 – QUALITY REQUIREMENTS

D. Commissioning for Quality and Innovation (CQUIN)

CQUIN Table 1: CQUIN Schemes

| |
|---|
| <p>Insert completed CQUIN template spreadsheet(s) or state Not Applicable</p> <p>*20 percent of the total value for annual delivered activity will be subject to the achievement of Outcomes / Service Performance indicators selected by the Commissioner and specified in Schedule 4C. Each selected outcome will be weighted equally. Sanction will be applied on the individual indicator failed in accordance with weighting i.e. one indicator failed is a sanction of 4 percent reduction; five indicators failed is a sanction of 20 percent reduction.</p> |
|---|

CQUIN Table 2: CQUIN Payments on Account

| Commissioner | Payment | Frequency/Timing | Agreed provisions for adjustment of CQUIN Payments on Account based on performance |
|--------------|---------|------------------|--|
| | | | |
| | | | |
| | | | |

SCHEDULE 4 – QUALITY REQUIREMENTS

E. Local Incentive Scheme

Insert text locally or state Not Applicable

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