Hearing Loss
Consultation on draft scope
Stakeholder comments table

29 March 2016 – 26 April 2016

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
1	SH	Queen Margaret University	General	General	The draft seems weighted heavily towards the fitting of hearing aids. We feel other methods of rehabilitation should be specifically noted and considered to provide a comprehensive service.	Thank you for your comment. The scope will include the following question which will look at other methods of rehabilitation: What tools (for example, patient-centred decision aids) help people with hearing loss difficulty choose between different management strategies, including: (combinations of) hearing tactics, lip reading, hearing aids, assistive listening devices, communication training, counselling? - What is the clinical and cost effectiveness of assistive listening devices (such as loops to support use of audiovisual devices)? Please note these questions are draft and may be subject to change following consideration by the guideline committee during the development phase.
80	SH	ENT UK	General	General	Will the scope look at prevention for example in relation to noise induced loss, which is the most prevalent preventable cause of hearing loss globally. Or give guidance in relation to the prescribing of ototoxic medications.	Thank you for your comment. The guideline remit is: assessment and management of adult-onset hearing loss and therefore primary prevention is outside the scope of this guideline. Ototoxic medication will not be covered specifically but assessment and treatment within primary care or onward referral will be covered by

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						the guideline.
81	SH	ENT UK	General	general	Will there be any involvement with the military in this guideline. The military are interested in this area. Once deafened service personnel are medically discharged, our veterans then become dependant on the NHS.	Thank you for your comment. The military will be covered by this guideline but veterans will not be a group for special consideration. There is no other planned input from the military aside from via the standard channels available to registered stakeholders.
101	SH	Portsmouth Hospitals NHS Trust	General	General	Should a distinction be made between *'hearing difficulty'* and *'hearing loss'* bearing in mind not all those with the former actually have the latter? The sooner an audiological assessment is done to confirm hearing loss, the better.	Thank you for your comment. The terminology of 'hearing difficulty' has been adopted where appropriate in the scope.
102	SH	Portsmouth Hospitals NHS Trust	General	General	Similar to 5 above, the distinction between 'secondary' and 'tertiary' care can be blurred. This is historical. Should 'tertiary' be replaced by 'specialist centres'?	Thank you for your comment. We accept that the distinction is not always clear cut. The settings section has now been amended to 'all settings where NHS care is commissioned or provided' but going forwards we will use the term 'specialist centres' as opposed to 'tertiary care' as suggested.
103	SH	Portsmouth Hospitals NHS Trust	General	General	We assume there will be another opportunity to provide comments on future detailed documents.	Thank you for your comment. The draft guideline will be submitted for stakeholder consultation in late 2017 following the development phase. Stakeholders will be notified by NICE when the consultation period begins.
111	SH	Conversor Ltd	Gen	Gen	There is little reference to the use of assistive listening	Thank you for your comment. The scope now

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					devices as effective other than as referred to under management of hearing loss. Hearing aids in noisy environments struggle to provide the necessary speech in noise differentiation. Since most of our lives in offices, workplace or schools and colleges are in a noisy environment. Providing just a hearing aid will not be an effective solution. A treview of how to cope with speech in noise and how a hearing aid/assistive listening device copes with its resolution would be essential in reviewing the management of a patients hearing loss and their ability to cope with hearing loss.	includes the following questions: - What is the clinical and cost effectiveness of different types of hearing aid microphones and digital noise reduction technologies? - What is the clinical and cost effectiveness of assistive listening devices (such as loops to support use of audiovisual devices)? Please note these questions are draft and may be subject to change following consideration by the guideline committee during the development phase.
112	SH	NHS England	Gen	Gen	No comemnts	Thank you for your response.
113	SH	Cambridge University Hospitals NHS Trust	General	General	Specific mention should be made of tinnitus: as an indicator for a diagnostic opinion and investigations, and as a factor that needs to be taken into account in auditory rehabilitation.	Thank you for your comment. Tinnitus without hearing loss is excluded from this guideline, however where tinnitus accompanies hearing loss, it will be included and the guideline committee will consider it as a factor when making recommendations.
115	SH	Medtronic	General	General	Question: Considering the NICE draft Guideline scope is only applicable for adult onset of Hearing loss, will there	Thank you for your comment. At present there are no current plans to commission a guideline on

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					be a draft guideline scope applicable for children with hearing loss?	children with hearing loss.
116	SH	Medtronic	General	General	Will there be a NICE draft guidance applicable to surgical management of hearing loss, specific to Bone Anchored Hearing Implants (BCHI) in select patient populations? *adult population *paediatric population	Thank you for your comment. At present there are no current plans to commission guidance specifically on bone anchored hearing implants for either adult or paediatric populations.
136	SH	Hearing Link	general	General	We agree (strongly) that the title of the guideline should be revised as suggested. Hearing Link works with many adults who fit this description (ie hearing loss retrospectively recognised as having its onset in childhood but only presented as causing difficulties in adulthood) and we believe that the title 'Adult Onset' would risk the unintended consequence of excluding these individuals.	Thank you for your comment. The guideline title has been changed to 'Hearing Loss (adult presentation)' based on feedback from stakeholders.
142	SH	Department of Health	Gen	Gen	No comments	Thank you for your response.
145	SH	Royal College of Nursing	Gen	Gen	No comments	Thank you for your response.
150	SH	National Community Hearing Association		General	The National Community Hearing Association (NCHA) represents community hearing care providers in the UK. We welcome this opportunity to comment on *Hearing Loss (adult onset): assessment and management.* We attended the NICE workshop on 4 March and, in our view, this is an improved draft scope. However we still have some concerns and further recommendations,	Thank you for your comment.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					these are set out in our response below.	
151	SH	National Community Hearing Association	General	Question to consider	*"Question to consider: People whose hearing loss begins in childhood but do not receive care until adulthood will be included within this guideline. Given this, should the title of the guideline be changed from 'Hearing loss (adult onset)' to 'Hearing loss (adult presentation)'?"* No, in our view the title should be changed to *"Hearing loss: assessment and management in adults"* because: • the original title made assumptions about needs without objective justification • for example it assumed that a person aged 25 with the same diagnostic results, symptoms and communication needs as another person aged 25 would require separate NICE guidance on hearing loss based on what age their hearing loss was diagnosed • the suggested change by NICE does not address original assumptions. We do not dispute that the hearing needs of a child – especially during the critical period for language development – are different from somebody with acquired hearing loss in older age. We must however challenge	Thank you for your comment. The guideline title has been changed to 'Hearing Loss (adult presentation)' based on feedback from stakeholders. Adults with hearing loss who presented in childhood would already be in contact with hearing services and on a management pathway. In children presenting with hearing loss, the cause is usually different and often requires a different investigation pathway. They also have different needs with regard to speech and language, particularly if the onset is prelingual. The guideline is not intended to cover this population, so we feel that specifying adult presentation in the title makes it clear that this is out of scope. We do not believe that this population will have fewer rights when it comes to choice, control and available interventions on the NHS because this guideline is not considering the clinical pathway for this group.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					excluding people based on year of diagnosis or presentation despite being an adult with the same condition, and arguably needs, as other adults; especially given that this does not appear to be based on evidence. The number of people with hearing loss aged 0 to 18 is also very small – e.g. likely prevalence 0.1 to 0.3%, i.e. up to 35,000 people in England. It is unlikely NICE will produce guidance for adults that fall outside of the current scope, yet many of these adults will use hearing aids and many of the same research questions will apply to them. We think NICE should consider whether there is credible evidence that an experienced hearing aid user at age 25 (having used hearing aids all their life) should be "tagged" as more complicated or otherwise excluded from this guidance. We know of no evidence that an adult with hearing loss since childhood, other things being equal, should have fewer rights than any other adult when it comes to choice, control and available interventions on the NHS. By excluding adults who experienced a hearing loss before the age of 18 this is what is likely to be the ultimate commissioning outcome in many regions. We are also concerned that this approach could result in marginalising a group of society that is already often excluded. For example if the output of NICE guidance influences commissioning decisions in England, it is	

