Clinical Guideline AQP Patient Discharge Management

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

We have ceased accepting AQP (Any Qualified Provider) patients in Worcestershire. This decision has been collaboratively reached with the ENT department and the contracting/finance departments. The current AQP pathway has been determined to be financially unsustainable. The implementation of new tariffs for hearing aids would not yield sufficient funding to sustain the continued operation of the service.

This guideline is for use by the following staff groups:

Audiologists all bands
Locum Audiologists

Lead Clinician(s)

Edward Southan	Interim Audiology Manager Kidderminster Hospital
Approved by Audiology Governance Meeting	17/05/2024
Approved by Medicines Safety Committee on: *Where medicines included in guideline*	N/A
Review Date: This is the most current document and should be used until a revised version is in place	01/01/2027

Key amendments to this guideline

Date	Amendment	Approved by:
17th May, 2024	First document approved	Audiology Governance Committee

All DAHAP and end of pathway Reassessment.
(End of pathway reassessment. This is when a patient has not had a reassessment for 3 years or their current hearing aid is > 3 years old.)

Every registered patient on AuditBase must undergo an assessment based on the AQP criteria. This evaluation can occur either during a reassessment appointment or a Direct Access hearing aid appointment. If they satisfy the criteria, they are to be discharged with the audit base letter **ICB AQP discharge**. The letter instructs them to seek further treatment from a supplier of their choice. The comprehensive AQP assessment criteria are outlined in table 1. Further management of reassessments in provided in table 2.
Upon discharge, they are no longer considered our patient, add **alert 'N' (Not our patients)** to signify the change in status.
The discharge letter contains information on the complaints process through the ICB encase the patient is dissatisfied with the decision.

Table 1.

Patient Sign / Symptom	YES or NO	**If Yes – Manage as below**
Has your patient had a sudden (within 72 hours), likely sensorineural (inner ear) drop in hearing? Urgent referral to ENT see guidelines.	Yes ☐ / No ☐	**Complex Audiology** These patients stay within Worcestershire acute audiology service. Document clearly in auditbase. Consider onward referral to ENT/ refer to GP where/referral to specialist team where appropriate. See ENT onward referral guideline at the end of this document. Continue with hearing aids/amplification if appropriate.
Is your patient reporting fluctuating hearing loss (not associated with colds)?	Yes ☐ / No ☐	
Is your patient reporting a rapid deterioration in their hearing (within 90 days or less)?	Yes ☐ / No ☐	
Does your patient report a substantially noticeable difference in their hearing between their two ears?	Yes ☐ / No ☐	
Is your patient complaining of True rotatory vertigo (TRV) and has persisted for > 90 days	Yes ☐ / No ☐	
Does your patient report new tinnitus that has not been investigated previously, that is a primary complaint and distressing (e.g. stops sleep), Tinnitus that is only in one ear (> 3 mths) or tinnitus that pulses in line with their heartbeat?	Yes ☐ / No ☐	
Does your patient report sensitivity to sound that is distressing (e.g. intolerance to everyday sounds).	Yes ☐ / No ☐	
Does your patient have an abnormal ear drum, including presence of middle ear fluid (glue ear)?	Yes ☐ / No ☐	
Is your patient aged between 16 and 49 years old (i.e. hearing difficulties are not routine, i.e. not age-related)?	Yes ☐ / No ☐	

Does your patient have severe learning difficulties or severe cognitive impairment, that is likely to prevent them from participating in a routine hearing test? *E.g. individuals who may require two clinicians or staff with specialist experience.*	Yes ☐ / No ☐	
Does the patient have a Conductive hearing loss, defined as 20dB or greater average air-bone gap over **three** of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz. – testing of bone conduction thresholds at 3000 and 4000Hz would only be necessary if one of other frequencies shows a conductive loss of 20dB or greater airbone gap.	Yes ☐ / No ☐	
Asymmetrical hearing loss of 15dB or more at any 2 adjacent air conduction test frequencies, using test frequencies of 0.5, 1, 2, 4 and 8 kHz.	Yes ☐ / No ☐	
Does your patient have a hearing loss that would meet Cochlear implant referral criteria. Two Frequencies 80dHBL or worse in the better ear. (0.5 -4Khz)	Yes ☐ / No ☐	**Complex Audiology Please consider onward referral to Cochlear implant centre or keep within complex audiology.** These patients stay within Worcestershire acute audiology service. Document clearly in auditbase. Consider onward referral to ENT/ refer to GP where appropriate. See ENT onward referral guideline at the end of this document. Continue with hearing aids/amplification if appropriate.

