SECTION B PART 1 - SERVICE SPECIFICATION

Service: Core Podiatry Service Specification

Service Specification No.	
Service	Core Podiatry
Commissioner Lead	
Provider Lead	
Period	Until September 2015
Date of Review	

B1_1.0 Population Needs

B1_1.1 National/local context and evidence base

The following are extracts from A Guide to the Benefits of Podiatry to Patient Care, The Society of Chiropodists and Podiatrists, 2010:

Foot and lower limb problems are common and are a significant cause of ill health, pain and disability and can lead to impaired balance increasing the risk of falling. It is estimated that eighty percent of older people have foot related problems *(Harvey et al., 1997)* and in an ageing society the prevalence of chronic foot problems will rise significantly *(Levy, 1992).*

General health and/or social problems are often detected by podiatrists who signpost patients to the appropriate agency, the self-referral process and community accessibility for these patients often proves to be the first point of contact for treatment and the podiatrist may be the first healthcare professional to assess their care needs.

Podiatry and foot health services are important to the public and this has been supported by the Government in the following publications:

- Health Care Commission Report ref C200601_0118, March 2007.
- Best Foot Forward, Help the Aged 2006 and Age Concern, Feet for Purpose 2007.
- Parliamentary Early Day Motion 777 to improve NHS access to foot health services.
- Alan Johnson Statement May 2008, *'development of good foot health services will be a priority objective of the national prevention plan'.*

B1_2.0 Scope

B1_2.1 Aims and objectives of service

The aims of the service are to achieve:

- High quality podiatric care efficiently and cost effectively to increase mobility and independence for adults and children
- In this context quality is defined through clinical effectiveness, patient experience and safety

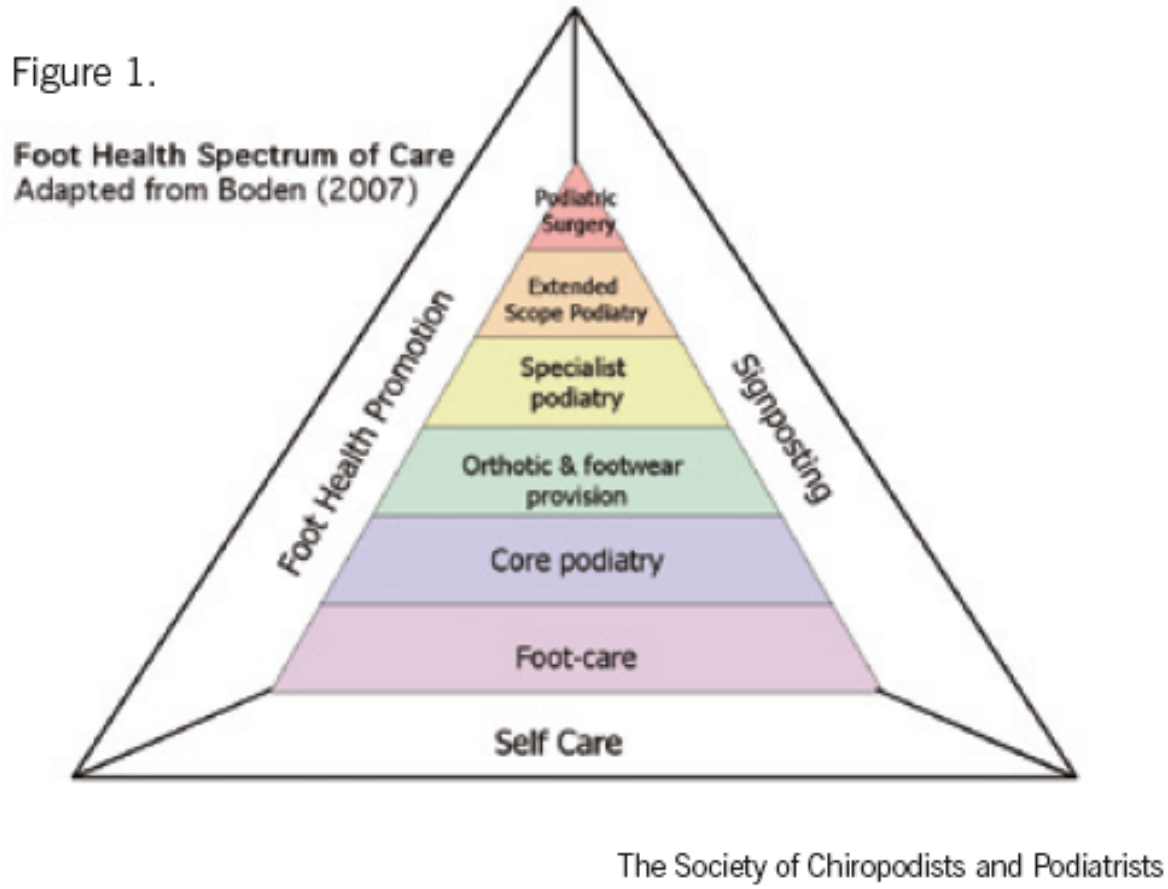
The objectives of the services are:

- To provide assessment and intervention for those patients with painful foot conditions where this has reduced mobility and independence
- To provide a surgical option for nail pathologies
- To provide management of foot pain associated with foot function and/or structural abnormalities for common foot and ankle conditions
- To provide footwear advice and orthotics as part of personalised care plans
- To provide foot health education information and public health information and to signpost to services
- To contribute towards falls prevention and maintain mobility and independence

B1_2.2 Service description

Figure 1 below illustrates the full spectrum of foot health care.

Figure 1: Foot Health spectrum of Care



This Any Qualified Provider Service Specification is restricted to elements of Core Podiatry within the spectrum with the emphasis on community delivery of services and preventative treatment.

Core Podiatry is defined as *'the assessment, diagnosis and treatment of common foot pathologies associated with the toenails, soft tissues and the musculoskeletal system with the purpose of sustaining or improving foot health'* (Farndon, 2006).

It is focused on the needs of those with low and medium levels of foot health need with referral on to specialised podiatry and extended scope podiatry and signposting to non-podiatric services where clinically appropriate, e.g. smoking cessation or weight management services. Providers will be expected to provide appropriate staff training to ensure appropriate referrals to higher-tier podiatric services and non-podiatric services are made when needed.

This Service Specification **covers**:

- Elements of core podiatry defined as the scope of practice obtained at graduation including the treatment of patients with biphasic peripheral pulses as a minimum determined by Doppler ultrasound; eighty percent (80%) peripheral sensation based on mononfilament assessment and **excluding** any co-morbidities requiring immuno suppressant medication including Anti-TNF and people with diabetes assessed under NICE Clinical Guideline 10 as at Increased Risk or above.
- Core podiatric conditions for people meeting the above criterion would include painful nail pathologies, dermatological conditions, corns, callus and fissures; heel pain and metatarsalgia; nail surgery procedures; vascular assessments and wound management associated with this case mix.
- Core Podiatry to only include patients who are clinically assessed as eligible through the medical and podiatric needs criteria assessment (see Section B1_2.4).
- Referral on to specialist podiatry service (as per local pathways) and signposting to non-podiatric services where clinically appropriate.
- Integral to the above is the provision of falls prevention advice (following local falls prevention pathway and guidance into specialist services where appropriate) and health education.
- Adults and children with a podiatric need including iatrogenic conditions without co-morbidity, i.e. foot conditions that are a result of health care treatment that do not have direct pathology but do have related lesions elsewhere in the foot.

This Service Specification **does not** cover:

- Personal foot care defined as toenail cutting and skin care including the tasks that healthy adults would normally carry out as part of their everyday personal hygiene.
- Specialist podiatry covering diabetes; peripheral arterial disease; systemic musculo-skeletal disorders; immune mediated connective tissue disorders; forensic podiatry, and; the use of advanced technology, e.g. surgical debridement.
- Extended scope podiatry practice including requesting blood tests; scans and interpreting results; injection therapy, and; the use of diagnostic ultrasound.
- Podiatric surgery, i.e. the surgical treatment of the foot and its associated structures by a podiatric surgeon.
- Complex biomechanics.
- Podiatry for children with concurrent medical conditions.
- Annual diabetic foot checks as these are commissioned from primary care. Local arrangements may be made for GPs to sub-contract this work to podiatrists but this is outside the scope of this specification.
- Domiciliary visits and care home service provision.

Services covered under Core Podiatry are detailed in Table 1 below:

Table 1: Services covered under Core Podiatry

Service	Description
Patients with foot problems, such as: Nail Pathologies • Dermatological conditions • Corns Callus/fissures • Long Term conditions where the risk of foot ulceration and infection is low, e.g. low risk diabetes, stable and low risk rheumatoid arthritis, multiple sclerosis, Parkinson's disease • Structural and functional abnormalities • Acute soft tissue pathologies requiring the use of local anaesthesia	To be responsible for the assessment, diagnosis, planning and implementation and evaluation of patients with subsequent production of individual care packages and provision of appropriate foot care education.
Non-specialised biomechanical clinics • Excluding complex biomechanical conditions	This may involve: • Anatomical and functional assessment of static and dynamic joint mobility • Assessment of soft tissue and muscle function • Strapping techniques • Neurological assessment • Footwear advice and referral to orthotist and specialised podiatry input
Diabetes Management consistent with NICE Clinical Guideline 10 • To be responsible for the podiatric assessment, diagnosis, planning and implementation, delivery and evaluation of people with diabetes assessed as Low Current Risk • Excludes annual foot health check which should be provided through primary care. (Note: GPs and commissioners may sub-contract this work to core podiatry but this will not be covered by the Any Qualified Provider Contract)	This will involve the examination of a patient's feet and lower legs to detect risk factors. Examination of patients' feet to include: • Testing of foot sensation using 10 g monofilament or vibration • Palpation of foot pulses • Inspection for any foot deformity • Inspection of footwear Classify foot risk as: • Low current risk (normal sensation, palpable pulses) • At increased risk (neuropathy or absent pulses or other risk factor) • At high risk (neuropathy or absent pulses plus

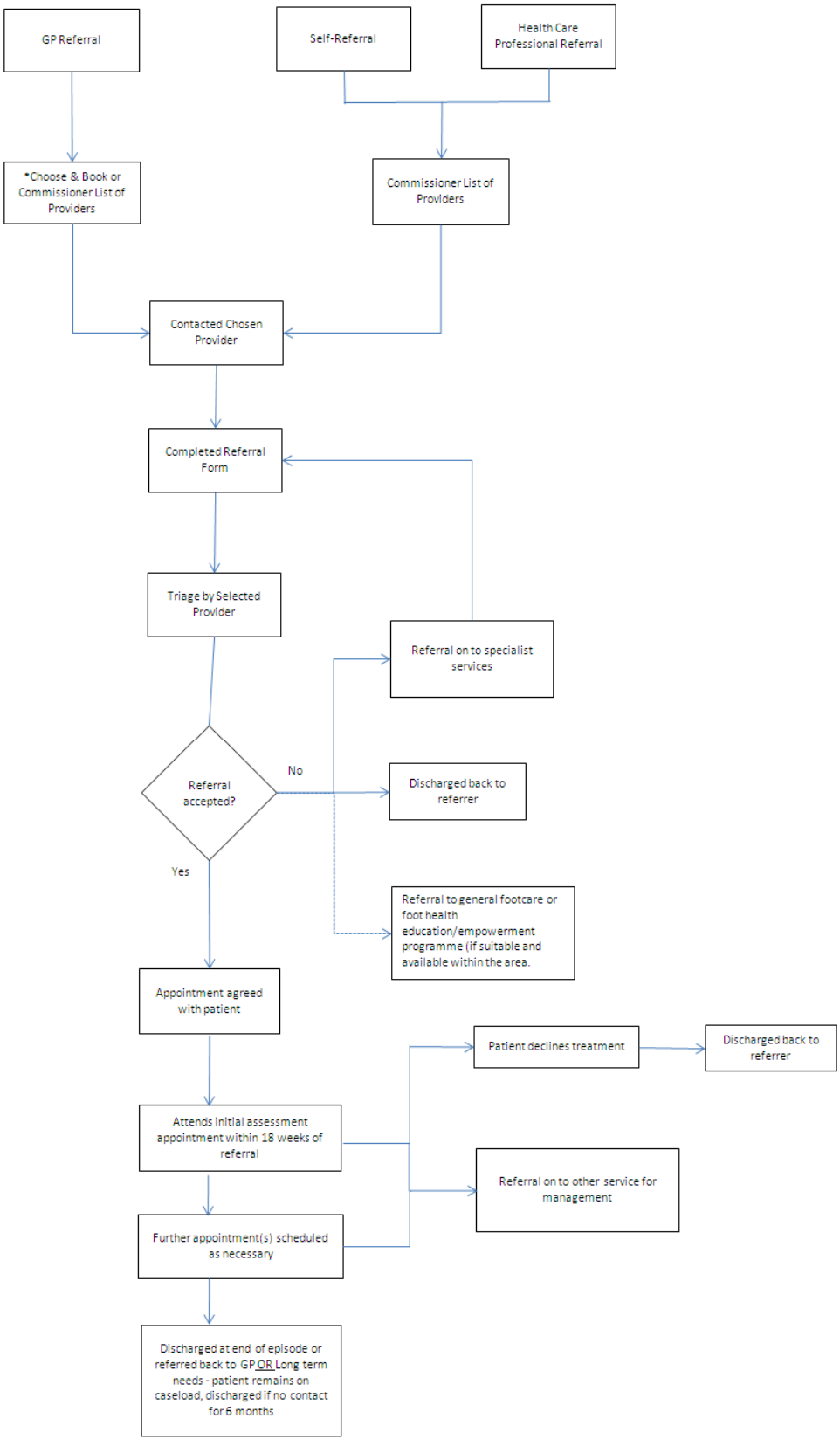
Service	Description
	deformity or skin changes or previous ulcer) • Ulcerated/infected foot Referral of at increased risk, high risk patients and patients with an ulcerated/infected foot to: • Specialist Podiatry or Extended Scope Podiatry as part of Multi-Disciplinary Team as per local pathway Treatment of patients assessed as low current risk may include: • Wound Care to include grades 0-1 on the Wagner Scale or equivalent and/or wound not healed after 4 weeks (see Appendix **Error! Reference source not found.**). (Note: Wagner Scale 2-5 patients to be referred to specialised wound care). • Assessment of vascular neurological and disease activity to help with treatment planning • Footwear advice and footwear referral • Provision of simple foot orthoses, basic insoles • Patient and carer foot and health education
Management of podiatric need of patients with rheumatoid arthritis. • To be responsible for the podiatric assessment, diagnosis, planning and implementation, delivery and evaluation of people with rheumatoid arthritis assessed as Low Current Risk • Excluding the at risk rheumatoid foot as defined by: ▪ Current use of TNF blockers, other biological disease modifying agents, or systemic immunosuppressants. ▪ A history of more than five years of medication with oral steroid. ▪ Current or recent vasculitis in the past 12 months. ▪ A history of ulceration and/or skin infection related to their inflammatory disease.	Assessment and Management of foot problems associated with many rheumatological conditions. • Biomechanical assessment • Provision of simple foot orthoses, basic insoles • Assessment of vascular neurological and disease activity to help with treatment planning • Footwear advice and referral to therapeutic footwear services • Referral to specialised team when tissue breakdown and/or acute episode or flare up • Patient and carer foot and health education