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					probable those commissioning community services will state that only adults aged 18 and over who did not have their hearing loss diagnosed before their 18th birthday are eligible for care out of hospital, limiting choice and the same opportunities given to other people of the same age.	
182	SH	University of Southampton	General	General	I would support the inclusion of people whose hearing loss begins in childhood but who only present in adulthood being included in the guidance and thus the title change to "Hearing loss (adult presentation".	Thank you for your comment. The guideline title has been changed to 'Hearing Loss (adult presentation)' based on feedback from stakeholders.
183	SH	University of Southampton	General	General	The document mentions that in the current model patients do not always get sufficient support in the use of their hearing aids which I would agree with. Also there needs to be careful and frequent follow-up of patients with progressive losses to ensure that their hearing aids are still appropriately set or determine if they should be assessed for a cochlear implant or other form of auditory implant if they are unable to tolerate air conduction hearing aids	Thank you for your comment. Follow up of patients will be addressed in the following questions: - How and when should people with hearing- related communication needs (including those with hearing aids) be monitored and followed up? - What is the clinical and cost-effectiveness of aftercare to support continued use of devices? Guidance on providing cochlear implants is available in TA166.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						Please note these questions are draft and may be subject to change following consideration by the guideline committee during the development phase.
184	SH	Action on Hearing Loss	General	General	Action on Hearing Loss is the charity formerly known as RNID. Our vision is of a world where deafness, hearing loss and tinnitus do not limit or label people and where people value and look after their hearing. We help people confronting deafness, tinnitus and hearing loss to live the life they choose. We enable them to take control of their lives and remove the barriers in their way. We give people support and care; develop technology and treatments and campaign for equality. Our response will focus on key issues that relate to people with hearing loss. Throughout this response we use the term 'people with hearing loss' to refer to people with all levels of hearing loss, including people who are profoundly deaf who may use British Sign Language (BSL). We are happy for the details of this response to be made public. Action on Hearing Loss welcomes this scope and the development of the guideline on adult onset hearing loss.	Thank you for your response.
205	SH	British Society of Hearing Aid	N/A	N/A	The British Society of Hearing Aid Audiologists is the professional body recognised by HCPC as the	Thank you for your response.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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		Audiologists			organisation representing the professional interests of Hearing Aid Dispensers –the protected title of the only clinical practitioners permitted to operate in the private sector to assess hearing and sell hearing aids.	
227	SH	British Society of Hearing Aid Audiologists	general	GEN	There is no mention in the scope about the important capability of binaural hearing, to be able to sense the direction and distance of sounds. This feature of sensory identification can be lost/ impaired both by hearing loss itself, and by inadequate consideration of the nature of support offered. Unilateral fitting for instance will restrict the sense of location and directional sensitivity of hearing. Individuals, their significant others, and the healthcare professionals need to be adequately informed about this aspect of hearing loss, in order to develop the optimum coping strategies,, and to make best use of hearing aid technology. The guidance should provide advice and relevant information.	The following question in the guideline will address advice and support for patients and their carers: - What are the information, support and advice needs of people with hearing difficulty and their families and carers? The baseline is for 2 hearing aids to be offered for binaural hearing loss. The guideline will review the clinical and cost effectiveness of 1 hearing aid (for 1 ear) compared with 2 (for 2 ears). Please note these questions are draft and may be subject to change following consideration by the guideline committee during the development phase.
228	SH	British Society of Hearing Aid Audiologists	general	GEN	In its economic evaluation, NICE should advise on both the workforce and budget implications of the current reality that only around 1/3 of all who could benefit from support with hearing are currently receiving it. The	Thank you for your comment. Implementation costs are not considered as part of the original economic analysis in line with the NICE cost-effectiveness reference case. Such costs (that

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					pressure for a credible public health agenda for hearing and to address current inequalities cannot be met within current resource priorities, and this is leading to a situation of rationing through a combination of inertia, stigma and ignorance on behalf of the public. A more honest, transparent and effective approach to entitlement, prioritisation and joint responsibility between the NHS and individual is required. The effect of alternative models on financial and workforce resources should be considered e.g. individual co-payment/voucher schemes (similar to the arrangement in eye care)	also consider changes from current practice) are instead examined in the separate costing tool developed by NICE to support this guideline. The resource impact of all potential recommendations will however be examined during the guideline development stage and areas of high impact will be flagged.
206	SH	British Academy of Audiology	GENERAL	GENERAL	Wax is the largest problem for people with hearing aids. It should be included in this scope. As currently most Hearing aid users (if a local ear care clinic is not commissioned) are required to bounce the patient back to GP for de-waxing, and if problems then onto ENT. Whereas if audiologists could do it there and then, this would reduce the extensive delay to hearing aid provision.	Thank you for your comment. The guideline will cover the management of ear wax following comments from stakeholders. However how this service is organised locally is beyond the remit of this guideline.
208	SH	British Academy of Audiology	General	General	The draft seems weighted heavily towards the fitting of hearing aids. We feel other methods of rehabilitation should be specifically noted and considered to provide a comprehensive service.	Thank you for your comment. The scope will include the following questions which will look at other methods of rehabilitation and support and advice respectively. - What tools (for example, patient-centred decision aids) help people with hearing loss difficulty choose between different management strategies, including:

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						(combinations of) hearing tactics, lip reading, hearing aids, assistive listening devices, communication training, counselling? - What are the information, support and advice needs of people with hearing loss and their families and carers? The following question was added in response to stakeholder comments: - What is the clinical and cost effectiveness of assistive listening devices to support use of audiovisual equipment e.g. television? Please note these questions are draft and may be subject to change following consideration by the guideline committee during the development phase.
168	SH	National Community Hearing Association	General	158-224	The lack of references in this section and the similarity with policy/campaign documents is slightly disconcerting. We appreciate however that this is only a working draft. We therefore offer feedback on lines 158 to 224 below.	Thank you for your comment. Guideline scopes do not usually contain references.
160	SH	National	GEN	89-90	*"Which tests and investigations should be used in*	Thank you for your comment. We will pass this on

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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		Community Hearing Association			*medical services to assess the underlying cause of hearing loss?"* This is a crucial question. At the present time the sector has three main professions, audiologists (diverse range of skills), ENT and audiovestibular physicians. Each has a subgroup with a history of erecting barriers to change based on judgement rather than reviewing evidence[i]. We appreciate that NICE will not be recommending how services are commissioned, but we do feel NICE has an important role to play in providing trusted and reliable evidence on the relative and absolute risk and the marginal cost per additional diagnosis when reviewing this particular question. This should also help minimise the risk of supplier-induced demand at a local level – e.g. over utilisation of diagnostic tests that have an associated tariff. There is also often a significant opportunity cost associated with over utilisation that extends beyond direct expenditure – e.g. ordering MRI scans for a low risk of differential diagnosis here could result in delays for an MRI for groups at higher risk of morbidity/mortality.	to the guideline committee for consideration.
162	SH	National Community Hearing Association	GEN	100-101 106-107	• "*What is the effectiveness and cost effectiveness of 1 hearing aid compared with 2?"* • In our view this is a key question which should help reduce some uncertainty for	Thank you for your comment. The guideline will now cover the management of ear wax following stakeholder comments and will also cover the