Is your patient reporting severe ear pain or discharge?	Yes ☐ / No ☐	**GP in first instance.** These patients stay within Worcestershire acute audiology service. Document clearly in auditbase. See ENT onward referral guideline at the end of this document. Continue with hearing aids/amplification if appropriate.
Is your patient reporting distressing dizziness, vertigo or imbalance within the last 90 days? (see ENT onward referral guidelines)	Yes ☐ / No ☐	**GP in the first instance.** These patients stay within Worcestershire acute audiology service. Document clearly in auditbase. Consider onward referral to ENT/ refer to GP where appropriate. See ENT onward referral guideline at the end of this document. Continue with hearing aids/amplification if appropriate. GP to arrange referral to ENT if signs/symptoms cannot be managed in Primary Care.
Is your patient **50 years** of age or older, with none of the above signs / symptoms. (No ticked for all above)	Yes ☐ / No ☐	**AQP Audiology** Please print ICB AQP discharge letter from auditbase. Outcome as R and set N Alert
Is your patient 50 years of age or older, with none of the above signs / symptoms and they have already been fitted within the last 3 years by a AQP provider but are dissatisfied with hearing/service received. Has No been ticked for all the above	Yes ☐ / No ☐ Yes ☐	**Speak to audiology manager.**

All Patients who have been booked for a reassessment before their 3 year pathway expires. (Patients who have a modern hearing aid fitted < 3 years ago) Includes patients previously registered as AQP and complex. Using table, one firstly decide if your patient is AQP or complex. Then see table 2 below to help with management.
Table 2

Patient Sign / Symptom	YES or NO	If Yes – Manage as advised.
Following history and hearing test are you treating your patient as complex?	Yes ☐ / No ☐	**Complex Audiology manage as appropriate. Consider any onward referrals as appropriate.**
Does your patient meet AQP criteria their hearing has not changed significantly they have a modern aid that is < 3 years old, and they are happy with their current setup and are not requesting any changes. Modern aid = Engage, Xceed, Play, Oticon CROS	Yes ☐ / No ☐	**Temporarily keep within Complex Audiology Tubing and batteries can be issued. A hearing aid can be replaced if lost (normal charges apply) or faulty and aid is under warranty. Patient can continue AQP after care within audiology until their pathway ends. (3 years from date the modern hearing aid was fitted)**
Does your patient still meet AQP criteria however their hearing or level of difficulty has changed significantly, and adjustments or new hearing aids are now required. (This includes patients who now require a 2nd aid and patients with aids < 3 years that cannot be adjusted quickly today)	Yes ☐ / No ☐	**AQP Audiology Tubing and batteries can be issued. A hearing aid can be replaced if lost (normal charges apply) or faulty and aid is UNDER WARRANTY. Adjustments can be made in clinic if time allows however no follow –up reviews are to be organised for verification.** Please print ICB AQP discharge letter from auditbase. Outcome as R and set N Alert. The patient will need to restart their pathway to obtain the appropriate assistance via AQP provider.

Does your patient still meet AQP criteria however they have an obsolete or faulty hearing aid that requires replacing/upgrading?	Yes ☐ / No ☐	**AQP Audiology We are not funded to replace this aid today. As a gesture of good will you may issue a pack of batteries and carry out simple repairs like a retube/simple adjustment before discharging.** Please print ICB AQP discharge letter from auditbase. Outcome as R and set N Alert
Does your patient meet AQP criteria but none of the above apply (No has been ticked for all).	Yes ☐ / No ☐	**Please discuss with audiology manager.** Batteries and basic services can be offered and explain we will contact patient in due course.

