DRAFT Guidance on shared care of children, young people and adults using audiology services

1. Introduction

Person-centred care is providing care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions.

"The NHS aspires to put patients at the heart of everything it does"

(guiding principle of the NHS) (i)

Individuals working with children, young people, adults, and their families in audiology services are working to provide the best quality of care that they can to achieve the best possible outcomes for their patients. However, no one professional can provide every element of support individuals and their families require. The families of children and adults who have hearing or balance difficulties may be referred to, or may seek further support from other service providers. These services may be other NHS, private, independent, or third sector providers. Situations when this might happen include:

- When all audiology services are not available on one site
- When referred for further support (such as the sensory support services or hearing therapy)
- When referred to specialist services (such as to an auditory implant centre)
- When a referral is made for a second opinion
- When patients or a child’s family seek additional or an alternative opinion (such as when considering alternative treatments (such as surgery), or due to concerns about the accuracy of the diagnosis, the benefit of existing hearing aids or current (re)habilitation programmes, or with concerns about language or educational progress)

The British Society of Audiology has identified four guiding principles that should be central in achieving patient-centred audiological practice with
Throughout this document the term patient is used to mean all audiology service users who may be an adult, child or young person and their carers/family where relevant. By providing guidance on shared care this document aims to support development in person-centred care locally. The document focuses on four key areas:

Section 3.1 Working together and sharing information
Section 3.2 Working together for children and young people with special educational needs
Section 3.3 Working together across NHS and private providers
Section 3.4 What to do if there are concerns about care within shared care arrangements

“The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population” (guiding principle of the NHS) (i)

2. Scope
This document has been written by the British Academy of Audiology’s Service Quality Committee and is intended as guidance to support professionals involved in the care of children or adults who use audiology services from the NHS, independent, private and third sector. However, they cannot be implemented in isolation by audiology professionals. It is hoped that the principles of the document are appropriate and can be adopted by other providers involved in shared care to the mutual benefit of patients, within the
context of any local or national guidance which may be in place.

3. Guidance

3.1 Working together and sharing information

Working within current information governance and confidentiality policies, and the Data Protection Act, professionals have a duty to share information with others who provide care and treatment for their patients, for safe and effective care.

There may be issues of consent. Patient/parents may not wish some aspects to be shared with other providers.

Audiology service users may have their care shared with a number of other related professionals, e.g. other NHS or private audiology departments, ENT or auditory implant departments, or educational audiology. Key to successful management and coordinated care is clear and accurate information exchange between relevant professionals\(^{(iii)}\). It is important that each agency involved in providing services has a systematic approach to explain to children, families, and adults when they first access services, openly and honestly, what and how information will, or could be shared and why, and seek their agreement.

Patients should always be encouraged to advise their audiology professional of, and be able to feel comfortable with this, their intention to seek a second opinion or an alternative view of their management.

Every professional must act in the best interests of their service users\(^{(iv)}\) This will usually mean following professional standards and protocols, or best evidence. There may be occasions where there is disagreement between professionals on what is best practice for an individual patient. Each professional must discuss their proposed management, expected outcomes, the on-going care pathway and how progress will be measured with the patient or the child's family. The decision to alter the care plan is the decision of the patient or child's carers in discussion with their professionals. Changes to care plans must be communicated with other relevant professionals in a timely manner to ensure everyone working with the patient is aware and alerted to potential changes in responses or behaviours etc.
It may be useful to set up an agreement locally to establish a key worker or lead clinician, particularly for children and those with additional complex needs. This person will be responsible for generation, modification and implementation of the patient’s individual care plan. For each patient it is recommended that all organisations involved agree their roles in the patient’s management, and that patient preferences are prioritized when these agreements are reached.