Hearing Loss

Consultation on draft scope
Stakeholder comments table
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					commissioners. NICE is probably aware that this is a question that many CCGs in England have asked. We would however urge NICE to use a health economist with special interests in medical devices – see comment 8.*"What is the clinical and cost-effectiveness of different types of hearing aid microphones and digital noise reduction technologies?"* We feel that whilst this an interesting question, it ignores the way in which the NHS purchases and delivers hearing care. For example, modern technology is likely already to include these additional benefits included without any additional marginal cost to the NHS – i.e. the question on line 100-101 should suffice and any review of the international literature on this specific question (line 106-107) is unlikely to be transferable to the English NHS (especially not cost-effectiveness analysis). See comment 8. If NICE can ask one rather than two questions here, it will have scope to address a different – and arguably more important – question. For example the main cause of temporary hearing loss is occlusive earwax and it's estimated that over 2 million people seek professional support for earwax each year[ii]. This represents a significant burden on both patients and	clinical and cost-effectiveness of 1 hearing aid (for 1 ear) compared with 2 hearing aids (for 2 ears). The guideline will also cover the clinical and cost-effectiveness of hearing aid microphones and digital noise reduction technologies.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					the NHS – particularly GPs, nurses and ENT. Yet there are no robust guidelines on how to manage earwax in people with age-related hearing loss for example, but there is a HTA on the topic[iii]. If this could be addressed then it is very likely that millions of NHS appointments could be managed more effectively each year – possibly making better use of pharmacists and audiologists, and freeing up GP and ENT resources. We would therefore propose that the question: *"What is the clinical and cost-effectiveness of different types of hearing aid microphones and digital noise reduction technologies?"* be replaced with: "*What is the clinical and cost-effectiveness of different types of earwax management in adults with hearing loss?"*	
163	SH	National Community Hearing Association	GEN	110-111	It would, in our view, be a missed opportunity for the current review questions to guide a systematic review of the literature. We hope NICE will review the questions and take a proportionate, objective and needs based approach and consider changing some of the questions asked.	Thank you for your comment.
152	SH	National Community Hearing Association	General	20	Equality considerations The prevalence and severity of hearing loss increases exponentially with age. The average person that requires	Thank you for your comment. We recognise age is a protected characteristic but as you say, the prevalence of hearing loss increases with age so

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					domiciliary care will therefore – on average – be more likely to have a hearing loss, and a more severe hearing loss, than the general population. Individuals in this group are also more likely to have more than one protected characteristic as defined in the Equality Act 2010. We feel that people in care and/or living at home that cannot access hearing care warrant special consideration.	it will be the case that the majority of the population covered by this guideline will be older people. We feel that people in care and/or living at home that cannot access hearing care are adequately covered in the scope and do not require special consideration.
159	SH	National Community Hearing Association	GEN	87	Most people with hearing loss are likely to report hearing difficulty in noise as their primary symptom. We therefore welcome that the guideline will cover measuring speech and hearing in noise. The NHS however does not fund speech and hearing in noise assessments. The additional time per test and the knock on effects on capacity (i.e. opportunity costs) are likely to require NICE to consider the economic and practical impact of this form of assessment on the NHS.	Thank you for your comment. Cost effectiveness will be examined in all review questions of the present guideline. Implementation costs are not considered as part of the original economic analysis in line with the NICE cost-effectiveness reference case. Such costs (that also consider changes from current practice) are instead examined in the separate costing tool developed by NICE to support this guideline. The resource impact of all potential recommendations will be examined during the guideline development stage and areas of high impact will be flagged.
176	SH	National	GEN	209	*"In many cases hearing aids are tried but discontinued*	Thank you for your comments. Cost effectiveness

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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		Community Hearing Association			*because the person has not had the support they need to use them"* This is an important point. In our review of the grey and published literature we found gaps in follow-up care and that these could be traced back to 1982; this has had an impact on hearing aid use (as acknowledged by the Audit Commission in 2000 in their review of audiology services) and patient satisfaction with their hearing aids (as acknowledged by Monitor in its review of adult hearing services in 2014/2015); and despite guidance, standards and lobbying to address gaps in follow-up care, people still do not always get the support they need[iv]. It is important to assess the root cause of why such a chronic problem might exist and/or be tolerated. For example, this could be due to a lack of capacity and if NICE's review of the evidence shows ongoing support is important, then it might be acknowledged by commissioners and audiology departments that rationing follow-up care to meet referral to treatment times (i.e. prioritise capacity in this way) is not a cost-effective strategy, and that by focussing instead on increasing efficiency and capacity might be more beneficial for patients and taxpayers.	will be examined in all review questions of the present guideline and identified evidence will be discussed before the guideline committee makes any recommendations. Questions on both monitoring and after care will be addressed within this guideline.
114	SH	Medtronic	General (pg 3,4,5)	General (58, 100,	Question: This NICE draft Guideline scope for Hearing loss is not applicable to surgical management of hearing	Thank you for your comment. Surgical management is not included in the scope of this

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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				120,126,128)	loss? *under list of non-covered items – surgical management of hearing loss * key issues and questions – effectiveness and cost-effectiveness of 1 vs 2 hearing aids * main outcomes – appropriate use of hearing aids *NICE guidance that will be incorporated include: Cochlear implants for children and adults with severe to profound deafness *Auditory brain stem implants	guideline. However, the guideline will link to other NICE guidance that is deemed relevant.
170	SH	National Community Hearing Association	7-8	165-171	"*It is estimated that, in 2013, the UK economy lost more than £24.8 billion in potential output because people with hearing loss were unable to work. Research shows that hearing loss doubles the risk of developing depression and increases the risk of anxiety and other mental health issues, and it is thought that hearing aids may reduce these risks. There is also evidence that people with hearing loss have a higher risk of dementia: this risk is 3 times higher in moderate hearing loss and 5 times higher in severe hearing loss*." We would ask the committee to review this evidence especially carefully as it is important for NICE to be thoroughly evidence based and credible.	Thank you for your comment. These are widely quoted figures and at this stage of the guideline, we are only using them to highlight the impact of hearing loss. Should they be used in any of the evidence reviews during the guideline development process, these studies will be critically appraised and discussed by the guideline committee before including them in the guideline.
167	SH	National Community Hearing	6-7	154-157	In our view, this diagram is a significant improvement on the original diagram and we are pleased to see that the 4 March workshop feedback has been taken on board.	Thank you for your comment. Your feedback will be considered by the team responsible for the