Service	Description
Nail Surgery Procedures • The treatment of nail pathologies such as ingrowing toe nails, involuting nails and mycotic or thickened toe nails	The correction of nail pathologies with the use of local anaesthesia (LA) and minor surgical techniques which involves: • Taking a medical history to ensure that the patient is medically fit to have local anaesthesia • Removal of part or the whole of the nail that is causing the problem • The use of a chemical to obliterate the nail matrix • Application of a post operative dressing • Arrange post operative follow up where patients undertake daily wound changes with review appointments with podiatrists until resolution and discharge
Vascular Assessments	• The use of Doppler to undertake vascular status • Visual observations of the lower limb • Onward referral where appropriate
Simple Wound Management • Wound Care to include grades 0-1 on the Wagner Scale or equivalent and/or wound healed within 4 weeks (see Appendix **Error! Reference source not found.**)	This may involve: • Debridement of the wound • Use of appropriate wound dressing • The use of deflective padding to ensure pressure relief • Provision of simple foot orthoses, basic insoles where appropriate • Review appointments until resolved or liaison with or referral to a specialised service • Referral of Wagner Scale 2-5 patients or patients whose wound has not healed within 4 weeks to specialised wound care
Integral to the above is:	
Contribution towards Falls Prevention	• Ability to refer to other services • Provision of simple foot orthoses, basic insoles where appropriate • Footwear evaluation and recommendation of appropriate footwear • Education and information on how to reduce the risk of falling • Home exercise programme

Service	Description
Patient Education Programmes	This may involve: • Patient advice and information as part of their care plan • Promoting self-care to patients in order to ensure good foot health and mobility • Health education promotion and education on smoking cessation, nutrition and exercise and signpost patients as appropriate

B1_2.3 Care pathway

Figure 2: Care Pathway



*Choose and Book - when available to all Providers

Stage 1 – Referral to Clinical Assessment

There are three referral routes:

- GP referral where the patient consults their GP with a foot problem and then is referred on to podiatry services.
- Referral by another health care professional where the patient is being treated by another health care professional, e.g. a physiotherapist, and then is referred on to podiatry services with a foot problem.
- Self-referral where the patient accesses podiatry services direct.

Patients entering the care pathway via GP referral will use 'Choose and Book' (when available to all Providers) or the Commissioner List of Providers to view the list of qualified providers and make an informed choice of provider. Patients may either access the 'Choose and Book' website in the GP's Practice (with the help of a 'Choose and Book' clerk) or at home on their home computer.

Self-referral patients and patients entering the care pathway via Health Professional referral will view the list of qualified providers via the Commissioning Organisation's website or via paper information available at GP Practices, Pharmacies, Dentists, Opticians, or Commissioning Organisation's offices.

GPs/Patients will contact the patient's chosen provider and complete a Referral Form (see Appendix **Error! Reference source not found.**). The Provider will assess the referral against the eligibility criteria. If the patient referral is not accepted, the patient's GP/patient will be informed that their referral has been rejected and give reasons for this rejection. Alternatively, the Patient may be referred to an alternative, more appropriate service.

If the Patient's referral is accepted then the Provider will contact the patient to arrange an initial assessment appointment. The initial assessment appointment should take place within 12 weeks of the referral.

Where a possible cancer or Red Flag condition is identified at triage or upon assessment, the Provider must take responsibility to fast track these patients in the most appropriate manner.

Stage 2 – Clinical Assessment to Discharge

The Patient attends his/her initial assessment appointment at which his/her condition is assessed and a Treatment Plan is formulated. Depending on the Patient's condition, advice or treatment may be given at this initial assessment appointment. If the Patient declines treatment they will be discharged back to the referrer.

Patients whose condition falls outside the scope of the services, e.g. increased risk diabetes patients, will be referred on to an appropriate other service for management.

For Patients whose condition falls within the scope of services, further appointments may be scheduled consistent with the scope of service.

Patients will be discharged at the end of an episode of treatment or referred back to their GP. Patients with long term needs will remain on the caseload but will be discharged if there has been no contact for a period of six months.

B1_2.4 Patient Assessment Tool

To ensure a consistent approach to patient assessment for access to podiatry provision use the following assessment tool based on two main criteria - Podiatric need and Medical need.

Table 2: Medical Need

Increased Risk Group	Low Risk Group	No Medical Risk
Neuropathic conditions Ischaemic Limb Conditions Scleroderma Rheumatoid or related inflammatory arthritis Diabetes Mellitus (according to risk classification) Poor Tissue Viability Neurological Disorders Steroids/Warfarin Chemotherapy/immunosuppressives	Osteo-arthritis Visual Problems Physical Disability Mental disability Learning Disabilities	No relevant medical history

Table 3: Podiatric Need

High Need Acute Conditions	**Medium Need** Painful Conditions	**Low Need** Non-painful conditions
Ulcerations Infections of skin and nails Acute biomechanical problems	Symptomatic corns Symptomatic moderate/heavy callus Chronic Biomechanics Severe Foot Deformities Painful nail and skin e.g. involution, painful foot warts (pain reduction)	Minimal diffuse callus Non-painful verrucae Skin care advice e.g. athletes foot, pressure points

Using the medical and podiatric needs criteria assess the patient as to their matrix position.

Table 4: Medical and podiatric needs matrix

Podiatric Need	Medical Need Increased Risk Group	Low Risk Group	No Medical Risk
High	Specialist Podiatry Manage to resolution	AQP Manage to resolution	AQP Manage to resolution
Medium	Specialist Podiatry Devise care plan to include self care and discharge where appropriate	AQP Devise care plan to include self care and discharge where appropriate	AQP Initial appropriate treatment, advice and discharge
Low	AQP Devise care plan to include self care and discharge where appropriate	AQP Initial appropriate treatment, advice and discharge	AQP Discharge back to referrer with appropriate advice

B1_2.5 Discharge Criteria and Planning

A person should be discharged if one of the following applies:

- Their specified course of treatment/episode of care has concluded or on re-assessment it is found that continuing treatment is unnecessary or inappropriate. Advice on self-help and training will be offered. Appropriate written information will be given.
- Patient moves to an area where the Provider has not been commissioned.
- Patient discharged themselves/service refused by person.
- Non-podiatry problem and referral to another agency, e.g. physiotherapist.
- New patients: On assessment it is found that treatment/therapy is unnecessary because of low medical/podiatric need. The Service will then offer advice on self help. Appropriate written information will be given. The patient is then discharged.
- Existing podiatry patients will be discharged if they have not received treatment within the last 6 months.
- Non-compliance with agreed treatment plan will lead to discharge after a reasonable period of time, i.e. 3 consecutive treatments.
- Patients who DNA the first appointment
- Patients who DNA three consecutive follow up appointments

NOTE:

- If NHS funded patients, either new or existing, strongly disagree with the decision to discontinue treatment they should contact the local commissioning group to complain. The podiatrist would provide the appropriate clinical decision making justification as part of the complaints process.
- Once discharged a patient will need a new referral.
- Where clinically appropriate, the Provider will send discharge information to the patient's GP.

B1_2.6 Population covered

This service specification covers the population of NHS Merseyside (currently Halton CCG, Knowsley CCG, Liverpool CCG, Sefton CCG and St Helens CCG). Merseyside has a patient population of around 1.2m. The communities served by the Clinical Commissioning Groups (CCG) include some of the most deprived areas of the country, and some of the most affluent. Its people are equally diverse in their ethnicity and social background. Overall, the area follows the national trend of an ageing population, with Southport in North Sefton have a higher than the national average proportion of older people.

In terms of number of GP practices across the Merseyside area, details are below

Sefton - 55

Liverpool – 94

Knowsley – 28

Halton- 17

St Helens – 47

PCT Population Estimates, selected age groups

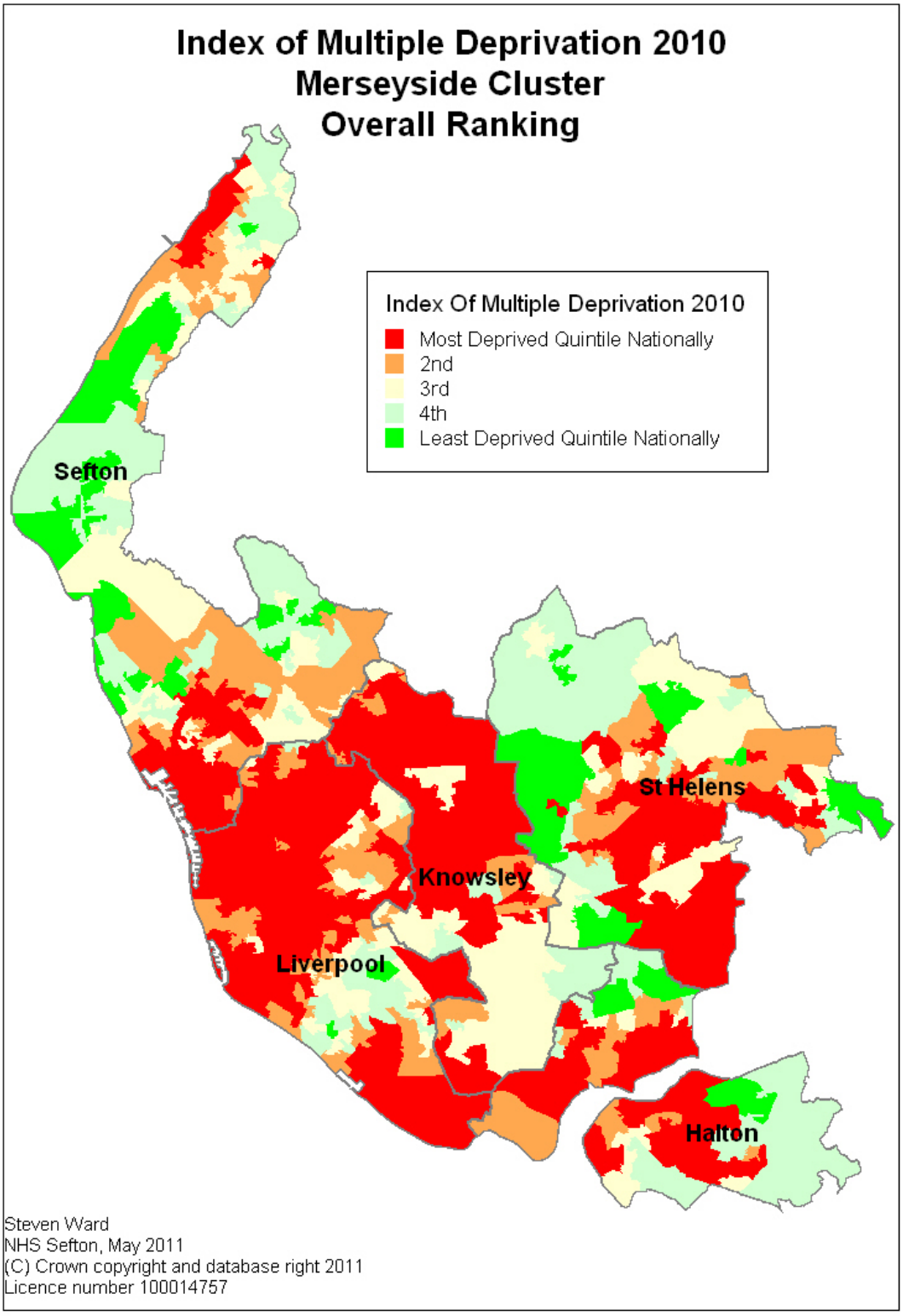
PCT	Persons All Ages	Persons 0-15 years	Persons 16-64 years	Persons 65 years and over
Knowsley	149,100	29,500	96,400	23,300
Liverpool	445,200	75,000	307,100	63,100
Sefton	272,900	47,300	169,200	56,400
Halton	119,300	24,200	77,700	17,400
St. Helens	177,400	32,700	11,3900	30,800

PCT	Persons All Ages	Persons 0-15 years	Persons 16-64 years	Persons 65 years and over
Knowsley	100%	19.8%	64.7%	15.6%
Liverpool	100%	16.8%	69.0%	14.2%
Sefton	100%	17.3%	62.0%	20.7%
Halton	100%	20.3%	65.1%	14.6%
St Helens	100%	18.4%	64.2%	17.4%

Source: 2010 Mid Year Population Estimates, ONS.

Deprivation

In terms of deprivation, according to the overall Indices of Deprivation 2010, Liverpool (ranked most deprived) and Knowsley (5th) are ranked in the five most deprived local authorities (out of 326 local authorities nationally). Halton (27th) is in the top 10% most deprived LAs, with St Helens (51st) in the top 16% and Sefton (92nd) in the top 30%


Index of Multiple Deprivation 2010
Merseyside Cluster
Overall Ranking
Index Of Multiple Deprivation 2010
Most Deprived Quintile Nationally
2nd
3rd
4th
Least Deprived Quintile Nationally
Sefton
St Helens
Knowsley
Liverpool
Halton
Steven Ward
NHS Sefton, May 2011
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Ethnicity

PCT	Persons	Persons	Persons	Persons	Persons	Persons
	All Groups	White	Mixed	Asian or Asian British	Black or Black British	Other
Knowsley	149,300	144,300	1,800	1,500	900	900
Liverpool	442,300	402,600	8,800	13,000	8,300	9,400
Sefton	273,300	263,700	2,500	3,000	1,500	2,700
Halton	118,700	115,700	1,000	900	400	600
St Helens	177,200	172,200	1,500	1,600	600	1,200

Source: ONS 2009 Ethnicity Estimates (Experimental)

Note: These totals will not match the overall population figures quoted in the 2010 population estimates above due to the different time periods.