The agreement must establish:

- Who the Lead Clinician is and who is responsible for the overall management plan. Patient preference may be a significant factor in establishing who this person is.
- Which organisation will provide the equipment (hearing aid, batteries, moulds etc.) and their ongoing maintenance.
- Which organisation will provide, maintain and set up additional support devices, such as FM systems, direct input systems, etc.
- Whether other qualified audiology professionals, be they in the private, other NHS or education setting, can make minor adjustments to hearing aid settings to the benefit of the patient. Minor changes may include applying directional microphone setting, adding additional programmes (e.g. for a loop system).
- How effective communication is to be achieved. An appropriate agreed system of written notification should be set up to support this shared care, and use of standard letters or templates should be considered.
- Procedures and timescales for review of the patient’s progress, provision of updates on management changes (e.g. hearing aid settings) and clinical outcomes.
- Identification of any significant differences in clinical processes (for example differences in prescription targets used, whether spare aids will be provided etc.).
- The procedures and timescales for reviewing and making alterations to the shared care agreement.
• Procedures on what to do in the event of a breakdown in services or communication. The patient or carers and all professionals should be aware of these procedures.

• Where shared care relationships are well-established it is anticipated that the key principles will be agreed in general, with the fine detail (e.g. the name of the Lead Clinician) confirmed for each patient.

• If minor changes are made then the mechanism for communicating them back to the Local Provider needs to be defined including how Patient Management System/device fitting module record will be updated (it is suggested that this should be as soon as is reasonably practical and within 2 working days).

• The Local Provider should be provided with copies of any clinical assessments (including paediatric assessment, real ear measurement) particularly if they have been used to modify the patient’s amplification provision.

• A typical NHS turnaround time for reporting on clinical contacts, including changes to hearing aid settings, accessories and the patient’s management plan, is 5 working days (for example as specified in a typical AQP specification). Local targets will apply and these should be agreed by all parties. It is advisable to copy the correspondence to the patient to keep them informed. Some areas may have patient held care plans, which may be used as an alternative.

• Joint clinics may be supportive of shared care arrangements for some services (e.g. with Teachers of the Deaf or educational audiologists).

• Audiology Working Groups, Children’s Hearing Services Working Groups (CHSWG) and Patient Forums are frequently helpful for developing good communication within and across multi-agency and multi-disciplinary groups.

An Example Agreement is detailed in Appendix 1.
3.2 Working together for children and young people with special educational needs

"Health and education services are both involved with a hearing impaired child and their family regarding the child’s audiological assessment and the management of the hearing loss. It is, therefore, of crucial importance to the child that proper channels of communication are established between health and education services within a paediatric audiology service for the efficient exchange of information regarding all aspects of the child’s hearing care"\(^{(vi)}\).

Audiology professionals are frequently asked to contribute to assessments for other agencies such as for welfare benefits claims (e.g. Disability Living Allowance, Personal Independence Payments), and for education (e.g. Individual Education Plan, Statement of Special Educational Needs, Education, Health and Care Plan (EHCP), Co-ordinated Support Plan, or equivalent). Professionals can share good quality information which contributes to a full and thorough understanding of the child’s needs.

Professionals in England should acquaint themselves with the 2014 SEND Code of Practice\(^{(v)}\) which gives statutory guidance for organisations who work with and support children and young people (0-25 years) with special educational needs and disabilities including the roles and responsibilities of health services, collaboration between education, health and social care services, and involvement in Education, Health and Care needs assessments and plans (EHCP).

3.3 Working together across NHS and private providers


Key elements of this are:-

- Patients who are entitled to NHS funding can opt in and out of NHS care at any stage. They may pay for additional private care whilst continuing to receive care from the NHS\(^{(vii)}\). This private care can be outside of or within the patient’s NHS Trust.
A patient whose private consultant has recommended treatment normally available as part of NHS-commissioned care can ask his or her NHS clinician to prescribe the treatment as long as it is considered appropriate in his or her clinical discretion, is normally funded by the NHS, and the clinician is willing to accept clinical responsibility for this action\(^{(viii)}\).

Patients may not be charged for the provision of referrals to or sharing of clinical information with private practitioners.

Just as a private prescription for a particular drug which is not available on the NHS will not normally be funded when a patient transfers to NHS care, likewise there would normally be no obligation for an NHS audiology service to maintain a device outside of their NHS contracted stock.