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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		Association			However we think the diagram needs to be changed to reflect current practice in England. The diagram should, in our view: • second box *"initial assessment and treatment in primary care"* should be changed to *"initial assessment and treatment in primary or community care settings"*. This is because commissioners in England are now starting to commission open access audiology where people with hearing problems can access NHS hearing care in the community without a GP visit. GPs and CCGs are supportive of this because in the vast majority of cases people have earwax and/or age-related hearing loss, thus it is likely to free up GP and practice nurse time. By the time NICE publishes it guidance we expect most hearing loss will be managed in primary and community care settings – i.e. no longer by non-medical staff in acute hospital settings. This has also been Department of Health Policy since 2007[v] and something the RNID (now Action on Hearing Loss) is documented as supporting many times between 1988 and 2011[vi], Action on Hearing Loss also now delivers hearing care closer to home with a range of providers • the fourth box should become the third box, and the text *"management in community or secondary care:…"* changed to *"audiology management of non-medical hearing loss and other non-medical ear problems".* It should also include an additional bullet	NICE pathway and any necessary amendments will be made.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					point *"monitoring and follow-up"* • the third box should be the fourth box, and changed from *"when to refer to specialist"* to *"when to refer for medical opinion"* • then the last box should be changed to *"medical management and follow-up or referral to audiology to support hearing loss"*	
75	IND	IND	6/7	154	Accepting that the new pathway is very simplistic and is only one way, it will be necessary when improved to stress the importance of return paths particularly between the community and AQP schemes and medical/technical etc support.	Thank you for your comment. Your feedback will be considered by the team responsible for the NICE pathway and any necessary amendments will be made.
10	SH	British Society of Audiology	1	7-10	What is the distinction between a guideline and the quality standard for hearing loss?	Thank you for your comment. NICE guidelines aid decision-making by individual clinicians. NICE quality standards are concise sets of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. The quality standard for hearing loss will be derived from the hearing loss guideline once it is published.
65	IND	IND	1	10	Editorial – this line should reflect the title. Suggest add 'assessment and management'	Thank you for your comment. This topic has been referred to the NICE Quality Standards library as Hearing Loss (adult onset). The title of the QS may be changed once the guideline has been published.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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185	SH	Action on Hearing Loss	1	13	'Commissioners of health and social services' should be included here as an audience under 'who the guidance is for'. Having worked with commissioners on the NHS England Commissioning Framework it is clear that they will be interested in this guideline and should be encouraged to reference it in contracts and service specifications.	Thank you for your comment. This audience has been added.
11	SH	British Society of Audiology	1	14	Agree with wording on who this guideline is for - the scope is comprehensive, NHS or private provision in all relevant settings.	Thank you for your comment.
97	SH	Portsmouth Hospitals NHS Trust	1	14	*'Healthcare professionals in primary, secondary and tertiary care'.* Elsewhere in the document, Line 40, distinction is made between 'primary (GP) and 'community' care. Should 'Community' be included in the sentence above?	Thank you for your comment. We have amended the settings to 'All settings where NHS care is commissioned or provided' to avoid confusion in this section.
153	SH	National Community Hearing Association	1	14	Primary care is often used to refer to the four contractor professions (GPs, dentists, optometrists and pharmacists). Secondary care is usually taken to mean care in hospitals. Today, over 60% of Clinical Commissioning Groups (CCGs) offer people access their hearing care in the community – i.e. but not at a location that those working in the NHS recognise as primary or secondary care[vii]. It is important to reflect the current provision of services and be consistent throughout the guideline scope. We therefore recommend the following change:	Thank you for your comment. We have amended the settings to 'All settings where NHS care is commissioned or provided' to avoid confusion in this section.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					Current: "*Healthcare professionals in primary, secondary and tertiary care*", To: "*Healthcare professions in primary, community, secondary and tertiary care*".	
67	IND	IND	1	16	There is no reference to AQP schemes until 3.2 line 198 of the document. It should be made clear that the guidelines are for these organisations. Suggest that to make this clear there should be a separate line for them in this section	Thank you for your comment. We have amended the settings to 'All settings where NHS care is commissioned or provided' to avoid confusion in this section. This implicitly includes AQP schemes and we do not feel there is a need to make this more explicit.
12	SH	British Society of Audiology	1	25	Here, and elsewhere (ln 96) the word 'disability' is used. Although widely used in common parlance the 2001 WHO International Classification Framework of Functioning Disability and Health refer to disability as 'activity limitations'. This is the term typically used in journal articles in hearing science and audiology. Suggested wording: activity limitations (previously known as disability)	Thank you for your comment. The equality impact assessment takes into account the 9 'protected characteristics' of which disability is one. As the term 'disability' is used in a legal context within the Equality Act, it is appropriate that the term 'disability' is used in this context to make the link explicit and clear.
42	SH	NIHR Nottingham Hearing Biomedical Research Unit	1	25	Here, and elsewhere (ln 96) the word 'disability' is used. Although widely used in common parlance the 2001 WHO International Classification Framework of Functioning Disability and Health refer to disability as 'activity limitations'. This is the term typically used in	Thank you for your comment. The equality impact assessment takes into account the 9 'protected characteristics' of which disability is one. As the term 'disability' is used in a legal context within

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					journal articles in hearing science and audiology. Suggested wording: activity limitations (previously known as disability)	the Equality Act, it is appropriate that the term 'disability' is used in this context to make the link explicit and clear.
66	IND	IND	1	25	Is hearing loss not a disability? Add 'other than that due to hearing loss'. Also add 'Initial groups for special consideration are identified in the NICE guidelines Equality impact assessment'. It might be useful to list the groups so that the reader has some indication of disabilities that are being considered.	Thank you for your comment. Hearing loss is not necessarily a disability as there are varying degrees of hearing loss. The scoping group has considered feedback from stakeholders and decided that people with disabilities will be considered as part of the equality impact assessment, so they do not need to be listed as groups for special consideration in the scope.
117	SH	Sense	2	28-34	There are approx. 259,000 people in the UK who are classed as deafblind, 200,000 of which are aged 70 or over. Deafblindness (having both a hearing and sight impairment) brings unique challenges to accessing information, communication and mobility. As such we feel that, in addition those listed, special consideration should also be given to those with additional sight impairment.	Thank you for your comment. The scoping group has considered feedback from stakeholders and decided that people with disabilities will be considered as part of the equality impact assessment, so they do not need to be listed as groups for special consideration in the scope.
118	SH	Sense	2	28-34	Prevalence of adult onset hearing impairment for people with learning disabilities is significantly higher than for those without learning difficulties. As such, we feel that special consideration should be given to this group of individuals in addition to those listed.	Thank you for your comment. The scoping group has considered feedback from stakeholders and decided that people with disabilities will be considered as part of the equality impact assessment, so they do not need to be listed as groups for special consideration in the scope.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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119	SH	Sense	2	28-34	A high proportion of individuals with dementia also have a hearing loss. There is also a significant risk of diagnostic overshadowing. Due the unique needs of this group we feel that special consideration should be given to this group of individuals in addition to those listed.	Thank you for your comment. The scoping group has considered feedback from stakeholders and decided that people with disabilities will be considered as part of the equality impact assessment, so they do not need to be listed as groups for special consideration in the scope.
13	SH	British Society of Audiology	2	31-34	Rather than a focus on bilateral hearing loss, the current wording here reads as though the guideline will focus on young adults, unilateral hearing loss and those with speech and language difficulties. Additionally, specific consideration of people with speech and language difficulties is not regarded by the BSA as a priority for adults, whilst adults with complex needs (eg,dementia, cognitive decline, dual sensory impairment or intellectual/learning disabilities) would benefit from specific consideration. Word 'special' implies as higher priority whereas specific implies different in some way and worthy of separate consideration. It is not clear as to the rationale is for making Young Adult worthy of special consideration inclusion is perhaps not a priority - it could be argued that younger-older adults (50-65) represent a group that affords special consideration. Suggested wording:	Thank you for your comment. The groups for special consideration are groups that we feel face specific issues that may require exploration within this guideline. They are part of the broader population of adults presenting with hearing loss and will not be the only focus of the guideline. People with disabilities including those you have listed are identified within the equality impact assessment so do not need to be listed as groups for special consideration in the scope. The term 'special consideration' is standard NICE wording. Young adults have been identified for special consideration because they may face particular issues and difficulty relating to continuing education.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					'Whilst the focus will be on adults with bilateral hearing loss, specific consideration will be given to: • *Young adults (age 18-25)* • *Adults with complex needs including dementia* • *People with unilateral hearing loss'*	
43	SH	NIHR Nottingham Hearing Biomedical Research Unit	2	31-34	For adult onset hearing loss it is not clear why people with speech and language difficulties should be given special consideration, as it is not a priority as it would be with a paediatric population. However, those with conditions comorbid with hearing loss such as those with dementia (or cognitive decline) or dual-sensory impairment (i.e. deaf-blind) or those with learning disabilities warrant a far greater need for special consideration, and would be more appropriate here.	Thank you for your comment. People with speech and language difficulties have been identified as a group for special consideration because the scoping group considered that assessment may need modification for this group. It was felt that this group captured a broader group of people who may not necessarily be captured in the equality impact assessment under the protected characteristics of ethnicity or disability.
143	NICE	QS	2	29-30	In response to the question asked above I would change the title to 'Hearing loss (adult presentation)' to avoid confusion about the population covered.	Thank you for your comment. The guideline title has been changed to 'Hearing Loss (adult presentation)' based on feedback from stakeholders.
68	IND	IND	2	28	This section under special considerations should have a section relating to people who have severe speech discrimination problems due to hearing loss but can benefit from hearing aids	Thank you for your comment. People with speech and language difficulties have been identified as a group for special consideration and this will include whose difficulty is caused by hearing loss.
122	SH	University of	2	28	Suggest adding the following groups:	Thank you for your comment. The scoping group