Public/Private Sector workforce

In terms of workforce, estimates of the Public and Private Sector workforce shows that for LAs in Merseyside Sefton has the highest rate of public sector employment. At 23.5% the public sector employment rate is significantly higher than the UK average, while at 46.6% the private sector employment rate is significantly below the UK average.

Table 2: Public and private sector employment, by local authority, Jan-Dec 2010

Local Authority	Public Sector Employees as a Share of Total Employees[1]	Public Sector Employee Density[2]	Public Sector Employment Rate[3]	Private Sector Employee Density[4]	Private Sector Employment Rate[5]	Significance test of difference from UK average (95% confidence level)			
						Public Sector Employment Rate		Private Sector Employment Rate	
						Above UK Average	Below UK Average	Above UK Average	Below UK Average
	%	%	%	%	%				
Halton	18.1	12.0	15.9	54.1	50.0				
Knowsley	26.7	15.1	17.9	41.6	42.7				✓
Liverpool	29.9	21.5	18.1	50.4	41.4				✓
St. Helens	22.8	11.8	20.0	39.8	47.5				✓
Sefton	32.3	17.3	23.5	36.2	46.6	✓			✓
Wirral	29.5	14.4	19.5	34.3	45.7				✓
Liverpool City Region LEP	28.1	16.7	19.4	42.8	44.8	✓			✓

Source: ONS

1 Public Sector Employee jobs located in the area as a share of total employee jobs located in the area.
2 Public Sector Employee jobs located in the area divided by the area's population of 16 to 64 year olds.
3 Share of 16 to 64 year old residents of the area who report that they are employed in the public sector
4 Private Sector Employee jobs located in the area divided by the area's population 16 to 64 year olds.
5 Share of 16 to 64 year old residents of the area who report that they are employed in the private sector.

Source: Assessing the Impact of the Economic Downturn on Health and Wellbeing, Liverpool Public Health Observatory, February 2012.

B1_2.7 Any acceptance and exclusion criteria

The Provider will accept referrals meeting the following criteria:

- Patients registered with a GP practice within NHS Merseyside (currently Halton CCG, Knowsley CCG, Liverpool CCG, Sefton CCG and St Helens CCG) OR patients resident in the NHS Merseyside footprint
- Patients with a condition covered by the scope of the specification and who qualify for this service using the Patient Assessment Tool.
- It is the responsibility of the Provider to ensure that referrers to the service are eligible to refer to the service. NHS Somerset will not pay for any non eligible referrals.

B1_2.8 Interdependencies with other services

The Provider will accept self-referrals and referrals from GPs and health and social care professionals. The service will form interdependencies with the following services:

- GP practices

- Community health and social care services
- Independent providers
- Third sector organisations
- Patient support groups i.e. Expert Patient Programme
- Specialist NHS podiatry services
- Other NHS commissioned services
- Clinical Commissioning Groups

It is the responsibility of the providers to ensure that all appropriate details are communicated to the necessary recipients. Providers will be responsible for ensuring the accuracy of this information and any notifications.

The Provider needs to develop their relationships with other providers to become an integral member of the local health community. The role of service users will be an important component of this development and Providers should ensure effective mechanisms for their involvement and develop a positive relationship with the local involvement network (Healthwatch). The Provider will participate in service improvement in any relevant area where a need for service improvement has been identified.

The Provider will be required to comply with locally agreed pathways.

The Provider is expected to be involved in local care pathway discussions and work, ensuring the best and most efficient means of treating patients are adopted, including the movement of all relevant clinical information.

B1_2.9 Workforce

The Provider should have an appropriate skill mix within their team. Assessment should always be provided by a Health Professionals Council (HPC) member of staff. Treatment can be provided by staff who are either registered or supervised by a registered practitioner and who are appropriately trained, qualified and experienced.

In terms of training and development:

- All staff should be appropriately trained to undertake all procedures within the scope of their job role
- All staff should be able to demonstrate Continuing Professional Development activity
- Staff should participate in peer review networks, appraisal and Professional Development Plans

Providers are responsible for:

- Ensuring that all their staff who interact with service users are appropriately trained, qualified, Criminal Record Bureau (CRB) enhance checked and approved and professionally registered, where appropriate

B1_2.10 Facilities

Provider outlets and facilities should be accessible both in terms of public transport links and parking facilities and compliant with all relevant local and national laws, regulations and service requirements including:

- The Equality Act 2010
- The Disability Discrimination Act
- Building must meet all Statutory Compliance regulations

If relevant Acts or guidance is updated then Providers would be expected to comply with these updates.

Particular attention should be paid to the accessibility needs of people with sensory, physical and mental impairments, as well as those who may face, for instance, cultural or language barriers. The Provider should make adequate and reasonable provision for interpreters, carers and others from whom the patient may require assistance, providing information and signage in an appropriate range of formats, media and languages, and ensuring service and customer care is delivered in an inclusive manner which respects the diversity of users.

B1_2.11 Information Management & Technology (IM&T)

Providers should:

- Ensure that all NHS patient information and data gathered in the course of delivering the service is only used in pursuance of delivering the NHS services and is not held or used for any other purpose.
- Understand that all patient records (in any format) gathered in the course of delivering the service remain the property of the NHS and should be surrendered to the commissioner at any time on request, and in any case at the end of the contract.
- Have in place appropriate IM&T Systems and infrastructure to support the delivery of the specified services, management of patient care, contract management and business processes and comply with specific requirements and the underpinning information standards and technical specifications expected for NHS service provision.
- Ensure they have effective systems in place for handling information securely and confidentially and that they have appropriate sharing agreements in place with all partner organisations.

B1_2.12 Governance

The provider is required to have in place:

- An organisational structure that provides leadership for all professions and disciplines involved in delivery of the services

- Clear organisational and integrated governance (including clinical governance) systems and structures with clear lines of accountability and responsibilities for all functions
- A professional head of service/clinically accountable director with responsibility for operational and clinical governance within the service including clinical management and quality assurance

B1_2.13 Complaints

The provider must:

- Have formal complaints policies and procedures through which patients can raise issues with the service
- Respond to complaints in line with the NHS complaints procedure
- Provide to the NHS complaints service a summary of all complaints, responses and actions taken as a result on a monthly basis

B1_2.14 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 service
- Not market NHS products and services as inferior to other products or services they or any organisation in which they have an interest provide
- Offer patients an opportunity to opt into receiving marketing information, and not make future contact without the patient's explicit opt-in consent

B1_2.15 Patient Engagement

The provider will record and monitor levels of patient experience with the service and identify themes, trends and areas for improvement.

The Provider will supply the results of surveys in full along with action plans for service improvement based on the outcome of patient surveys to the Commissioner.

Patient surveys will include questions around access, communication, quality and overall experience.

The Provider will comply with the NHS duty to involve users and stakeholders, and to undertake patient involvement under sections 242 and 244 of the NHS Act 2006, and subsequent involvement legislation.

The Provider will ensure that arrangements are made to secure the involvement of service users in the planning and development of services and in any proposals for changes in the way services are provided and/or in decisions that affect the operation of services.

B1_3.0 Applicable Service Standards

B1_3.1 Applicable National Standards

Good quality evidence for podiatry is identified within each of the following national documents:

- National Service Framework for Older People (2001)
- National Service Framework for Long Term Conditions (2005)
- Musculoskeletal Framework Services Framework (2006)
- Type 2 Diabetes Prevention and Management of Foot Problems (NICE, 2004)
- A Guide to the Benefits of Podiatry to Patient Care (The Society of Chiropodists and Podiatrists, 2010)
- National Service Framework for Diabetes: Standards (2001)
- Diabetes Commissioning Toolkit (2006)
- Rheumatoid Arthritis: National Clinical Guideline for Management and Treatment in Adults (Royal College of Physicians, 2009)

B1_3.2 Applicable Local Standards

This is intended as a non-exhaustive list. Clause [16] takes precedence.

B1_4.0 Key Service Outcomes

The key service outcomes are:

- Improved mobility and independence for patients
- Reduced foot pain
- Improved foot health
- A good patient experience

B1_5.0 Location of Provider Premises

The Provider's Premises are located at:
Not applicable

B1_6.0 Individual Service User Placement

Not applicable

SECTION B PART 1 - SERVICE SPECIFICATION

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

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

All subheadings for local determination and agreement.

Service Specification No.	
Service	AQP Back and Neck Pain Musculoskeletal Treatment Service
Commissioner Lead	
Provider Lead	
Period	2012/13
Date of Review	

This service specification forms part of the NHS Standard Contract Terms and Conditions and must be read in conjunction with the same.

B1_1.0 Population Needs

B1_1.1 National/ local context and evidence base

In Europe nearly one-quarter of adults are affected by long-standing musculoskeletal (MSK) problems that limit everyday activity[1]. In the UK 16.5 million people have back pain[2]. In addition, 20% of the population present each year with a new onset or recurrences of an MSK problem[3].

Musculoskeletal disorders are the fifth highest area of spend in the NHS consuming £4.2 billion in 2008/9 [4] and increasing each year. MSK conditions also have a significant social and economic impact, with up to 60% of people who are on long-term sick leave citing MSK problems as the reason[2] and patients with MSK forming the second largest group (22%) receiving incapacity benefits[5].

1 Department of Health, 2006. Musculoskeletal Services Framework
2 Clinical Standards Advisory Group for Back Pain. London, HMSO, 1994
3 Clarke A & Symmons D. The burden of rheumatic disease. Medicine 2006; 34 (9): 333-335
4 ARMA 2010. Liberating the NHS: Transparency in outcomes – a framework for the NHS
5 CBI in associate with AXA, 2005. 'Who care wins: absence and labour turnover 2005'

Currently there are wide variations in the quality of service provision for the treatment of MSK back and neck problems, with:

- Limited patient choice in some areas;
- Long waiting times to access the service;
- Lack of community based services; and
- Poor patient experience and outcomes.

[Local commissioners to insert local population needs data and drivers for change]

B1_2.0 Scope

B1_2.1 Aims and objectives of service

The aim is to provide a comprehensive, patient-centred, easy to access back and neck pain service in the community, which delivers high quality, efficient services in line with national guidance and local requirements.

The service objectives are:

- To give patients a choice of provider.
- To provide improved access to services closer to home.
- To reduce waiting times to access the service and deliver treatment to enable patients to reach their individual treatment goals sooner. This could include an improved quality of life, return to work, more manageable pain.
- To deliver clinically effective treatments, that reduce the demand on secondary care services and reduce the need for more costly interventions.
- To provide community services that have a strong emphasis on patient education and self-management, thereby promoting active, healthy lifestyles and reducing recurrence of injury or illness.

B1_2.2 The Service

The service required is for the community based provision of assessment, treatment and management of back and neck pain in line with the acceptance and exclusion criteria and service requirements outlined in this specification.

The service requirements have been designed with consideration of NICE guidelines for Low back pain: early management of persistent non-specific low back pain[1]; Map of

[1] Clinical guidelines CG88 Low back pain: Early management of persistent non-specific low back pain, 2009. National Institute for Health and Clinical Excellence

Medicine pathways for Low Back Pain – initial management[1] and for neck pain[2]; Musculoskeletal Services Framework[3]; and built upon the learning from existing service model studies[4].

B1_2.3 Any acceptance and exclusion criteria

B1_2.3.1 Referral criteria:

A patient is eligible for referral to the service if they present with primarily back or neck pain with or without 'referred' symptoms to the limbs including:

- Whiplash associated disorders
- Stiffness and restricted movement
- Cervicogenic headaches
- 'Mechanical' neck and back pain
- Degenerative pain
- Postural related neck and back pain.

B1_2.3.2 Referral Mechanisms:

Routine: All patient referrals that are not categorised as urgent, for example:

- Patient with intermittent pain.
- Patient has a mild to moderate reduction in functional ability.
- Mild to moderate impairment of activities of daily living.
- Patient's condition has the potential for improvement with intervention.

Exclusions: Patients who meet any the following conditions are not appropriate for referral and therefore not covered in this service:

- Suspicions of serious pathology– urgent to secondary care or as per locally agreed pathways.
- Patients under 16 years of age
- Patients that do not meet referral criteria.
- Patients who are not registered with a GP in locality.
- Patients who it is recognised at point of referral / initial assessment have little or no potential for further or sustained improvement through undertaking a course treatment.
- Housebound patients

[1] **http://healthguides.mapofmedicine.com/choices/map/low_back_pain1.html**
2 **http://healthguides.mapofmedicine.com/choices/map/neck_pain1.html**
3 Department of Health, 2006. Musculoskeletal Services Framework
4 Back and neck pain services case study: Manual Therapies Back & Neck Service, NHS North East Essex – **http://healthandcare.dh.gov.uk/back-and-neck-pain-services**

- Patients with widespread or chronic (greater than 1 year) musculoskeletal pain.
- Patients who have a primary peripheral limb problem with secondary back and neck pain (e.g. hip or shoulder problems, foot or gait abnormalities).
- Women who are over 28 weeks pregnant.
- Patients requiring diagnostic tests

Urgent*:* Patient referral is considered urgent if one or more of the following apply:

- Patient dependent on strong analgesics
- Severe sleep disturbance due to condition.
- Clinical condition likely to significantly and quickly deteriorate without intervention.
- Severe impairment of activities of daily living.
- Deteriorating neurological states.

Patients who do not meet the referral criteria will be referred as per local pathways.

B1_2.4 Service description

The community based back and neck pain treatment service incorporates a package of care including:

- An initial assessment;
- Follow up appointments as appropriate to clinical need; and
- Support to patients for self-care.