If you discharge patients with the ICB AQP discharge letter found in auditbase remember to outcome the appointment as R (discharged) and then change or add an alert for **N (no batteries not our patient)**

ENT referral guidelines approved via ENT directorate meeting January 2024

WAHT-AUD-001

It is the responsibility of every individual to ensure this is the latest version as published on the Trust Intranet

Worcestershire Acute Hospitals NHS Trust

Referral to GP:

The following conditions, if identified during assessment, require onwards referral to the GP. If there is any query regarding an onwards referral, please consult with the appropriate, on-site principal clinician for further guidance. Hearing aids can still be organised if appropriate and referral back to GP should not delay treatment.

Dizziness- Troublesome true rotatory, dizziness, imbalance and presyncope that has started within the last 90 days.

Persistent pain- Affecting either ear, defined as earache lasting more than 7 days and has not responded to first-line treatment. Avoid fitting hearing aid in the ear that patient complains of pain until this has been resolved by GP.

History of discharge- If the patient refers to a history of discharge or discharge is visible in the ear canal. Avoid fitting hearing aid in discharging ear until this has been resolved by GP.

Obstruction of external auditory meatus- Complete or partial obstruction of wax. If found during a DAHAP/DR/RA/, please refer to GP if wax removal service is available or Audiology led microsection service (If ear is considering routine, please see local microsuction guidelines). Depending on waiting times service users may choose to consider private micro suction.

Fluctuating Hearing loss- When there is no associated colds or flu. Clinic judgement needed. If this is a non-organic loss, then further investigation in audiology will be required initially. If a patient has vestibular symptoms as well as fluctuating loss then a referral to ENT may be required.

Hyperacusis- (intolerance to everyday sounds that causes significant distress and affects a service user's day-to-day activities). Explain within GP letter that we do not have a hearing therapy service locally and they can consider onward referral to Birmingham QE.

WAHT-AUD-001

It is the responsibility of every individual to ensure this is the latest version as published on the Trust Intranet

NHS Worcestershire Acute Hospitals NHS Trust

Referral to ENT:

The following conditions, if identified during assessment, require onwards referral to ENT. If there is any query regarding an onward referral, please consult with the appropriate, on-site principal clinician for further guidance. Hearing aids can still be organised if appropriate and referral back to ENT should not delay treatment in most cases.

Abnormal otoscopy- abnormal appearance of external auditory meatus, tympanic membrane. Inflammation, polyp formation, perforated eardrum abnormal bony or skin growths, swelling of the outer ear, blood in the ear canal. Clinical judgement needs to be used. If you feel a referral to ENT is unlikely to be beneficial you can take a video otoscopy image and send to Mr. Tom Martin for a 2nd opinion. thomas.martin4@nhs.net
If you decide to proceed without referring to ENT please take an image with video otoscope and send a standard referral advising ENT they may wish to see the patient in clinic due to the attached image. ENT can then choose to reject this referral.

Unilateral Tinnitus- If a patient is presenting with constant, unilateral tinnitus that has persisted for longer than 3 months.

Pulsatile Tinnitus- Either unilateral or bilateral, refer directly to Leah Hannant (Team leader for Audiology and ENT) These patients will be booked straight into an ENT clinic.

Vertigo - True rotatory vertigo that is troublesome and has persisted for > 90 days. Symptoms of dizziness, light headiness and imbalance should be referred to GP for management.

Sudden Hearing Loss- If hearing loss had developed over a period of 3 days or less within the past 30 days, **bleep (866) to contact junior doctor for urgent referral.**

Unexplained Conductive/Mixed Hearing Loss- This is defined as a 20dB or greater average air-done gap over three of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz (refer to BSA guidelines on unmasked audiometry in reference to 3+4k testing). This excludes long standing conductive/mixed hearing losses which have previously been investigated by ENT. Adults with conductive loss due to Otitis media with effusion (OME) should have 2 x audiograms 3 months apart with flat tympanograms in both ears before referring to ENT. Clinical judgement is again needed. It may not be appropriate to refer all mild conductive losses especially in the presence of normal tympanometry and no subjective patient complaints/history.

Unexplained Asymmetry- Where there is asymmetry of 15db+ at 2 adjacent, air or bone conduction frequencies using frequencies, of 0.5, 1, 2, 4 and 8 kHz. Clinic judgement needed. It is not appropriate to refer asymmetrical hearing loss that have a clear cause. E.g. Noise damage.