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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		Manchester			• People with learning disabilities, • People with neurodegenerative disease, • People with sudden hearing loss, • People with severe and profound hearing loss.	has considered feedback from stakeholders and decided that people with disabilities will be considered as part of the equality impact assessment, so they do not need to be listed as groups for special consideration in the scope.
206	SH	British Society of Hearing Aid Audiologists	2	29	People with a component of persistent conductive loss (or mixed loss), should be added to this list for they may require special type of hearing aids e.g. bone conduction hearing aids on temporary or bone anchored contraptions. The assessment and fitting for bone conduction devices require a different considerations than air conduction hearing devices	Thank you for your comment. Surgical management of hearing loss is not being covered within the guideline so we do not feel that it is necessary to include this group as a group for special consideration.
2	SH	Queen Margaret University	2	31	The very elderly are not mentioned specifically. We feel this group needs additional resources and should be considered as an individual group.	Thank you for your comment. Very old people are covered within the general population for this guideline and we do not feel that the assessment and management of this group is different to a degree that they would require special consideration within the guideline.
5	NICE	Social Care	2	31	Given that people suffering hearing loss are often older, please could you explain why this group is not being given special consideration?	Thank you for your comment. As this guideline is for adults and the prevalence of hearing loss increases with age, the population this guideline will be most relevant for is older people. Because of this we do not feel it is necessary to specify this group as a group for special consideration in the scope.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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83	SH	University of Southampton	2	31	Additionally, special consideration could be given to adults with learning difficulties, adults with complex needs, adults with co-morbid disorders such as dementia, visual impairment etc.	Thank you for your comment. The scoping group has considered feedback from stakeholders and decided that people with disabilities will be considered as part of the equality impact assessment, so they do not need to be listed as groups for special consideration in the scope.
186	SH	Action on Hearing Loss	2	31	We recommend adding 'People with hearing loss and other conditions that would affect diagnosis and management such as tinnitus, vestibular disorders, learning disabilities, dementia and sight loss' to the list of groups who will be given special consideration. These are groups that require additional or alternative support yet this support is often not available for them.	Thank you for your comment. The scoping group has considered feedback from stakeholders and decided that people with disabilities will be considered as part of the equality impact assessment, so they do not need to be listed as groups for special consideration in the scope.
207	SH	British Society of Hearing Aid Audiologists	2	31	Additional groups requiring special consideration-those with Learning Disabilities and people with dementia should be given special consideration as there is greater prevalence and more difficulty with assessment and diagnosis.	Thank you for your comment. The scoping group has considered feedback from stakeholders and decided that people with disabilities will be considered as part of the equality impact assessment, so they do not need to be listed as groups for special consideration in the scope.
205	SH	British Academy of Audiology	2	31	What about those with learning difficulties as some will require special considerations?	Thank you for your comment. The scoping group has considered feedback from stakeholders and decided that people with disabilities will be considered as part of the equality impact assessment, so they do not need to be listed as groups for special consideration in the scope.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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209	SH	British Academy of Audiology	2	31	The very elderly are not mentioned specifically. We feel this group needs additional resources and should be considered as an individual group.	Thank you for your comment. Very old people are covered within the general population for this guideline and we do not feel that the assessment and management of this group is different to a degree that they would require special consideration within the guideline.
154	SH	National Community Hearing Association	2	32	We would question whether there is any objective justification for giving special consideration to people aged 18 to 25 – especially given the confusion over what to name this guidance (see comment 2)? We understand that people in transition are often missed/failed because of poor handover and a dearth of leadership on this issue. We therefore support NICE giving special consideration to this group. However if NICE excludes people diagnosed with hearing loss before the age of 18, this is likely to be a very small group. We would recommend that the guideline includes all adults – regardless of when they were diagnosed or presented with hearing loss – and that then people aged 18 to 25 are given special consideration so that transition services can be improved across England.	Thank you for your comment. Young adults have been identified for special consideration because they may face particular issues and difficulty relating to continuing education. This guideline will not cover the principles of transition to adult services as this is already addressed in NICE guideline NG43: Transition from children's to adults' services for young people using health or social care services.
4	NICE	Social Care	2	33	Suggest using a plain English version of "unilateral hearing loss" as this may not be understood by everyone	Thank you for your comment. We have changed the terminology to 'people with single sided deafness'.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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44	SH	NIHR Nottingham Hearing Biomedical Research Unit	2	33	Unilateral hearing loss is vague and needs a clearer definition. An international consensus statement has defined single sided deafness as a 4 frequency PTA <=30 dB in one ear and 'severe-profound deafness' in the other ear, which ASHA and BSA guidelines define as > 70 dB HL. Furthermore, there should be some consideration as to the diagnosis (i.e. conductive od SNHL) as this can impact management decisions.	Thank you for your comment. We have changed the terminology to 'people with single sided deafness'.
104	SH	Evident	2	33	Why are people with unilateral hearing loss receiving special consideration? It may be worth specifying this.	Thank you for your comment. We have changed the terminology to 'people with single sided deafness'. The scoping group recognises that people with hearing loss in one ear require different investigation of causation.
155	SH	National Community Hearing Association	2	33	We are pleased to see that NICE will – rightly – focus on non-medical hearing loss (although the review questions will result in the literature driving this, rather than being explicitly stated in the draft scope). The vast majority of people with hearing loss have age-related hearing loss (a non-medical condition)[viii]. Age-related hearing loss is a bilateral and slowly progressive hearing loss. We would also challenge why NICE believes people with unilateral hearing loss warrant special consideration – i.e. they have hearing in the other ear, whereas those with bilateral hearing loss do not and are arguably, other	Thank you for your comment. The committee does not recognise the concept of 'non-medical hearing loss'. The scope includes all causes of hearing loss in adults, apart from acute temporary hearing loss caused by traumatic head injuries. By saying that certain groups will be given special consideration, NICE means that the recommendations made for the general population addressed by the guideline may need to be modified for those groups to meet their

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					things being equal, more disadvantaged by hearing loss. The guideline committee might also consider that prevalence of hearing loss is often based on better ear averages and that NICE will be reviewing the cost-effectiveness of one vs. two hearing aids etc. – i.e. it does not appear to be logical to single out people with unilateral hearing loss. Instead NICE might want to give special consideration to people who do not have age-related hearing loss – i.e. give special consideration to medical rather than non-medical causes of hearing loss. If the evidence justifies giving unilateral hearing loss special consideration, then it would be helpful for NICE to make this clear.	differing or specific needs. This may well be the case for people with unilateral hearing loss.
123	SH	University of Manchester	2	35	Suggest referring readers to NDCS guidance on managing transition patients.	Thank you for your comment. Transition between services is outside of the scope of this guideline and additionally it is not possible to refer to non-NICE guidance. Nevertheless adults who present with hearing loss before the age of 18 will already be in touch with hearing loss services and therefore we do not think a reference is necessary. General guidance on the transition from children to adult services is provided in NICE guideline