B1_2.4.1 Requirements at each stage of the care package

B1_2.4.1.1 Self-care

The provider must encourage patients to be more involved in their own care and empower them to take further responsibility for wellness. The provider must provide information to patients (and as appropriate their carers) regarding self-care, in accordance with best practice. This should include weight management and exercise advice, and may include signposting to Health Trainers or other recognised community support services. Providers must ensure that this is undertaken at the outset and continued throughout the whole package of care and that a self-care management plan is provided to the patient upon discharge from the service.

B1_2.4.1.2 Initial clinical assessment

Providers are required to undertake an initial assessment appointment for all patients. During this appointment the provider must assess whether it is an appropriate referral and that the patient would benefit from their treatment package. For accepted referrals, it is expected that treatment should normally commence during this initial assessment appointment and a patient management plan should be agreed.

This initial assessment must include the identification of any red flags (indicators in the history or examination suggestive of serious underlying pathology) which should be managed as per local pathway.

The initial assessment must also include the identification and any yellow flags (indicators in the history or examination of psychosocial (surmountable) obstacles to recovery). All providers must be able to identify these obstacles and be able to work with patients towards overcoming them.

For all accepted referrals a Patient Reported Outcome Measure (PROM) pre-treatment questionnaire should be completed by the patient at the time of this initial assessment.

For all accepted referrals the provider should notify the GP and provide a copy of the patient's agreed intended care package. Any treatment agreed with the patient must be evidence based.

If a referral is not accepted by the provider, the provider will return the referral documentation to the referrer (GP or interface service) with detailed reasons for rejection sufficient to minimise inappropriate referrals in the future, and make recommendations (where appropriate) for on-going management of this patient.

B1_2.4.1.3 Follow-up appointments

For all referrals that are accepted, the provider will provide a package of care consisting of the necessary treatment required to meet the individual clinical needs of the patient.

Providers will need to set out in their response document which treatments they will provide. Any treatment offered as part of the package of care must have robust, evaluated clinical evidence. Treatments may include, but not be limited to, the following:

- Manual therapy: joint mobilisations and manipulation;
- Soft tissue mobilisation: muscles, ligaments, cartilage, neural;
- Exercise programmes;
- Acupuncture.

It is anticipated that the treatment will consist of, a maximum of 4 follow-up sessions,[1] however the duration of treatment should be appropriate to clinical need, and therefore where patients require more sessions this should be provided as part of the package. It is anticipated that a significant proportion of patients will be discharged with management plan at assessment stage. Note that as NICE Guidelines for Non-Specific

Deleted:

[1] Please refer to the accompanying currency paper that includes further details regarding the decision to suggest an average based on initial to follow up ratio of 1:4.

Low Back Pain[1] state up to 9 sessions, any patient who is deemed to require more than 4 sessions should be sent back to the GP following the 4th session for determination of appropriate course of action. The intervals between sessions should be consistent with good practice and appropriate for individual patient needs.

B1_2.4.1.4 Discharge from service

Patients should be discharged from the service when the expected clinical outcomes have been reached and/or it is deemed that a patient could derive no further benefit from continuing the course of treatment. Patients should be invited to complete the post-treatment PROM questionnaire and patient experience questionnaire at this stage.

Upon discharge patients are to be provided with a written maintenance programme and advice specific to their individual needs.

Within 5 working days of discharge from the service the provider will supply a discharge summary to the patient, and their GP. Where it is deemed possible, discharge information to GPs should be done via a secure electronic method. Discharge summary will include:

- A copy of the written maintenance programme
- Details of treatment given
- Details of clinical outcomes
- Any additional recommendations, including the conditions for re-referral to the same or another service

It is a requirement of all providers to ensure that at the end of their NHS-funded treatment patients are discharged promptly from the care of the provider and GPs are informed. If a patient re-presents within a 1 year, with either the same problem or with a different problem and requests a private consultation then the GP should be informed of this, provided that the patient consents to this.

B1_2.4.1.5 Out of scope

All diagnostic tests are out of scope for this service. If diagnostic tests are required, the provider must pass this request to the referring GP. It should be recognised that it is not anticipated that diagnostic tests will be a common request.

Patient transport arrangements do not form part of this service specification. Patients will be expected to make their own transport arrangements to the provider for treatment. Those patients who are entitled to assistance with transport under existing NHS

[1] Clinical guidelines CG88 Low back pain: Early management of persistent non-specific low back pain, 2009. National Institute for Health and Clinical Excellence

arrangements will be able to access this and it will be organised by their GP / as per local arrangements.

B1_2.4.1.6 Did Not Attend (DNA)

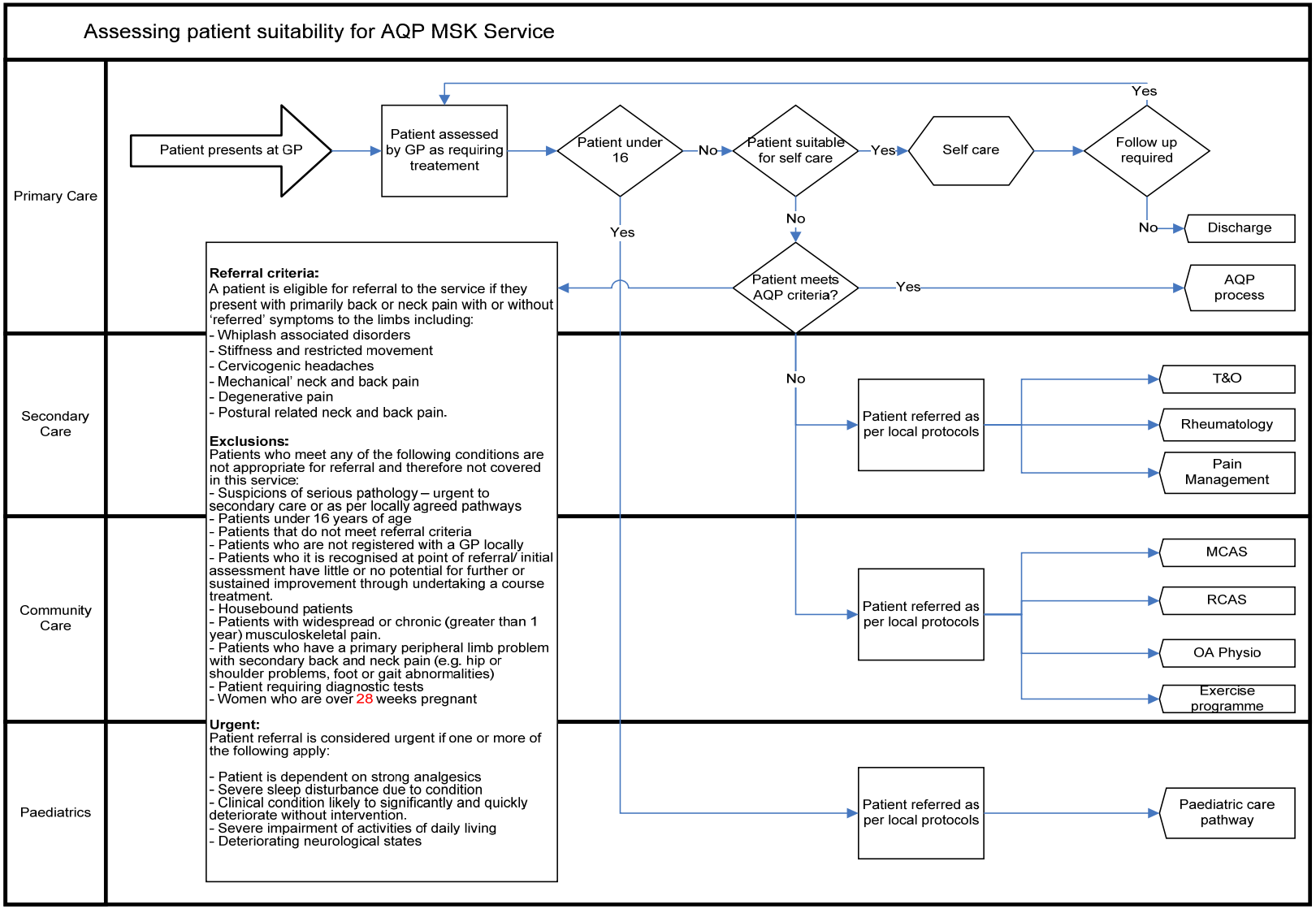
It is in the providers' interest to ensure they have mechanisms in place to minimise the number of patients who fail to attend pre-arranged appointments. If a patient DNAs an appointment they should be discharged from the service. The patient should be sent a copy of their self-care management plan upon discharge from service, and the GP sent a discharge letter.

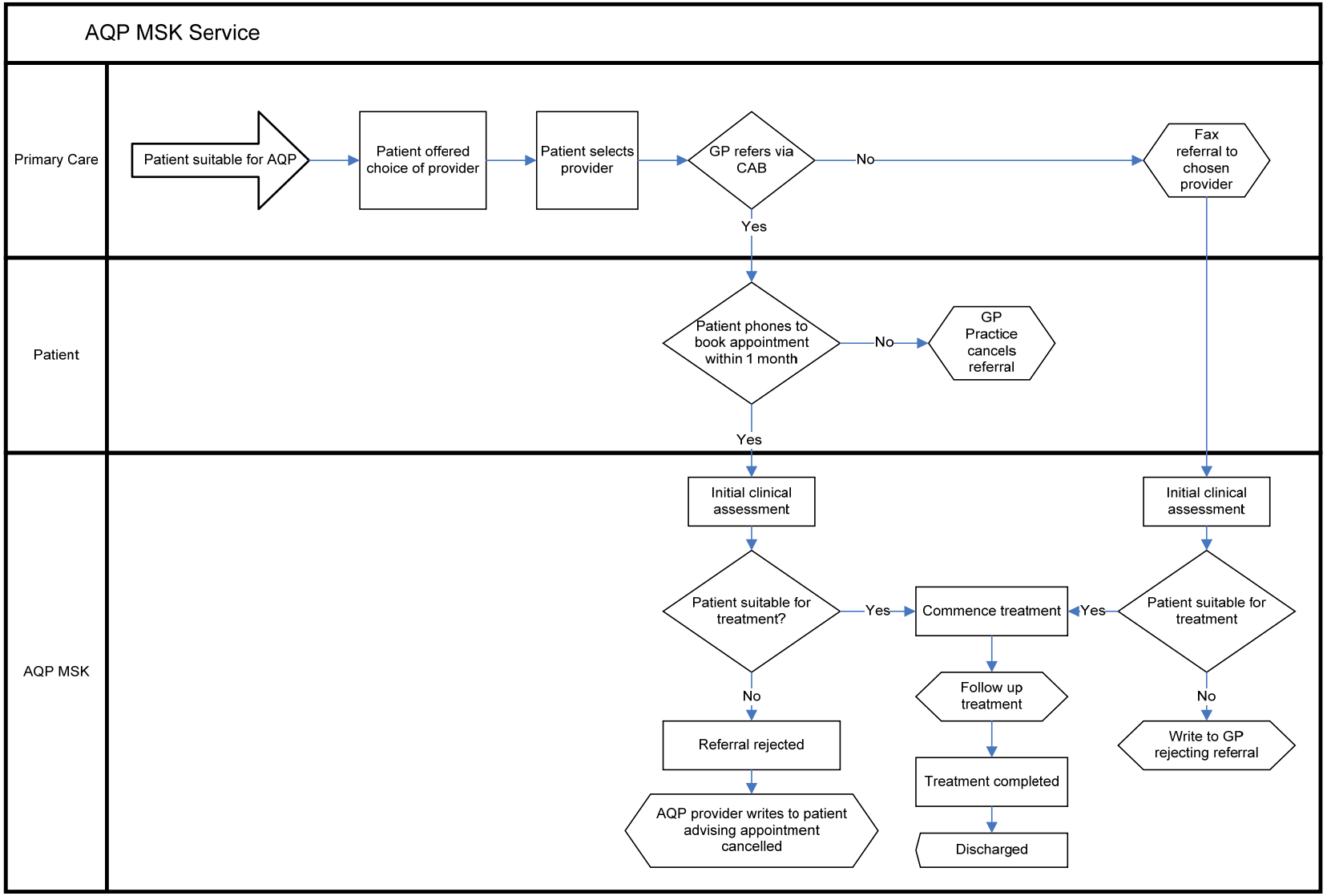
B1_2.5 Care pathway

This specification is designed to capture the activity following decision to refer to the back and neck pain service. ***[The care pathway will be as per local agreements, and factors for consideration, will necessarily be specific to your locality].***

The process flows below illustrate:

- Assessing patient suitability for AQP MSK Service
- Patient journey for AQP MSK Service


Assessing patient suitability for AQP MSK Service
Primary Care
Secondary Care
Community Care
Paediatrics
Patient presents at GP
Patient assessed by GP as requiring treatement
Patient under 16
No
Patient suitable for self care
Yes
Self care
Follow up required
Yes
No
Discharge
Yes
No
Patient meets AQP criteria?
Yes
AQP process
Referral criteria:
A patient is eligible for referral to the service if they present with primarily back or neck pain with or without 'referred' symptoms to the limbs including:
- Whiplash associated disorders
- Stiffness and restricted movement
- Cervicogenic headaches
- Mechanical' neck and back pain
- Degenerative pain
- Postural related neck and back pain.
Exclusions:
Patients who meet any of the following conditions are not appropriate for referral and therefore not covered in this service:
- Suspicions of serious pathology – urgent to secondary care or as per locally agreed pathways
- Patients under 16 years of age
- Patients that do not meet referral criteria
- Patients who are not registered with a GP locally
- Patients who it is recognised at point of referral/ initial assessment have little or no potential for further or sustained improvement through undertaking a course treatment.
- Housebound patients
- Patients with widespread or chronic (greater than 1 year) musculoskeletal pain.
- Patients who have a primary peripheral limb problem with secondary back and neck pain (e.g. hip or shoulder problems, foot or gait abnormalities)
- Patient requiring diagnostic tests
- Women who are over 28 weeks pregnant
Urgent:
Patient referral is considered urgent if one or more of the following apply:
- Patient is dependent on strong analgesics
- Severe sleep disturbance due to condition
- Clinical condition likely to significantly and quickly deteriorate without intervention.
- Severe impairment of activities of daily living
- Deteriorating neurological states
No
Patient referred as per local protocols
T&O
Rheumatology
Pain Management
Patient referred as per local protocols
MCAS
RCAS
OA Physio
Exercise programme
Patient referred as per local protocols
Paediatric care pathway


AQP MSK Service
Primary Care
Patient
AQP MSK
Patient suitable for AQP
Patient offered choice of provider
Patient selects provider
GP refers via CAB
No
Fax referral to chosen provider
Yes
Patient phones to book appointment within 1 month
No
GP Practice cancels referral
Yes
Initial clinical assessment
Patient suitable for treatment?
Yes
Commence treatment
Follow up treatment
Treatment completed
Discharged
No
Referral rejected
AQP provider writes to patient advising appointment cancelled
Initial clinical assessment
Patient suitable for treatment
Yes
No
Write to GP rejecting referral

B1_2.5.1 Referral source and route

It is recognised that self-care is important in ensuring healthy back and necks, and where appropriate (non-urgent referrals) the referrer may choose to provide conservative management (medication, advice, literature, re-assurance) for an appropriate period of 'watchful waiting'. Those patients whose conditions do not respond to conservative management will then be considered for the back and neck pain service.