Patients are permitted to pay for private assessments and then join the NHS waiting list for treatment (placed on list following available guidance)\(^{(vii)}\), e.g. for hearing aid provision.

Although most second opinions are obtained within the NHS, if a patient requests a second opinion in the private sector, the clinician should facilitate this where possible\(^{(vii)}\). The patient should not be charged for this service.

A private clinician may request NHS treatment for a patient\(^{(vii)}\). The NHS clinician must treat this referral as any other received (for example when triaging and prioritising). They do not necessarily need to carry out a further assessment prior to delivering the treatment, but may do so if clinically appropriate.

Professionals have a duty to share information with others providing care and treatment for their patients. This includes NHS professionals providing information to private practitioners\(^{(viii)}\).

**Section 3.4 What to do if there are concerns about care within shared care arrangements**

Retaining a clear idea of which professional and organisation is responsible for the assessment and management of the patient, and the management of
any potential complications will inevitably be a complex process. It is advised that audiology professionals keep clear patient notes that record changes in management at all times. These guidelines aim to support open and transparent communication between professionals who are all involved in the individual’s care. Occasionally these relationships may falter or break down. Where there are concerns about the care provided by another professional or organisation, professionals should consider:

- Discussing concerns with the other party. For example to establish whether there are differences in equipment or methods that could account for differences in recommended management, or to discuss the evidence being used.

- Discussing concerns with local Audiology Working Groups, Children’s Hearing Services Working Groups, Patient Advice and Liaison Services, etc where appropriate.

- Advising the patient of appropriate routes for complaints if necessary.

- Raise concerns using relevant organisation or Trust complaints procedures.

- Raise concerns with relevant registration body, for example HCPC\(^{(ix)}\) or regulator, for example CQC\(^{(x)}\).
Appendix 1 Example Agreement

Local Agreement between ____________________ (The Local Provider) and ____________________ (Secondary Provider) for Joint Audiology Working

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<tr>
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<th>Local Provider</th>
<th>Secondary Provider</th>
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<td>Contact Name</td>
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<td>Contact Address</td>
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<td>Contact (Secure) E-mail</td>
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It is agreed that the **Local Provider** is the lead clinician responsible for the overall management plan of the child unless the patient/family choose otherwise. The **Local Provider** is the default provider in all cases.

Where the **Local Provider** is the default provider they will provide and maintain the prescribed personal hearing instruments/devices. Batteries are also be provided by **Local Provider**.

It is agreed that both organisations will use national guidelines/protocols where appropriate (e.g. BAA, BSA, NHSP). Where these are supplemented by local guidelines (e.g. management of unilateral hearing loss) then these will be shared by both organisations.

It is agreed that the **Secondary Provider** may/may not* take impressions for new earmoulds and invoice the **Local Provider**.
The **Local Provider** provides the necessary adjustments to hearing aid settings needed with a new earmould after notification from the **Secondary Provider**.

The method for secure electronic transfer of information will be agreed and compliant with policies and procedures of both organisations.

The complaints policies and processes for both services will be shared.

Where the **Secondary Provider** is concerned with the provision of an auditory implant then the clinical responsibility rests with the Local Service up to the point of implantation. The **Local Provider** remains responsible for any prescribed hearing instruments/devices which may be used with the auditory implant.

The **Secondary Provider** shall not make any recommendations for the provision of /or changes to any ancillary equipment without first discussing with the **Local Provider** to assess the implications of this (which may need to include Local Authority/Education services).

It is agreed that **Minor Changes** (defined below) may/may not* be made by the **Secondary Provider**.

We agreed these **common** definitions

<table>
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<th>Common (tick as appropriate)</th>
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<tr>
<td>[ ] The prescription for reference would be DSL 5.0/NAL4.2/Other*</td>
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<td>[ ] The standard for reports/letters would be 5/_* working days</td>
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<td>[ ] The use of MCHAS tolerances (+/- 5 dB &lt; 2kHz, +/- 8 dB &gt;= 2kHz)</td>
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<td>[ ] A tolerance of +/- 3 dB if different Real Ear Measurement platforms used</td>
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<td>[ ] Technical/Clinical information will be forwarded within 2/___* working days</td>
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We agreed these definitions for **Major** and **Minor** Changes.