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						NG43: Transition from children's to adults' services for young people using health or social care services.
156	SH	National Community Hearing Association	2	29-30 and 36	If the title is not changed (see comment 2), in our view the following text should be changed to help clarify the scope. <u>Line 29-30</u> Current: *"Adults (aged 18 years and older) with hearing loss, including those with onset before the age of 18 but presenting in adulthood."* To: *"Adults (aged 18 years and older) with hearing loss, including those with onset before the age of 18 but diagnosed in adulthood."* <u>Line 36</u> Current: "*Adults who presented with hearing loss before the age of 18*" To: "*Adults with hearing loss diagnosed before the age of 18*" We think this group should be included however - see comments 2 and 5.	Thank you for your comment. This guideline includes the period before diagnosis is made, so we do not agree that this change is appropriate. The guideline title has been changed to 'Hearing Loss (adult presentation)' based on feedback from stakeholders.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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98	SH	Portsmouth Hospitals NHS Trust	2	36	*'Adults who presented with hearing loss before the age of 18'*. This statement assumes that this population would have received care in childhood. If so, I suggest it may not be entirely correct. Some may have ignored or not considered their hearing loss a priority or may have moved to England from abroad. Line 29 only partially covers some in this group. Line 36 could be deleted and Line 29 rephrased as follows: *'Adults (aged 18 years and older) with hearing loss, including those with onset before the age of 18 but presenting in adulthood or those who had not received care for their hearing loss before the age of 18 years'.*	Thank you for your comment. We have indeed assumed that adults who presented with hearing loss before the age of 18 would have received care for their hearing loss. We think this is a reasonable assumption to make, and think the numbers of people who presented before age 18, but did not receive care for whichever reason, are likely to be small. It will be up to individual clinicians to use their clinical judgement when implementing the guideline with this population. This point will be noted and a statement made in the full guideline to acknowledge this assumption.
208	SH	British Society of Hearing Aid Audiologists	2	36	Adults who presented before age 18 (or 16 –see point 4) should not be excluded as ongoing review may be capable of being managed within the arrangements for routine age-related hearing loss.	Thank you for your comment. The guideline addresses the management pathway for adults. The evidence on hearing aids will be useful for all patients regardless of the age of identification.
209	SH	British Society of Hearing Aid Audiologists	2	36	Consider changing it to age of 16 for many paediatric audiology departments will transition children to adult services when they turn 16	Thank you for your comment. The guideline addresses the management pathway for adults. Young people aged under 16 should be managed as children.
69	IND	IND	2	38	AQP schemes should be itemised in this section	Thank you for your comment. We have amended the settings to 'All settings where NHS care is commissioned or provided' to avoid confusion in

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						this section. This implicitly includes AQP schemes and we do not feel there is a need to make this more explicit.
210	SH	British Society of Hearing Aid Audiologists	2	39 and elsewhere	Primary care – as a broad description of healthcare provision, this is generally understood to include pharmacy, optician, dentistry and general practice, but is rarely assumed to include hearing care. Out-of-hospital audiology is more commonly described as community healthcare, and the scope throughout should replace mention of primary care with primary and community care.	Thank you for your comment. We have amended the settings to 'All settings where NHS care is commissioned or provided' to avoid confusion in this section.
6	NICE	Social Care	2	40	'Community settings where NHS-commissioned care is provided' – does this mean that this guidance only applies to the NHS care for hearing loss? It may be that non-NHS practitioners need to use the guidance to help manage hearing loss and it may be that social care should be included here.	Thank you for your comment. The remit of NICE is to provide guidance for the NHS. Non-NHS services may also wish to follow the guidance. We have amended the settings to 'All settings where NHS care is commissioned or provided' to avoid confusion in this section.
14	SH	British Society of Audiology	2	41	Confirm agreement with wording as it is (as per comment 2)	Thank you for your comment
84	SH	University of Southampton	2	41	Scope to clarify that AQP is included	Thank you for your comment. We have amended the settings to 'All settings where NHS care is commissioned or provided' to avoid confusion in this section. This implicitly includes AQP schemes and we do not feel there is a need to make this more explicit.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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3	SH	Queen Margaret University	2	46	The draft refers to management of hearing loss but is does not specifically state whether this is restricted to hearing aid fittings or management in the wider sense	Thank you for your comment. The guideline will include several aspects of management including medical management and alternative strategies to hearing aids.
105	SH	Evident	2	46	It may be useful to discuss the UK current position on screening for hearing loss.	Thank you for your comment. This guideline will not cover screening. Population screening is covered by the National Screening Committee.
106	SH	Evident	2	46	Management of Hearing loss should also include patient follow up, since this is an area of key importance.	Thank you for your comment. We have included the question below on follow up of patients: - How and when should people with hearing-related communication needs (including those with hearing aids) be monitored and followed up?
180	SH	University of Southampton	2	46	It is worth clarifying earlier in the document than is currently the case that the scope of the document includes sudden sensorineural hearing loss should be included in the scope of the document, as is made clear later on e.g. in 3.3 and 4.4, e.g. by stating clearly this is within remit within section 1.3. This is an excellent opportunity to tighten up on the very varied practice of how primary care professionals deal with sudden hearing loss in terms of consideration for immediate ENT treatment/steroids etc.	Thank you for your comment. We do not think it is necessary to include this level of detail in section 1.3 – there are specific review questions in section 1.5 on sudden-onset sensorineural hearing loss so it is clear that the scope covers this topic and considers it a priority.
211	SH	British Society of Hearing Aid Audiologists	2	46	Additional coverage: a) Hearing and cognition should be another key areas for it is important to recognise the	Thank you for your comment. a) Hearing and cognition does not come

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					direct/indirect effects of hearing issues on overall cognitive status of individuals in light of recent evidence and reference to this elsewhere in this document. b) Advocacy for better hearing in general public via both prevention and appropriate management of hearing loss should be another key area. WHO recently produced statistics indicating that there are 1.1 billion young people between the ages of 12 and 35 years, who are at risk of noise induced hearing loss due to unsafe listening habits	under the key areas because it is not a step in the pathway. The group will be covered but Key Areas refers to particular pathway steps. b) The remit of the guideline only includes assessment and management (tertiary prevention). Therefore primary prevention is beyond the scope of this guideline.
210	SH	British Academy of Audiology	2	46	The draft refers to management of hearing loss but is does not specifically state whether this is restricted to hearing aid1fittings or management in the wider sense	Thank you for your comment. The guideline will include several management strategies including medical management and alternative strategies to hearing aids.
15	SH	British Society of Audiology	2	47	Initial assessment requires clarification so that it may be interpreted as the patients first point of contact for hearing assessment rather than point of entry to a new pathway (by professional or within a setting). Change bullet point wording to: *'Initial Assessment (first point of contact)'*	Thank you for your comment. The section heading has been amended to 'Initial assessment (first presentation) and triage'
45	SH	NIHR Nottingham Hearing Biomedical	2	47	It is not clear what initial assessment refers to. On first reading it suggested this was 'initial hearing assessment', typically used to refer to the first hearing assessment in audiology. This then throws uncertainty on ln 49. Then	Thank you for your comment. The section heading has been amended to 'Initial assessment (first presentation) and triage'

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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		Research Unit			Section 4.1 refers to primary care. Suggested wording for ln 47: Initial hearing assessment in primary care	
146	SH	Royal College of general Practitioners	2	47	Can the whisper test, which is often used in people with cognitive impairment including people with intellectual disabilities in primary care and dementia, be evaluated?	Thank you for your comment. We will take this into consideration when formulating and agreeing the clinical questions with the guideline committee.
16	SH	British Society of Audiology	2	48	What does 'specialist care' mean? It would be helpful to offer some examples.	Thank you for your comment. In the context of this guideline, specialist care refers to care provided by a specialist, for example an audiologist, ENT surgeon or audiovestibular physician.
46	SH	NIHR Nottingham Hearing Biomedical Research Unit	2	48	What does 'specialist care' mean? Offer some examples.	Thank you for your comment. In the context of this guideline, specialist care refers to care provided by a specialist, for example an audiologist, ENT surgeon or audiovestibular physician.
85	SH	University of Southampton	2	48	Scope to consider appropriate referral to AQP and non AQP pathways	Thank you for your comment. Service organisation and delivery is outside the scope of this guideline. The scope now includes a the following question: - Which causes of hearing difficulty can be identified and treated by direct access audiology services (currently known as the 'any qualified provider' [AQP] scheme?