If the GP or Interface Service believes that the patient meets the referral criteria for the service, they will complete a referral form (as agreed locally). The GP or Interface Service will also provide the patient with an information sheet (as agreed locally).

Patient chooses their preferred provider(s) and referral is sent from GP practice. For referrals from the interface service, these should also go via the GP – although this is subject to local protocols and procedures.

The referral will be valid for one month and patients should be made aware of this and to book their appointment within this timescale for the referral to be accepted. This information should be reinforced with inclusion on relevant patient literature. If patient is referred via CAB the referring practices will have to delete any UBRN not booked after a month. CAB referrals are not time limited.

B1_2.6 Continual service improvement / innovation plan

There are key expectations of providers around continuous improvement, with the focus that providers will engage their patients and review their services periodically to sustain efficient, effective and high quality services. In particular:

Service Improvement:

- Providers are expected to review service provision in the light of recent research to ensure that they are providing the most effective package of care.
- Providers should also demonstrate how they have already developed and improved their services through innovation.
- Providers are required to participate in and support research undertaken across all of the areas covered by this service.

Patient engagement:

- The Provider will record and monitor levels of patient experience with the service and identify themes, trends and areas for improvement.
- The Provider will supply the results of surveys in full along with action plans for service improvement based on the outcome of patient surveys to the Commissioner.
- Patient surveys will include questions around access, communication, quality and overall experience.

- The Provider will comply with the NHS duty to involve users and stakeholders, and to undertake patient involvement under sections 242 and 244 of the NHS Act 2006, and subsequent involvement legislation.
- The Provider will ensure that arrangements are made to secure the involvement of service users in the planning and development of services and in any proposals for changes in the way services are provided and/or in decisions that affect the operation of services.

B1_2.7 Population covered

This service specification covers the population of NHS Merseyside (currently Halton CCG, Knowsley CCG, Liverpool CCG, Sefton CCG and St Helens CCG). Merseyside has a patient population of around 1.2m. The communities served by the Clinical Commissioning Groups (CCG) include some of the most deprived areas of the country, and some of the most affluent. Its people are equally diverse in their ethnicity and social background. Overall, the area follows the national trend of an ageing population, with Southport in North Sefton have a higher than the national average proportion of older people.

In terms of number of GP practices across the Merseyside area, details are below

Sefton - 55

Liverpool – 94

Knowsley – 28

Halton- 17

St Helens – 47

PCT Population Estimates, selected age groups

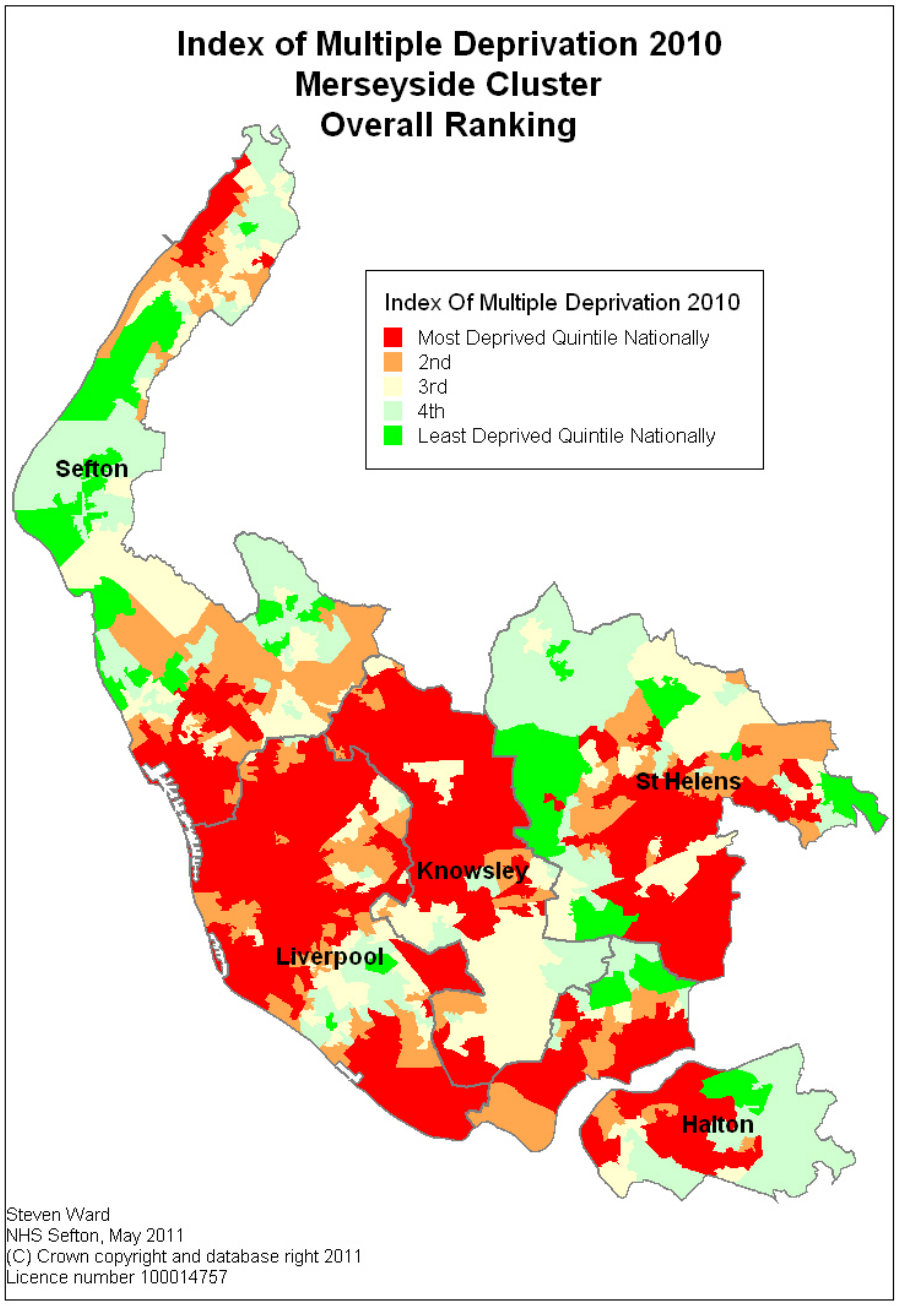
PCT	Persons All Ages	Persons 0-15 years	Persons 16-64 years	Persons 65 years and over
Knowsley	149,100	29,500	96,400	23,300
Liverpool	445,200	75,000	307,100	63,100
Sefton	272,900	47,300	169,200	56,400
Halton	119,300	24,200	77,700	17,400
St. Helens	177,400	32,700	11,3900	30,800

PCT	Persons All Ages	Persons 0-15 years	Persons 16-64 years	Persons 65 years and over
Knowsley	100%	19.8%	64.7%	15.6%
Liverpool	100%	16.8%	69.0%	14.2%
Sefton	100%	17.3%	62.0%	20.7%
Halton	100%	20.3%	65.1%	14.6%
St Helens	100%	18.4%	64.2%	17.4%

Source: 2010 Mid Year Population Estimates, ONS.

Deprivation

In terms of deprivation, according to the overall Indices of Deprivation 2010, Liverpool (ranked most deprived) and Knowsley (5th) are ranked in the five most deprived local authorities (out of 326 local authorities nationally). Halton (27th) is in the top 10% most deprived LAs, with St Helens (51st) in the top 16% and Sefton (92nd) in the top 30%


Index of Multiple Deprivation 2010
Merseyside Cluster
Overall Ranking
Index Of Multiple Deprivation 2010
Most Deprived Quintile Nationally
2nd
3rd
4th
Least Deprived Quintile Nationally
Sefton
St Helens
Knowsley
Liverpool
Halton
Steven Ward
NHS Sefton, May 2011
(C) Crown copyright and database right 2011
Licence number 100014757

Ethnicity

PCT	Persons	Persons	Persons	Persons	Persons	Persons
	All Groups	White	Mixed	Asian or Asian British	Black or Black British	Other
Knowsley	149,300	144,300	1,800	1,500	900	900
Liverpool	442,300	402,600	8,800	13,000	8,300	9,400
Sefton	273,300	263,700	2,500	3,000	1,500	2,700
Halton	118,700	115,700	1,000	900	400	600
St Helens	177,200	172,200	1,500	1,600	600	1,200

Source: ONS 2009 Ethnicity Estimates (Experimental)

Note: These totals will not match the overall population figures quoted in the 2010 population estimates above due to the different time periods.

Public/Private Sector workforce

In terms of workforce, estimates of the Public and Private Sector workforce shows that for LAs in Merseyside Sefton has the highest rate of public sector employment. At 23.5% the public sector employment rate is significantly higher than the UK average, while at 46.6% the private sector employment rate is significantly below the UK average.

Table 2: Public and private sector employment, by local authority, Jan-Dec 2010

Local Authority	Public Sector Employees as a Share of Total Employees[1]	Public Sector Employee Density[2]	Public Sector Employment Rate[3]	Private Sector Employee Density[4]	Private Sector Employment Rate[5]	Significance test of difference from UK average (95% confidence level)			
						Public Sector Employment Rate		Private Sector Employment Rate	
						Above UK Average	Below UK Average	Above UK Average	Below UK Average
	%	%	%	%	%				
Halton	18.1	12.0	15.9	54.1	50.0				
Knowsley	26.7	15.1	17.9	41.6	42.7				✓
Liverpool	29.9	21.5	18.1	50.4	41.4				✓
St. Helens	22.8	11.8	20.0	39.8	47.5				✓
Sefton	32.3	17.3	23.5	36.2	46.6	✓			✓
Wirral	29.5	14.4	19.5	34.3	45.7				✓
Liverpool City Region LEP	28.1	16.7	19.4	42.8	44.8	✓			✓

Source: ONS

1 Public Sector Employee jobs located in the area as a share of total employee jobs located in the area.
2 Public Sector Employee jobs located in the area divided by the area's population of 16 to 64 year olds.
3 Share of 16 to 64 year old residents of the area who report that they are employed in the public sector
4 Private Sector Employee jobs located in the area divided by the area's population 16 to 64 year olds.
5 Share of 16 to 64 year old residents of the area who report that they are employed in the private sector.

Source: Assessing the Impact of the Economic Downturn on Health and Wellbeing, Liverpool Public Health Observatory, February 2012.

B1_2.8 Access

B1_2.8.1 Provider requirements around access:

- The venue must be suitable and easily accessible to patients with good public transport links
- The service shall offer appointments at a suitable time and in easily accessible buildings (not restricted to medical buildings) for patients including provision for people with disabilities
- Special consideration may need to be paid to the provision of the service to accommodate race, language, physical and learning disability requirements and for those in employment as far as reasonable practicality allows
- A risk and suitability assessment of the venue must be undertaken and sent to the commissioner.

B1_2.8.2 Language:

- The service will be available to all patients who are registered with a local GP. If a translator is required the provider will be able to arrange and coordinate this via the commissioner
- The provider must ensure that printed materials can be made available in a suitable language and format so as to be accessible to all patients.

B1_2.9 Interdependencies with other services

B1_2.9.1 Whole system relationships:

To ensure a patient's experience is a streamlined journey and a good experience the provider must work collaboratively with the commissioner, primary care and secondary care providers and the interface service to deliver services in an organised and cohesive manner, and to reduce sequential waits between services. Where appropriate, the provider must demonstrate effective links with other statutory providers and voluntary sector organisations.

Providers are expected to cooperate and share information with others involved in a patients care, treatment and support while having regard to the patients' rights to confidentiality.

Upon initial receipt of referral (as well as throughout the course of treatment) the provider should contact the patient's GP for information that is appropriate and relevant to the referral and patient's care within the back and neck pain service. Upon discharge from the service the provider is required to supply a discharge summary to the patient's GP.

The patient information leaflet that all patients will be given at time of referral will state that patients should inform their provider at the time of initial contact if they do not wish for the provider to contact their GP; however it should be noted that there are circumstances where the patient's GP would be contacted without consent of the patient, particularly where there are issues of patient safety.

B1_3.0 Applicable Service Standards

B1_3.1 Applicable national standards e.g. NICE, Royal College

Any and all treatments undertaken by providers as part of the service must be robust, evidenced based, clinically effective treatments and the provider must be qualified and registered to provide these treatments.

B1_3.1.1 Professional standards and codes of conduct

Providers must be registered with the regulatory body appropriate to their profession and must adhere to the professional standards and codes of practice set out by that body.

B1_3.1.1.1 Chiropractic

Regulating body:
General Chiropractic Council

Standards:

- General Chiropractic Council Code of Practice and Standard of Proficiency (effective from 30 June 2010).
- Continuing Professional Development (CPD) Mandatory Requirements (September 2004).

B1_3.1.1.2 Osteopathy

Regulating body:
General Osteopathic Council

Standards:

- Code of Practice (May 2005)
- Standard 2000 – Standard of Proficiency (March 1999)
- Continuing Professional Development – Guidelines for Osteopaths

Note that this will be the new combined Osteopathic practice standards from September 2012.