*Please delete/detail as appropriate*

### Minor Change(s) / Procedures (tick as appropriate)

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<td>[ ]</td>
<td>Change(s) to output/frequency shaping =&lt; 3 dB</td>
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<td>[ ]</td>
<td>Running of Feedback Manager</td>
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<td>[ ]</td>
<td>Changes to VC range/Delay</td>
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<tr>
<td>[ ]</td>
<td>Earmould Impression(s) if inappropriate/feedback–billed to Local Service provider</td>
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<td>[ ]</td>
<td>Minor Earmould modifications (comfort, tubing)</td>
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<td>[ ]</td>
<td>Minor changes to Management Plan</td>
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### Major Change(s)

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<td>Assessment indicates difference &gt; 15 dB compared to baseline/local</td>
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<td>Change(s) to output/frequency shaping &gt; 3 dB</td>
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<td>[ ]</td>
<td>Changes to processing (including WDRC, noise reduction, NLFC, etc)</td>
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<td>Changes to VC configuration (enabled, range)</td>
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<td>[ ]</td>
<td>Changes to programs (number, configuration)</td>
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<td>[ ]</td>
<td>Changes to base audiometry used for prescription</td>
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<td>[ ]</td>
<td>Alternative Intervention/Device</td>
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<td>[ ]</td>
<td>Major changes to Management Plan</td>
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<td>Other* _________________________________________________</td>
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*Where **Minor Changes** (such as reducing the maximum output levels/minor changes during verification) are made to the hearing aid in the non default provider service these should be reported to the default provider within 2*
working days. Hearing aid settings and audiograms are to be sent within 2 working days via secure e-mail communication.

For Major Changes (such as change in hearing aid or significant difference in audiogram requiring major setting adjustment) when the patient is seen by the non default provider the default provider should be contacted immediately to arrange an urgent appointment to address any appropriate issues.
For **Minor or Major changes** the **Secondary Provider** will forward the following clinical information to the **Local Provider** to support/justify this within 2 working days via secure e-mail communication.

### Supporting Clinical Evidence

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<td>Copy of audiometry (including method, transducer, reliability)</td>
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<td>Copy of REM (including stimulus, prescription, parameters)</td>
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<td>Rationale for Changes to programs</td>
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<td>Rationale for Changes to earmould</td>
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<td>Other ________________________________</td>
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If a hearing aid is damaged by the **Secondary Provider** it is their responsibility to replace the aid free of charge.

Clinical guidelines used by the **Local Provider** and **Secondary Provider** are shared between both services to facilitate transparent working procedures. Any significant differences in clinical processes can be discussed and agreements made.

**Secondary Provider** to be copied into all **Local Provider** patient reports for 12 months after the child's initial appointment at Secondary Provider (with parental consent). **Local Provider** to be copied into all patient reports produced by **Secondary Provider** (with parental consent). Reports need to be clear and accurate to allow transparent joint working.

Appointment review guidelines used by the **Local Provider** and **Secondary Provider** are to be shared between both services to create transparent working procedures.

Review appointments are scheduled according to the default provider’s local guidelines around the needs of the family.
The written agreement of joint working between **Local Provider** and **Secondary Provider** will be reviewed annually.

The procedures for resolving problems, such as breakdown in communications between the organisations involved or patient complaints will be shared between the **Local Service** and **Secondary Service**.

Signed:...........................................  Signed:...........................................
Name:  Name:
Designation  Designation
Head of Local Service/Provider  Head of Secondary Service/Provider
4. References


vi. Modernising Children’s Hearing Aid Services (2005) *Guidelines for Professional Links between Audiology and Education Services within a Children’s Hearing Aid Service*. Available at: http://www.psych-sci.manchester.ac.uk/mchas/aboutus/guidelines


x. Care Quality Commission http://www.cqc.org.uk/