Service users of Chinese or south-east Asian family origin- Who have hearing loss and middle ear effusion not associated with an upper respiratory tract infection. **bleep (866) to contact junior doctor for urgent referral.**

Immunocompromised adults- with otalgia and otorrhoea who have not responded to treatment within 72 hours **bleep (866) to contact junior doctor for urgent referral.**

Adults with hearing loss and localising symptoms or signs- (such as facial nerve weakness) that might indicate a vestibular schwannoma or CPA (Cerebellopontine angle) lesion, irrespective of pure tone thresholds.

WAHT-AUD-001

It is the responsibility of every individual to ensure this is the latest version as published on the Trust Intranet

Worcestershire Acute Hospitals NHS Trust

Subjective asymmetry as main complaint- Patients who complain of significant, distressing asymmetry irrespective of PTA results. Patients who are just aware of an asymmetry and this is not impacting on them do not need to be referred for further investigation.

Acquired unilateral hearing loss- With altered sensation or facial droop on same side A&E or emergency ENT **bleep (866) to contact junior doctor.**

Keep within Audiology Service:

Bilateral Tinnitus - If tinnitus is a primary concern and is described bilateral, bothersome, non-pulsatile and has a duration of more than 5 minutes, the patient is to be directed to tinnitus counselling service. We do not require approval from ENT to proceed with Tinnitus retraining therapy anymore.

Bilateral Sudden hearing loss- which developed more than 30 days ago. Keep with audiology however write letter to ENT advising them they may wish to see the patient in clinic. Unilateral sudden hearing loss would meet the criteria for asymmetry hence would be referred to ENT as standard.

Sensorineural Hearing Loss that is not age related- It is unlikely that ENT will be able to offer an underlying diagnosis. Make sure Nonorganic loss has been ruled out. Proceed with a hearing aid if required. Clinical judgment needed. Patient can be referred to ENT if etiological investigations are likely to be beneficial in patient management.

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.

References

BAA onward referral guidelines September 2023

ICB Adult hearing services – Service Specification.

Contribution List

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Audiology Governance meeting

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Audiology Governance meeting

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	X	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Edward Southan**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Edward Southan	**Principal Audiologist/Interim Audiology manager**	**edward.southan@nhs.net**
Date assessment completed	**09/05/2024**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Clinical guideline			
What is the aim, purpose and/or intended outcomes of this Activity?	To maintain consistent patient management across audiology colleagues. Help to ensure audiologist discharge appropriately to Any Qualified Provider (AQP) pathway.			
Who will be affected by the development & implementation of this activity?	❑X ❑X ❑X ❑	Service User Patient Carers Visitors	❑X ❑ ❑ ❑	Staff Communities Other _____
Is this:	❑ Review of an existing activity			

	❑ X New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Following ICB guidance documents
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age			✓	Patients over the age of 50 which a similar loss to a patient under 50 will have their hearing care delivered outside of Worcestershire acute hospitals NHS trust. We can not be sure of audiology standards and model of hearing aids offered outside of our service.
Disability	✓			Criteria ensures patients with a disability which prevents them from performing a routine hearing test will be kept within audiology
Gender Reassignment		✓		Gender does not impact on decision making.
Marriage & Civil Partnerships		✓		Will not impact decision making.
Pregnancy & Maternity		✓		Will not impact decision making.
Race including Traveling Communities		✓		Will not impact decision making.
Religion & Belief		✓		Will not impact decision making.
Sex		✓		Will not impact decision making.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sexual Orientation		✓		Will not impact decision making.
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)			✓	Patients have to self-refer into a new service if in a area of social or economic deprivation they may not have access to telephone to initiate contact with new supplier. They may not be able to arrange suitable travel arrangements if new provider is too far away.
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		✓		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	Vulnerable groups	**Offer to assist in arranging next appointments**	**ES**	**On going**
How will you monitor these actions?	**audit**			
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the

diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	E Southan
Date signed	09/05/2024
Comments:	
Signature of person the Leader Person for this activity	E Southan
Date signed	09/05/2024
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	Potentially less referrals will be received.
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.