B1_3.1.1.3 Physiotherapy

Regulating body:
Health Professions Council

Standards:

- Guidance of health and character (Jan 2010)
- Standards for the Good Character of Health Professionals
- Standards for the Health of Health Professionals
- Standards of Conduct, Performance and Ethics (July 2008)
- Standards of Proficiency (November 2007)
- Standards of Education and Training (September 2009)
- Your guide to our standards for continuing professional development (May 2008)

B1_3.1.2 Requirement relating to premises for activity

The providers must ensure that the premises used are safe and suitable for the delivery of this service. The service must be provided in a geographically convenient, easily accessible location which:

- Complies with health and safety legislation
- Has disability access
- Has appropriate waiting and treatment area
- Is appropriately furnished and equipped with necessary equipment
- Is of the highest level of cleanliness and hygiene
- Is easily accessible via public transport.

B1_3.1.3 Complaints

The provider must:

- Have a formal complaints policy and procedures through which patients can raise issues with the service
- Endeavour to resolve any complaints directly with the patient, and only escalate to the commissioner if the complaint cannot be resolved directly
- Adhere to local commissioner policies and procedures regarding complaints, including the need to inform the commissioner of all complaints
- Respond to complaints in line with the NHS complaints procedure and the relevant statutory regulatory body.

B1_3.1.4 Marketing of 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.

In relation to the NHS branding, marketing and promotion of services, the Provider will comply with the terms and conditions of this contract (Clause 24).

B1_3.1.5 Safeguarding children and vulnerable adults

Providers must adhere to the terms and conditions of the contract (Clause 4A)

B1_3.2 Applicable local standards

This is intended as a non-exhaustive list. Clause [16] takes precedence

B1_3.2.1 Referral response times

The provider must demonstrate the ability to manage referrals in a timely fashion.

- Routine referrals should be offered an initial assessment appointment within 10 working days from the referral is received (subject to patient choice).

Note that for monitoring purposes the date of referral is the date that the provider receives the referral from the GP practice or when the patient books the appointment on Choose and Book.

B1_3.2.2 Integrated governance

The provider will demonstrate that there are clear organisation governance systems and structures, with clear lines of accountability and responsibility. The provider will ensure clinical and corporate governance processes are in place to include:

- Clinical governance lead
- Incident reporting
- Infection control
- SUI / PSI reporting and analysis
- Quality assurance
- Clear policies to manage risk and procedures to identify and remedy poor professional performance
- Evidence of peer and patient review and action taken

B1_3.2.3 Information technology and information governance

Providers must ensure that they are familiar with and comply with the NHS minimum information technology standards, and ensure (and be able to demonstrate) that they have the necessary systems and processes in place to comply with the NHS information governance requirements.

Providers must be Choose & Book compliant, or working towards compliance. Initial appointments must be directly or indirectly bookable through Choose & Book.

The Provider must ensure that the storage of medical records and information which is relevant to treatment and on-going care is passed between all parties in accordance with the Caldicott Principles and Data Protection Act (1998).

Providers should have an electronic patient administration and reporting system, meet IGSOC requirements and must be able to provide all necessary returns, including the Community Data Set, to the commissioner in the required format.

Providers must ensure that patient experience and PROM questionnaires are available in hard copy. Providers may also choose to offer patients the option of completing patient experience and PROM questionnaires electronically. The provider must ensure

that they have the necessary systems and processes in place to manage the administration of patient experience and PROM questionnaires.

B1_3.2.4 Audits

The provider must notify the commissioner of the result of any audit undertaken by a professional regulating body, or any other NHS commissioner.

The provider must allow the commissioner, or any individual or organisation acting on the behalf of the commissioner to inspect the quality of service through observation of service delivery, audit of patient records and data, audit of business processes and records relating to the service contract and audit of staff records, as required.

B1_3.3 Workforce

The service provider must describe and demonstrate that they are qualified to provide this service, and how they will assure commissioners of their competency to practice both at the time of contract letting, and throughout the contract life.

As per the NHS contract terms and conditions, providers must regularly and systematically review their professional practice in line with the professional standards as set out by their regulating body and be able to demonstrate how they assure this through regular review and/or appraisals. A report of any review or appraisal that takes place, including recommendations and any requirements for retraining, should be available to the commissioners upon request.

Each provider must encourage and allow for their staff to undertake Continued Professional Development consistent with the requirements of their professional regulator.

The provider must ensure that the following levels of supervision are provided to the clinical staff team:

- Management supervision
- Clinical supervision
- Safeguarding supervision

The provider must include the following roles (these do not need to be undertaken by different people):

- ***Service manager*** responsible for ensuring a high quality of clinical practice by all practitioners within the service, including necessary supervision of more inexperienced or junior staff and that all staff, including subcontractors, meet the requirements as set out in the service specification and the NHS Terms & Conditions
- ***Caldicott guardian*** responsible for ensuring compliance with all information governance requirements.

B1_4.0 Key Service Outcomes

The provider is to deliver a quality service to patients comprising safe clinical practice, clinical effectiveness and good patient experience. The service outcomes will be dependent on the local objectives for the service, but in all cases due consideration should be given to the mechanisms required to collect and analyse the data required to monitor and act on the delivery of these outcomes. The service outcomes are:

- 90% of patients for a non – urgent referral are offered an initial assessment appointment within 10 working days from receipt of referral
- 90% of patients sampled to have an individual care management plan (minimum sample size is 20% of all patients
- 100% of patients to be asked to complete a validated PROMS before treatment and afterwards
- 95% of patients sampled should report overall satisfaction with the service
- 95% of patients from protected characteristic groups (PCGs) should report overall satisfaction with the service
- 95% of all sampled GP referrers should report overall satisfaction with the service

B1_5.0 Location of Provider Premises

The Provider's Premises are located at:
[Name and address of Provider's Premises OR state "Not Applicable"]

Not applicable

B1_6.0 Individual Service User Placement

[Insert details including price where appropriate of Individual Service User Placement]

Not applicable for this service specification

SECTION B PART 2 -

SECTION B PART 1 - SERVICE SPECIFICATION

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

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

All subheadings for local determination and agreement.

Service Specification No.	Version 1
Service	Direct Access Adult Hearing Service for Age Related Hearing Loss
Commissioner Lead	NHS Merseyside
Provider Lead	TBC
Period	2012 - 2015
Date of Review	

B1_1.0 Population Needs

B1_1.1 National/ local context and evidence base

The impact of hearing loss in adults can be great both at a personal and a societal level leading to social isolation, depression, loss of independence and employment challenges.

Assessing the hearing needs of patients with hearing loss, developing an individual management plan and providing appropriate interventions can reduce isolation, facilitate continued integration with society and promote independent living.

The ageing population means that demand for both hearing assessment and treatment services is set to rise substantially over the coming years. However, a significant proportion of this client group will have routine problems that do not require referral for an Ear, Nose and Throat (ENT) out-patient appointment prior to assessment. These patients would benefit from direct access to adult hearing care services with a referral being made directly from their GP enabling timely diagnosis and treatment.

One in six people in the UK have some form of hearing loss. Most are older people who are gradually losing their hearing as part of the ageing process, with more than 70% of over 70 year-olds and 40% of over 50 year-olds having some form of hearing loss.

Around 2 million people currently have a hearing aid, however, approx. 30% of these do not use them regularly, and there are a further 4 million people who do not have hearing aids and would benefit from them.

In addition we are faced with an ageing population, where there will be an estimated 14.5 million people with hearing loss by 2031. The World Health Organisation predicts that by 2030 adult onset hearing loss will be a long term condition ranking in the top ten disease burdens in the UK, on a par or perhaps exceeding those of diabetes and cataracts.

B1_2.0 Scope

B1_2.1 Aims and objectives of service

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

The vision for people with age related hearing problems is for them to receive, high quality, efficient services delivered closer to home, with short waiting times and high responsiveness to the needs of local communities, free at the point of access.

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

- Improve public health and occupational health focus on hearing loss
- Reduce prevalence of avoidable permanent hearing loss
- Encourage early identification, diagnosis and management of hearing loss through improved patient and professional education
- Provide person-centred care, and respond to information and psychosocial needs
- Support communication needs by providing timely signposting to lip reading classes and assistive technologies and other rehabilitation services
- Promote inclusion and participation of people who are deaf or hard of hearing
- Compliance with clinical guidance and good practice

The Direct Access Adult Hearing Service is aimed at adults (over the age of 55) experiencing difficulties with their hearing and communication who feel they might benefit from hearing assessment and care, including the option of trying hearing aids to reduce these difficulties.

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

The purpose of the Direct Access Adult Hearing Service is to ensure:

- Equitable access to high and consistent quality care for all patients using the service
- A safe hearing service for patients that conforms to a recognised quality assurance tool e.g. the Improving Quality In Physiological Diagnostic Services - Self Assessment and Improvement Tool (IQIPS-SAIT) and is working towards IQIPS accreditation (as set out in Section 3 of the implementation pack). The service should also recognise published clinical guidelines/good practice (as set out in SECTION 1 APPENDIX 2).

Expected outcomes of the service:

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

B1_2.2 Service description

B1_2.2.1 Service overview

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

Complex audiology services (for patients who meet the contra-indications detailed in SECTION 1 APPENDIX 1) and services for adults under 55 are not covered by this specification and should continue to be accessed by GP referral to the appropriate service. Providers need to ensure clear and formal accountability processes and structures are in place to ensure a safe, effective and integrated continuity of clinical care for all patients.

The Direct Access Adult Hearing Service will consist of:

- Hearing needs assessment
- Development of an Individual Management Plan (IMP)
- Provision and fitting of hearing aids

- Appropriate hearing rehabilitation e.g. patient education
- Information on and signposting to any relevant communication/social support services
- Follow-up appointment to assess whether needs have been met
- Discharge from hearing assessment and fitting pathway
- Aftercare service for up to 3 years, including advice, maintenance and review at 3rd year
- Battery, tips, domes, wax filters and tube replacement service
- Annual aftercare and review after 3 year pathway, where required

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

B1_2.2.2 Interdependencies with other services

The Direct Access Adult Hearing Service should be seen as part of wider integrated adult health and social care hearing services working in partnership with GPs, Primary Health Care teams, Ear Nose & Throat (ENT) departments, Audio-Vestibular Medicine (AVM) Audiology Departments, local authorities, the voluntary & community sector and independent providers.

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

B1_2.3 Service model

B1_2.3.1 Assessment

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

The Provider should ensure patients have an adequate understanding of the hearing assessment process before the appointment, by providing information (in a suitable language and format) in advance (either via the referrer or to be received by the patient at least 2 working days before the appointment) that explains the purpose of the assessment, what it involves and the possible outcomes. Providers should make patients aware of their right to communication support, and how to request this if required.

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

place. Patients should be encouraged to bring a relative or significant other to the appointment for support if they wish.

AQPs should explicitly advise patients to ensure ears are wax-free prior to assessment (to avoid aborted/chargeable assessment appointments)

During the assessment appointment, the practitioner should ensure that communication with the patient is effective enough to be able to work in partnership with the patient to reach jointly agreed goals/outcomes, undertaking the following:

- A clinical interview to assess hearing and communication needs - this should establish relevant symptoms, co-morbidity, hearing needs, auditory ecology, dexterity, and cognitive ability, significant psycho-social issues, lifestyles (including driving, use of mobile phones, TV, etc) expectations and motivations
- Full otoscopy
- Measurements of pure-tone air and bone conduction thresholds - if there are contra-indications to performing Pure Tone Audiogram (PTA) - for example, occluding wax, discharging ear, exposure to sustained loud sound in the 24 hours preceding test - the patient must be informed of the reason for non-completion and rebooked or referred back to the GP for treatment as necessary. Such events should be recorded as 'Incomplete Assessments'
- Assessment of current activity restrictions and participatory limitations - using a formal validated self-report instrument - that will enable an outcome measure to be documented for both the individual patient and also the service. The Glasgow Hearing Aid Benefit Profile (GHABP) or Client-Orientated Scale of Improvement (COSI) or International Outcome Inventory for Hearing Aids (IOI-HA) are the preferred outcome measures for this service
- Assessment of loudness discomfort levels - where required
- Integration of assessment findings with patient expectations - to enable patients to decide on appropriate and suitable interventions (i.e. hearing aids, communication support, education etc)

Following the assessment, the practitioner should:

- Explain the assessment, including the extent, location, configuration and possible causes of any hearing loss and the impact hearing loss can have on communication e.g. poorer speech discrimination and sound localisation and the impact this can have on a personal and societal level.
- Discuss with the patient the management options available to address their hearing loss and whether a hearing aid would be beneficial, exploring the psycho-social aspects of the hearing loss, as well as the physical aspects (e.g. audibility of sounds and speech)
- Work collaboratively with the patient to establish realistic expectations for the management suggested providing all relevant literature (in a suitable language and format) to facilitate discussions

- Where hearing aids are expected to be beneficial and the patient wishes to accept provision of hearing aids, at the same appointment:
  - Undertake pre-fitting counselling, managing expectations as necessary
  - Develop a written Individual Management Plan (IMP) with the patient which defines the patients' goals and hearing needs and how they are going to be addressed
  - Discuss and document hearing aid options and agree types and models with the patient based on their suitability to the patients' hearing loss*
  - Discuss and document whether a unilateral or bilateral fitting is appropriate. Any decision in this respect must be based on clinical need and not financially driven. Bilateral fittings are not clinically appropriate where:
    - One ear is not sufficiently impaired to merit amplification
    - One ear is so impaired that amplification would not be beneficial (and should be referral back to the GP for onward referral to complex audiology or other support services)
    - The patient declines bilateral aiding where offered as appropriate (this should be confirmed in a signed statement by the patient)
    - Other reason (e.g. manipulative ability, otological)
  - Proceed to fitting (where appropriate – see sections B1_2.3.2 and B1_2.3.3) using open ear technology or take impressions and decide on choice of ear mould type and characteristics
  - Provide patient information (in a suitable language and format) and ensure that the patient has understood the major points arising from the assessment including details of the hearing aid(s) which have been, or will be, fitted and any follow-up arrangements
  - Electronically record details of the assessment appointment, including any comments by the patient.
  - AQPs to report back to GPs on the outcome of the assessment appointment
  - AQPs to refer patients with contra-indications back to the GP unless it is urgent