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						Please note these questions are draft and may be subject to change following consideration by the guideline committee during the development phase.
17	SH	British Society of Audiology	2	49	Change in wording in order to acknowledge the holistic assessment required in Audiology (to enable identification of individual need) – we consider it important that the scope of assessment is recognised as involving more than hearing tests. Change bullet point wording to: • *Holistic* assessment in audiology(community or secondary care settings)* ** including identification of individual communication needs*	Thank you for your comment. The scope does make it clear that individual communication needs are included. Further detail on assessment is provided in section 1.5 in the question on assessment of hearing and communication needs as follows: - How should hearing and communication needs be assessed? For example, history, examination, pure tone audiometry, tympanometry, speech and hearing in noise tests, needs and goal-setting (individual management plans). Please note these questions are draft and may be subject to change following consideration by the guideline committee during the development phase.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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18	SH	British Society of Audiology	2	51	It would be helpful to elaborate that management of hearing loss may include non-surgical medical treatment and rehabilitation by Audiology (surgical management is explicitly excluded in the scope). A key element of management of hearing loss is through rehabilitation which encompasses the majority of clinical activity relating to the scope title. Also the project will need to consider the large body of work relating to the theory and practice of rehabilitation relevant to this patient group. It would be helpful if the scope reflected this by reference to rehabilitation. To reflect this a change to bullet point wording is required to: '*Management of hearing loss (including treatment by secondary medical care and rehabilitation by Audiology)'*	Thank you for your comment. The scoping document is clear that rehabilitation is covered and further detail is provided in section 1.5 key issues and questions. These include: - What tools (for example, patient-centred decision aids) help people with hearing loss choose between different management strategies, including: (combinations of) hearing tactics, lip reading, hearing aids, assistive listening devices, communication training, counselling? - What are the information, support and advice needs of people with hearing loss and their families and carers? Rehabilitation is offered within secondary medical care as well as within 'Audiology' therefore we think the general heading of management followed by the specific areas within section 1.5 is clearer. Please note these questions are draft and may be subject to change following consideration by the

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						guideline committee during the development phase.
86	SH	University of Southampton	2	51	Clarify that initial and ongoing management of HL are key areas to highlight the importance of access to ongoing support after the initial management.	Thank you for your suggestion. We feel that ongoing management is covered implicitly and does not need to be made explicit. There are questions on ongoing support and management in section 1.5 which illustrate that access to ongoing support is a priority for this guideline.
147	SH	Royal College of general Practitioners	2	51	Can you ensure the removal of impacted ear wax for ambulatory and house bound patients in primary care is covered, including recommendations about equipment, consent requirements, minimum skills and experience and maximum frequency? Can the guideline also cover prevention of recurrence of ear wax? Could non health care professionals such as hairdressers and barbers be trained to provide these services? There is a useful review http://clinicalevidence.bmj.com/x/systematic-review/0504/overview.html This audit from Nigeria highlights the dangers of cotton buds http://www.alliedacademies.org/articles/clinical-profile-and-management-audit-of-ear-wax-impaction-in-owerri-south-east-nigeria.pdf. Can cotton buds have a health warning on them to avoid use in the ears?	Thank you for your comment. The guideline will cover the management of ear wax following feedback from stakeholders. There is now an additional question on 'How should earwax be treated?' Workforce and staffing issues are outside the scope of the guideline, as is the issue of health warnings on cotton buds. Please note these questions are draft and may be subject to change following consideration by the guideline committee during the development phase.
99	SH	Portsmouth	2	49 and 50	For consistency in the document, perhaps 'tertiary care'	Thank you for your comment the scope has been

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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		Hospitals NHS Trust			should be included here.	amended to make this clearer.
157	SH	National Community Hearing Association	3	59-66	We welcome the proposal that NICE will review economic aspects when making recommendations and that it will develop an economic plan for each review question. We would ask that NICE consider seeking advice from a health economist specialising in evaluating medical devices – a complicated area of economic evaluation due to different market access and licence conditions compared to medicines. Having studied the literature and sector in detail we would ask the health economist to note: • studies make different assumptions about continued hearing aid use and this can have a significant impact on the incremental cost-effectiveness ratio (ICER). In England there are different models of hearing care, that incentivise different behaviours, and these are likely to have an impact on continued use of hearing aids and the ICER – i.e. several of the questions posed by NICE will require detailed methodological examination to manage the risk of inappropriate generalisation and/or transferability • England has a unique purchasing model for hearing technology and hearing care, and this is likely to limit what can be generalised/transferred from the international literature. NICE recommendations might	Thank you for your comment and suggestions. Areas of particular economic importance and uncertainty will be discussed and prioritised by the guideline committee. During both the literature review of economic evidence and the potential original economic modelling the health economist will be working closely with the guideline committee to ensure that any considered evidence is relevant and applicable to the NHS. More information on the guideline development methods can be found in Developing NICE guidelines: the manual (NICE, 2014)

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					also have a fundamental impact on the ICER – for example the supply chain in England is dependent on a high volume, high spec, low marginal cost model and any treatment threshold that impacts volume is likely to have an impact on marginal cost of hearing aids and therefore the ICER. This is a complex market as the health economics literature will show • age-related hearing loss accounts for the vast majority of hearing aids fitted in the NHS. Age-related hearing loss is a long-term and slowly progressive condition. Economic analysis – unless funded independently – might extrapolate benefit without any sensitivity analysis for drop off in effect over a reasonable horizon, e.g. the cost of re-examination at year x might not be included but the benefit might extend into the future beyond year x • there are multiple funding models in England for NHS hearing care, some more transparent than others – e.g. packages of care with a fixed three *or* five year price and clear service specification, non-mandated tariff with variable marginal costs per patient over the three year care pathway with/without a service specification, and opaque cost-per case and block contracts. There is extensive market failure due to asymmetric information between purchasers and providers on prices, and many stakeholders – wrongly – believe that the non-mandated tariff price is the baseline price for analysis. In fact the package of	

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					care pathway/price is likely to dominate the non-mandated pathway/price in any economic analysis – and given the non-mandated price is derived by yardstick competition from reference cost data from hospital providers, a robust economic analysis is likely to show that community hearing care cost less per case and, other things being equal, is more cost-effective than care provided in hospital settings. For an example of variation in transparency, cost, access and standards see Monitor's (now NHS Improvement) review of adult hearing service[ix] • there is significant uncertainty in any ICER analysis due to generic instruments – most notably EQ5D – lacking sensitivity to hearing loss • that economic literature in this field might relate to old technologies (e.g. analogue hearing aids or early generation digital aids) and this is not always taken into account when analysing the literature. This is important because over time treatment thresholds have changed from c. 45dB HL in the 1980s to c. 25dB HL post 2000. This has largely been driven by changing need – e.g. more demanding and listening environments – and improved technology. This will therefore have a significant impact on the economic questions NICE has proposed. In terms of scale – based on NCHA analysis, controlling for age and gender – in 2014 8.8 million adults had a hearing loss of 25dB HL in the better ear, c.3 million had a hearing	