***Note:**

- Where an NHS-qualified provider also provides private hearing aids and a patient expresses a personal preference around hearing aids that cannot be met by the NHS funded service, or enquires about privately prescribed hearing aids, providers must advise the patient that the appointment is exclusively for NHS services and any further dialogue or information concerning private hearing aids must be dealt with at a separate patient booked appointment outside of the NHS-funded service.
- Providers should not promote their own private treatment service, or an organisation in which they have a commercial interest.
- Providers should not encourage patients to 'trade up' (i.e. to privately purchase more expensive hearing devices than is necessary)

- Where an enquiry is made because the patient is experiencing functional difficulty with an NHS provided device, every effort must be made to address this from within the NHS funded service. Where this is not possible, the Commissioner must be informed.
- Providers should issue patients with a maximum of 1 hearing aid for unilateral use or 2 hearing aids for bilateral use. Spare hearing aids are not part of standard NHS provision.
- For patients requiring assessment only (i.e. no fitting of hearing aids) tariff 1 applies (see Currency and Price details on pages 29-30)

B1_2.3.2 Fitting

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

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

- Otoscopy
- A review of the patient information and outcome measures (GHABP/COSI/IOI-HA)
- Selection and programming of hearing aids*
- Education of patient in order to reach a shared understanding of the benefits of hearing aid provision
- Objective measurements (e.g. Real Ear Measurements (REM)) to verify fitting by agreed protocol (e.g. BAA/BSA recommended procedure) and adjustment of hearing aid output to match target exceptions to be reported in the Individual Management Plan
- Modification of ear moulds/venting if necessary and repeat of objective measurements for verification
- Evaluation of subjective sound quality (including own voice) and fine tune if necessary
- With patients own aid(s) worn and switched on, teach the patient (using same model) how to:
  - Change battery – observe insertion and removal and correct processes for maintaining battery life
  - Operate controls
  - Switch between programmes
  - Insert and remove aids
  - Use loop
  - Take care of aids, including cleaning, re-tubing and what to do if the aid is damaged or appears not to be working

- Advise on acclimatising to the use of hearing aids and amplified sound
- Advise on battery warnings, battery supply, repair/maintenance service
- Supply cleaning wires if open ear fit
- Explain the purpose and function of hearing aid data-logging
- Advise on lost/damaged hearing aid charging policy
- Issue a copy of the audiogram, information (in a suitable format) on the aids, ear moulds, local services, and update the IMP and provide a battery issue book if appropriate
- Discuss patient's wider needs and provide signposting to any relevant support services (including lip-reading classes and assistive technologies), as agreed with the patient, in accordance with agreed local protocols
- Arrange a follow-up appointment - the patient should be offered a choice of face to face or non-face to face follow-up and given the option to bring a relative/carer

***Note:** Provision of NHS-funded hearing aid(s) will be of a minimum technical specification, as designated by the NHS, and obtained through the NHS Supply Chain. Supply Chain instruments/accessories must only be provided to patients seen in the NHS pathway.

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

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

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

AQPs should include a facility for the patient to change from a monaural to binaural fitting within 10 weeks of the original fitting.

B1_2.3.3 One stage 'Assess & Fit'

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

- A single 'assess and fit' pathway where suitable, for patients to receive hearing aids at the initial assessment appointment - suitability depends on hearing loss, dexterity, cognitive ability, emotional readiness and patient choice
- A two stage pathway, where an impression of the ear is taken at the first assessment appointment for an ear mould to be made and the patient returns at a later date for the hearing aid fitting (or bilateral impressions for bilateral fittings)

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

B1_2.3.4 Follow-Up

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

Patients should be offered a choice of a face to face or non-face to face follow-up (e.g. telephone review or postal questionnaire) – the Provider should seek to meet the patient's preference where possible. However, AQPs need to make a clinical judgement as to the suitability of a non-face-to-face follow-up appointment.

If the patient opts for a non-face to face follow up and this proves unsuitable (for either patient or Provider), a face to face appointment should then be undertaken within 7 working days of the non-face to face contact.

A quicker follow-up appointment may be necessary in advance of the patient's pre-booked follow-up appointment (e.g. if the patient is experiencing difficulty with their aids) and this should be offered within 5 working days of the request from the patient.

Within the follow-up the provider should:

- Discuss with the patient whether the outcomes agreed within the IMP have been met and if not how to resolve residual needs and update the IMP as necessary
- Check on use of hearing aid(s) in terms of comfort, sound quality, adequacy of loudness, loudness discomfort, noise intrusiveness, telephone use, battery life, cleaning, use of loop and different programmes
- Confirm patient's ability to remove and insert aid and provide further help if needed
- Review hearing aid data-logging
- Fine tune hearing aid (if necessary) based on patient's comments
- Continue usage of the preferred validated outcome measure (GHABP/COSI/IOI-HA) plus any additional measures used to assess the effectiveness of the intervention and respond to result
- Conduct objective measurements e.g. REM (if necessary)
- Provide information (in a suitable language and format) and sign-posting to any relevant communication/social/rehabilitation support services

The Provider should:

- Update the IMP in conjunction with the patient to ensure that any residual need has a plan of action

- Maintain confidential electronic records of the follow-up appointment including completed copies of the outcome tool, any adjustments made to the aid(s) and comments made by the patient

B1_2.3.5 Aftercare

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

Aftercare services should include:

- Cleaning advice and cleaning aids for patients with limited dexterity
- Battery removal devices for those with limited dexterity
- Replacement of batteries, tips, domes, wax filters and tubing, where required
- Replacement or modification of ear moulds
- Repair or replacement of faulty hearing aids on a like for like basis
- Provision of information (in a suitable language and format) about wider support services for hearing loss

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

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

Inclusion of: AQPs are required to replace lost or stolen hearing aids free-of-charge, though with the right to charge the patient if the provider believes the patient has been negligent.

B1_2.3.6 Review

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

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

It is expected that most patients will be discharged (see section B1_2.1) back to their GP after the 3 year review. Tariffs will be dependent on whether the patient was a unilateral (tariff 2) or a bilateral (tariff 3) hearing aid user. Whilst these tariffs include the

3 year aftercare and 3 year review as described in sections 2.3.5 and this section, tariffs should be paid after the follow-up (2.3.4). A recovery schedule is recommended in the Currency and Price section on pages 29-30 to allow NHS Merseyside to then reclaim a percentage of the tariff should any part of the 3 year aftercare and review pathway be undelivered.

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

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

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

B1_2.3.7 Battery Replacement Service

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

Options for battery replacement include:

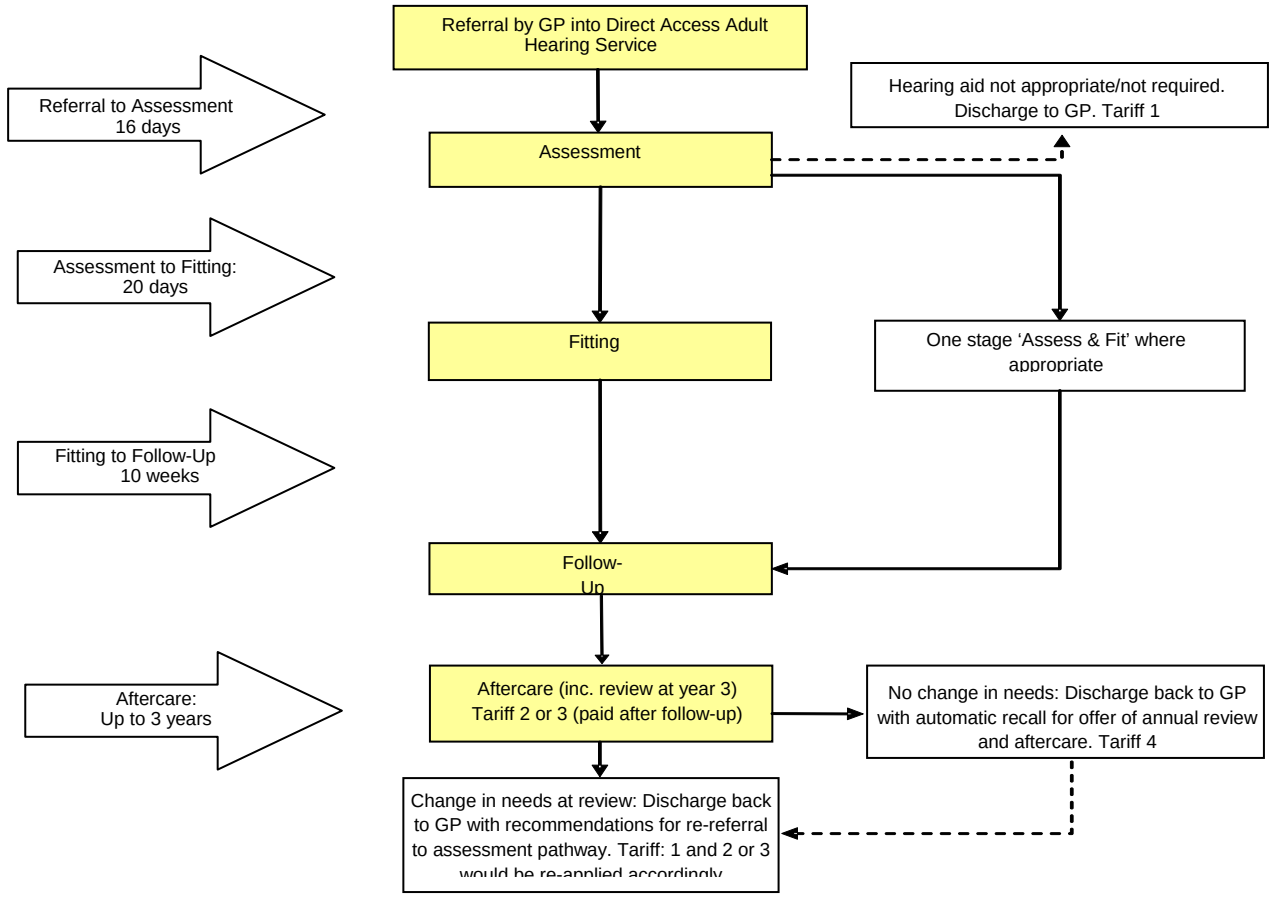
- By post (free of charge to the patient) from the Provider
- Collection from the Provider's service
- Via local supply points (e.g. a network of GP practices/health centres) supplied with stocks of good quality batteries in all commonly used sizes free of charge by the Provider.

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

B1_2.4 Care pathway

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

Figure 1: Expected pathway and response times



B1_2.5 Population covered

The Direct Access Adult Hearing Service is to be provided to eligible people registered to a GP practice within the NHS Merseyside area. This service specification covers the population of NHS Merseyside (currently Halton CCG, Knowsley CCG, Liverpool CCG, Sefton CCG and St Helens CCG). Merseyside has a patient population of around 1.2m. The communities served by the Clinical Commissioning Groups (CCG) include some of the most deprived areas of the country, and some of the most affluent. Its people are equally diverse in their ethnicity and social background. Overall, the area follows the national trend of an ageing population, with Southport in North Sefton have a higher than the national average proportion of older people.

In terms of number of GP practices across the Merseyside area, details are below

Sefton - 55

Liverpool – 94

Knowsley – 28

Halton- 17

St Helens – 47

PCT Population Estimates, selected age groups

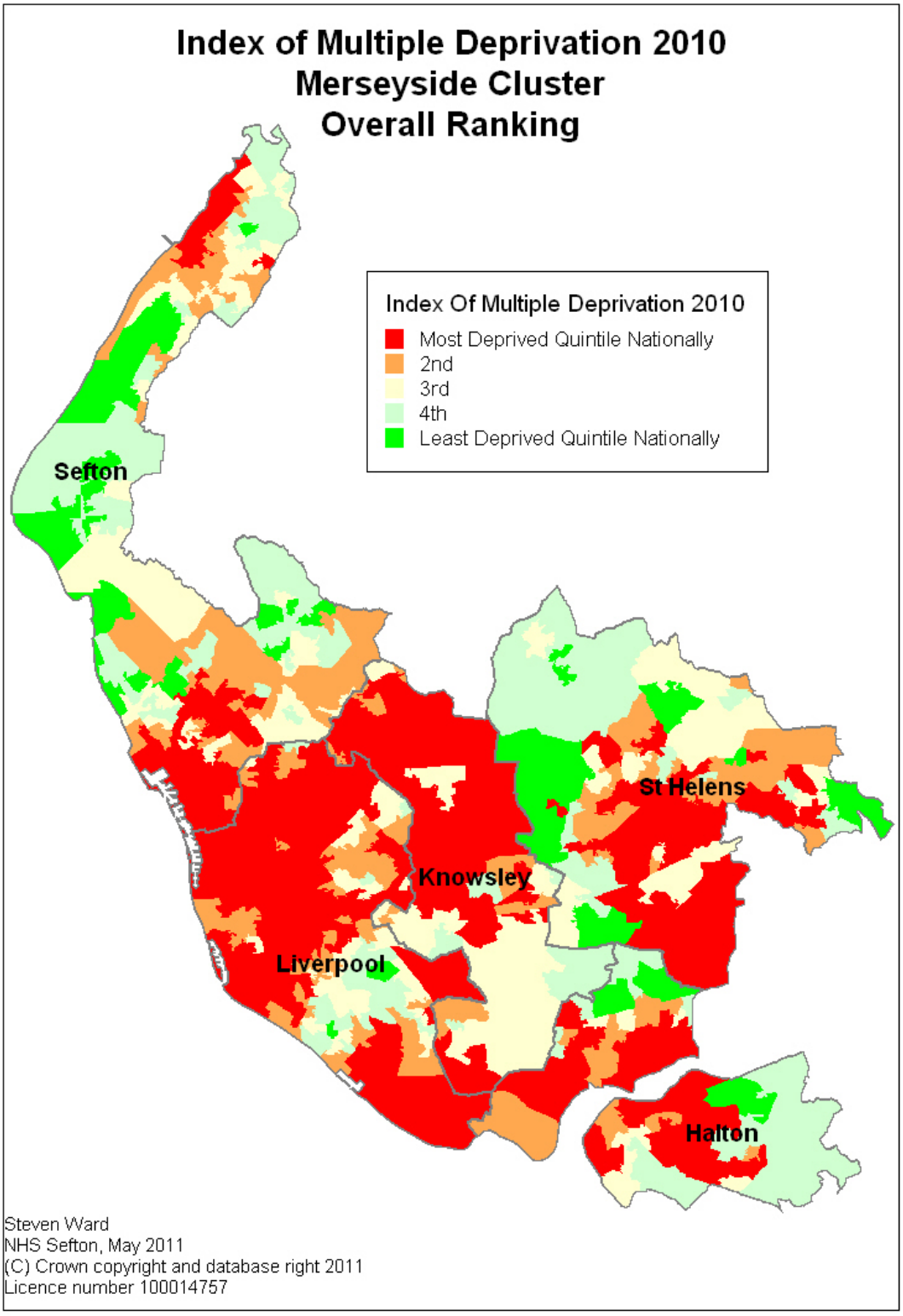
PCT	Persons All Ages	Persons 0-15 years	Persons 16-64 years	Persons 65 years and over
Knowsley	149,100	29,500	96,400	23,300
Liverpool	445,200	75,000	307,100	63,100
Sefton	272,900	47,300	169,200	56,400
Halton	119,300	24,200	77,700	17,400
St. Helens	177,400	32,700	11,3900	30,800

PCT	Persons All Ages	Persons 0-15 years	Persons 16-64 years	Persons 65 years and over
Knowsley	100%	19.8%	64.7%	15.6%
Liverpool	100%	16.8%	69.0%	14.2%
Sefton	100%	17.3%	62.0%	20.7%
Halton	100%	20.3%	65.1%	14.6%
St Helens	100%	18.4%	64.2%	17.4%

Source: 2010 Mid Year Population Estimates, ONS.

Deprivation

In terms of deprivation, according to the overall Indices of Deprivation 2010, Liverpool (ranked most deprived) and Knowsley (5th) are ranked in the five most deprived local authorities (out of 326 local authorities nationally). Halton (27th) is in the top 10% most deprived LAs, with St Helens (51st) in the top 16% and Sefton (92nd) in the top 30%


Index of Multiple Deprivation 2010
Merseyside Cluster
Overall Ranking
Index Of Multiple Deprivation 2010
Most Deprived Quintile Nationally
2nd
3rd
4th
Least Deprived Quintile Nationally
Sefton
St Helens
Knowsley
Liverpool
Halton
Steven Ward
NHS Sefton, May 2011
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Ethnicity

PCT	Persons	Persons	Persons	Persons	Persons	Persons
	All Groups	White	Mixed	Asian or Asian British	Black or Black British	Other
Knowsley	149,300	144,300	1,800	1,500	900	900
Liverpool	442,300	402,600	8,800	13,000	8,300	9,400
Sefton	273,300	263,700	2,500	3,000	1,500	2,700
Halton	118,700	115,700	1,000	900	400	600
St Helens	177,200	172,200	1,500	1,600	600	1,200

Source: ONS 2009 Ethnicity Estimates (Experimental)

Note: These totals will not match the overall population figures quoted in the 2010 population estimates above due to the different time periods.

Public/Private Sector workforce

In terms of workforce, estimates of the Public and Private Sector workforce shows that for LAs in Merseyside Sefton has the highest rate of public sector employment. At 23.5% the public sector employment rate is significantly higher than the UK average, while at 46.6% the private sector employment rate is significantly below the UK average.

Table 2: Public and private sector employment, by local authority, Jan-Dec 2010

Local Authority	Public Sector Employees as a Share of Total Employees[1]	Public Sector Employee Density[2]	Public Sector Employment Rate[3]	Private Sector Employee Density[4]	Private Sector Employment Rate[5]	Significance test of difference from UK average (95% confidence level)			
						Public Sector Employment Rate		Private Sector Employment Rate	
						Above UK Average	Below UK Average	Above UK Average	Below UK Average
	%	%	%	%	%				
Halton	18.1	12.0	15.9	54.1	50.0				
Knowsley	26.7	15.1	17.9	41.6	42.7				✓
Liverpool	29.9	21.5	18.1	50.4	41.4				✓
St. Helens	22.8	11.8	20.0	39.8	47.5				✓
Sefton	32.3	17.3	23.5	36.2	46.6	✓			✓
Wirral	29.5	14.4	19.5	34.3	45.7				✓
Liverpool City Region LEP	28.1	16.7	19.4	42.8	44.8	✓			✓

Source: ONS

1 Public Sector Employee jobs located in the area as a share of total employee jobs located in the area.
2 Public Sector Employee jobs located in the area divided by the area's population of 16 to 64 year olds.
3 Share of 16 to 64 year old residents of the area who report that they are employed in the public sector
4 Private Sector Employee jobs located in the area divided by the area's population 16 to 64 year olds.
5 Share of 16 to 64 year old residents of the area who report that they are employed in the private sector.

Source: Assessing the Impact of the Economic Downturn on Health and Wellbeing, Liverpool Public Health Observatory, February 2012.

B1_2.6 Location(s) of service delivery

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

B1_2.7 Days/hours of operation

Operating hours of the service across the geographic area covered by NHS Merseyside, should be 8.00am – 6.00pm, Monday to Friday, with an additional minimum of 5 hours regular extended opening hours on an evening/weekend, subject to local agreement.

Opening the service on statutory public holidays is for the discretion of the provider; however there will be a requirement for Providers to ensure patients are notified in advance of closures and have access to an emergency service for the provision of batteries and tubing.

B1_2.8 2.8 Any acceptance and exclusion criteria

B1_2.8.1 Acceptance criteria

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

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

- Have sight loss/dual sensory loss
- Have learning disabilities – as special test facilities and techniques are needed
- Require domiciliary care – the Provider should provide all parts of the service at the patient's domicile (including residential or nursing homes) where this is requested in writing by a GP

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

B1_2.8.2 Exclusion criteria

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

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

B1_2.9 Referral processes

B1_2.9.1 Accepting referrals

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

B1_2.9.2 Rejecting referrals

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

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

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

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

If a referral is received with insufficient information, the Provider should liaise with the GP to seek this information so as not to delay the patient's appointment. If it is not possible to get the necessary information then the Provider can return the referral to the GP for re-referral once all the missing information is known – providing patients are informed of any cancellations to pre-booked appointments following the return of the referral to the referrer.

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

With regards to DNAs, AQPs are advised that after 2 DNAs, the patient should be referred back to their GP.

B1_2.10 Discharge processes

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

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

B1_3.0 Applicable Service Standards

B1_3.1 Applicable national standards eg NICE, Royal College

Please see **Error! Reference source not found.** for applicable accreditation standards and guidelines.

B1_4.0 Other

B1_4.1 Workforce

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

Audiologists, Registered Hearing Aid Dispensers and assistant/associate audiologists may provide a direct service to patients according to appropriate qualifications, skills and experience which are set out in SECTION 1 APPENDIX 3.

In terms of training and development:

- All staff should be trained to identify the contra-indications (SECTION 1 APPENDIX 1) and undertake appropriate action according to defined protocols
- In order to work unsupervised, staff need to be able to evidence that they have undertaken a minimum of 50 assessments and fittings in the preceding 12 months
- Newly qualified Audiologists need to spend a minimum of 2 weeks observing a qualified audiologist or dispenser, followed by 2 weeks working under the direct, full-time supervision of a senior audiologist Newly qualified staff undertaking this training period should have a portfolio/evidence to demonstrate competence
- Development of a skilled and modern audiology workforce should be supported by offering suitable clinical training placements to postgraduate, undergraduate and foundation degree students

B1_4.2 Facilities

Hearing assessments should be conducted in appropriately sound treated rooms where possible, such that ambient noise levels are compliant with the 'BS EN ISO 8253-1:1998 standard, Acoustics- Audiometric Test Methods – Part 1: basic pure tone air and bone conduction threshold audiometry'. If this is not possible (care home or domiciliary visits, community premises etc) the 35dBA standard should be achieved before undertaking testing. This should be done in situ with a portable sound level meter and the evidence of this undertaking documented.

B1_4.3 Equipment and Software

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

- Otoscope
- Ear impression taking equipment
- Ear mould modification equipment
- Audiometer, objective measurement (e.g. REM) and 2cc test box systems that store data electronically in a form that can be readily exported and read into compatible NHS provider systems
- Appropriate and updated hearing aid fitting software
- A Patient Management System that stores data, including outcome questionnaire responses (e.g. GHABP/COSI/IOI-HA), electronically, in a form that can be readily exported and read into compatible NHS provider systems

- Computer hardware and software of a sufficiently robust standard to support the above systems, including secure back up facilities of all patient data

In addition:

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

B1_4.4 Governance, Accreditation and Quality Assurance

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

B1_4.5 Marketing and Promotion of Services

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

The Provider will:

- Undertake communication activity and marketing campaigns in order to promote the NHS funded service. This will include producing marketing materials, information and literature relating to the service. Both the Commissioner and the Provider have the right to approve content of such materials. Materials may include posters, information sheets or electronic media on accessing the service.
- Comply with NHS branding guidelines when producing communication, marketing and patient promotion literature
- Any communication, marketing and promotional activity must be separate from other non-NHS funded services marketing and promotion activities
- Not pro-actively promote non NHS-funded services, activities or products which could be considered to be an alternative option to NHS provision to NHS patients using the Direct Access Adult Hearing Service
- Not market NHS products and services as inferior to other products or services they or any organisation in which they have an interest provide
- Offer patients an opportunity to opt into receiving marketing information, and not make future contact without the patient's explicit opt-in consent

B1_5.0 Key Service Outcomes

- 90% of patients referred to the service should be assessed within 16 working days of receipt of referral
- 90% of patients requiring hearing aid fitting should be seen within 20 working days of the assessment
- 90% of follow-up appointments should be within 10 weeks of fitting
- 90% of patients should be able to access aftercare within 2 working days of a request
- 95% of responses received from patients sampled via a service user survey should report overall satisfaction with the service

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

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

SECTION 1 APPENDIX 1

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

S1A1.1 History:

- Persistent pain affecting either ear (defined as earache lasting more than 7 days in the past 90 days before appointment);
- History of discharge other than wax from either ear within the last 90 days
- Sudden loss or sudden deterioration of hearing (sudden=within 1 week, in which case send to A&E or Urgent Care ENT clinic)
- Rapid loss or rapid deterioration of hearing (rapid=90 days or less)
- Fluctuating hearing loss, other than associated with colds
- Unilateral or asymmetrical, or pulsatile or distressing tinnitus lasting more than 5 minutes at a time
- Troublesome, tinnitus which may lead to sleep disturbance or be associated with symptoms of anxiety or depression
- Abnormal auditory perceptions (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)

SECTION 1 APPENDIX 2

Accreditation Standards

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

Accreditation Standards and Criteria

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

S1A2.2 Published Clinical Guidelines and Best Practice

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

- NHS Core principles
- National Institute for Health and Clinical Excellence Guidance/Quality Standards, when available
- Department of Health: Standards for Better Health
- Clinical protocols specified by British Society of Audiology and British Academy of Audiology
- British Society of Audiology guidelines on minimum training standards for otoscopy and impression taking 12
- British Society of Audiology and British Academy of Audiology guidance on the use of real ear measurement to verify the fitting of digital signal processing hearing aids12 and 13
- Guidelines on the acoustics of sound field audiometry in clinical audiological applications.
- Hearing Aid Handbook, Part 512
- British Society of Audiology Pure Tone air and bone conduction threshold audiometry with and without masking and determination of uncomfortable loudness levels
- British Society of Audiology recommended procedure for taking an aural impression
- British Society of Audiology recommended procedure for tympanometry (when undertaken)
- British Academy of Audiology Guidelines for Referral to Audiology of Adults with Hearing Difficulty (2009)
- Recommended standards for pre-hearing aid counselling (Best Practice Standards for Adult Audiology, RNID, 2002)
- Recommended standards for deaf awareness (Best Practice Standards for Adult Audiology, RNID, 2002)

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

SECTION 1 APPENDIX 3

Suggested Minimum Qualifications and Skills of Clinical Staff

S1A3.1 Professional Head of Service

They must have as a minimum the following qualifications and skills (or equivalent):

- BSc Audiology (or equivalent e.g. Hearing Aid Council examination or Foundation Degree in Audiology) level of expertise in audiology, with a Certificate of Audiological Competence (or equivalent)
- Registered with the Health Professions Council (HPC) as a Clinical Scientist in Audiology or registered with the Registration Council for Clinical Physiologists (RCCP) voluntary register as an Audiologist.
- Where the Government's Modernising Scientific Careers (MSC) programme brings about changes to registration requirements, senior audiologists must be registered accordingly.
- Appropriate training, skills and experience in testing, assessing, prescribing, fitting digital hearing aids and providing aftercare.

Relevant experience at a senior managerial level, including experience of team management in adult audiology and evidence of CPD including the provision of patient education related to hearing loss and hearing aids.

S1A3.2 Audiologists

They must have as a minimum the following qualifications and skills (or equivalent):

- BSc Audiology or Post Graduate Diploma in Audiology or pre 2004, Medical Physics and Physiological Measurement (MPPM) B-TEC and British Association of Audiological Technicians (BAAT) parts I & II, with training in Clinical Certificate of Competency.
- Registered with the HPC as a Clinical Scientist in Audiology or a Registered Hearing Aid Dispenser, or with the RCCP voluntary register. Where the Government's MSC programme brings about changes to registration requirements, audiologists must be registered accordingly.
- Evidence of appropriate and recognised training (including CPD) to conduct hearing assessments and rehabilitation, including the provision of patient education related to hearing loss and hearing aids.
- Appropriate training, skills and experience in objective measurements (e.g. REM) of digital signal processing (DSP) hearing aids.

S1A3.3 Registered Hearing Aid Dispensers

They must have as a minimum the following qualifications and skills (or equivalent):

- Hearing Aid Council qualification or Foundation Degree in Hearing Aid Audiology
- Registered with the HPC as a Hearing Aid Dispenser

S1A3.4 Assistant/Associate Audiologists

Assistant/associate audiologists must be trained to perform the functions for which they are employed

Such training maybe provided by BAA accredited training centres or national training courses for assistant audiologists, or specific topics such as the BSA course in otoscopy and impression taking or audiometry.

Associate audiologists would be expected to have completed the Foundation Degree in Hearing Aid Audiology (or equivalent).