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					loss of 45dB HL in the better ear[x]. Some subject matter experts, including some Global Burden of Disease collaborators, are now arguing for treatment thresholds to be lowered to 20dB HL which we estimate would equate to 11.5 million people in England. NICE will, from its review questions, come across this politically sensitive issue. We have confidence that NICE will apply the highest standards of research and analysis to help the NHS effectively utilise its resources.	
23	SH	British Society of Audiology	3	80-82	Questions and 2.1 and 2.2 would essentially be considering the same issue. Suggest combined questions 2.1 and 2.2 to provide following: *'What are the criteria for referral to Audiology, AVM or ENT to ensure safe, effective and efficient care?*	Thank you for your comment. The scoping group have considered the feedback from stakeholders and agreed that question 2.2 should be kept as it clarifies non-urgent red flags for referral. Question 2.1 has been modified to: - Which causes of hearing difficulty can be identified and treated by direct access audiology services (currently known as the 'any qualified provider' [AQP] scheme?**'** We believe this change differentiates the two questions sufficiently and clarifies the main issues.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						Please note these questions are draft and may be subject to change following consideration by the guideline committee during the development phase.
20	SH	British Society of Audiology	3	75-76	Question 1.3 is quite narrow and could be expanded to provide answers that would be more useful in practice. The objective of the referral is to receive treatment rather than refer to a specialist, although this may be a common outcome dependent upon skills available at the initial assessment. Suggested wording: *'What surveillance is required to allow for the early recognition of hearing loss potentially requiring urgent treatment. '*	Thank you for your suggestion. The wording of the questions within the scope is provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee.
21	SH	British Society of Audiology	3	77-78	As currently worded question 1.4 may infer that measurement or identification of hearing loss is the key aim, whereas the primary objective should be to identify hearing loss of significance to the individual and their communication partners. Change to wording: *'How can hearing related communication needs be identified.....'*	Thank you for your comment. Following discussion the scoping group decided that this question should be changed as follows: - In whom should hearing loss be suspected? For example people with dementia, mild cognitive impairment and learning difficulties. Please note the wording of the questions within the scope is provided as a guide to the areas to

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						be covered. The clinical questions will be refined and finalised by the guideline committee
22	SH	British Society of Audiology	3	77-78	It is not clear why mild cognitive impairment would be raised here and not those with major cognitive impairment. It could be argued that their needs are even greater. Suggest amendment: *1.4 How can hearing loss be identified in people with complex needs such as those with cognitive impairment, dementia and intellectual disabilities?*	Thank you for your comment. Following discussion the scoping group decided that this question should be changed to 'In whom should hearing loss be suspected? For example people with dementia, mild cognitive impairment and learning difficulties'. The scoping group feels that it is appropriate to use the term mild cognitive impairment as it is a recognised medical term that precedes dementia. Please note the wording of the questions within the scope is provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee
47	SH	NIHR Nottingham Hearing Biomedical Research Unit	3	77-78	Question 1.4 may suggests that measurement or identification of hearing loss is the key aim, whereas the primary objective should be to identify hearing loss of significance to the individual and their communication partners. Change to wording: 'How can hearing related communication needs be identified.....'	Thank you for your comment. Following discussion the scoping group decided that this question should be changed to 'In whom should hearing loss be suspected? For example people with dementia, mild cognitive impairment and learning difficulties'.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						Please note the wording of the questions within the scope is provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee
126	SH	University of Manchester	3	80-81	Suggest combing into 1 question: How should primary care physicians decide who should be referred direct to Audiology and who should be referred to an audio-vestibular physician/ENT?	Thank you for your comment. The scoping group have considered the feedback from stakeholders. The first question has been modified to: - Which causes of hearing difficulty can be identified and treated by direct access audiology services (currently known as the 'any qualified provider' [AQP] scheme? The second question remains the same: - Who should be referred to audiovestibular medicine or ear, nose and throat (ENT) surgery for medical assessment? There is now a separate question on 'Which causes of hearing difficulty can be identified and treated in primary care?' which has the implication that anything that cannot be identified and treated in primary care should be referred on. We believe this change differentiates the two questions

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						sufficiently and clarifies the main issues. Please note the wording of the questions within the scope is provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee
158	SH	National Community Hearing Association	3	81-82	In developing this guideline we think it is important for NICE to give special consideration to workforce and physical capacity in the NHS. Given the structure of the committee we would ask that throughout the guideline development – whenever economically feasible – NICE relies on positive analysis, rather than normative analysis, when answering questions that are influenced by the workforce and/or physical capacity. For example: *"Who should be referred to audiovestibular medicine or ear, nose and throat (ENT) for medical treatment?"* could be rephrased in our view to *"Who should be referred for medical treatment – e.g. from ear, nose and throat (ENT), audiovestibular medicine or other specialist?"* This is because the number of audiovestibular physicians	Thank you for your comment. We will pass this on to the guideline committee to consider when refining the clinical questions and considering the evidence.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					in England has been in decline for some time and despite attempts by the Royal College of Physicians (RCP) in 2007 to increase the number of consultants by 326% by 2016, the number actually fell by 32% to 32 in 2015[xi]. Also, in our view, it is the indication for medical care that should determine referral, if necessary, following triage in primary/community care (which will account for the vast majority of presentations) rather than vice versa.	
100	SH	Portsmouth Hospitals NHS Trust	3	55	What is the definition of 'Acute' and 'Temporary' in the context of traumatic head injury? How long should one wait after head injury before deciding an associated hearing loss in NOT temporary?	Thank you for your comment. It would be up to local services to decide when hearing loss after head injury is permanent and not temporary.
212	SH	British Society of Hearing Aid Audiologists	3	55	Consider changing the language to traumatic perforation of ear drum for 'head injuries' can result in a permanent hearing loss that may be of both cochlear and retro-cochlear origin (auditory processing and auditory neuropathy issues), which require audiology attention.	Thank you for your comment. The guideline is only concerned with permanent hearing loss. Temporary hearing losses after all manner of head injuries will not be covered.
107	SH	Evident	3	58	Whilst it may not be prudent to discuss surgical management of hearing loss in detail, it may be helpful to identify that surgical options exist and can be effective. For example Cochlear Implant for presbyacusis, Stapedectomy or Bone Anchored Hearing Aids for Otosclerosis etc.	Thank you for your comment. Surgical management is outside the scope of this guideline. However other NICE guidelines including Cochlear implants for children and adults with severe to profound deafness (2009) NICE technology appraisal guidance TA166, and Auditory brain stem implants (2005) NICE interventional procedure IP108, will be signposted

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						in the final NICE pathway that will be available on the website.
108	SH	Evident	3	59	It would be useful to have an evaluation of the economic considerations for a national screening program for adult onset hearing loss.	Thank you for your comment. Screening for hearing loss is outside the scope of the present guideline. Conditions that qualify for national screening are instead examined by the National Screening Committee.
148	SH	Royal College of general Practitioners	3	59	Can the economic impact on primary care of treating impacted ear wax be evaluated and the projected for the next 10 years? It is clearly significant as found in other countries such as Oman. http://www.ncbi.nlm.nih.gov/pubmed/17478958	Thank you for your comment. The resource impact of all potential recommendations will be examined during the guideline development stage and areas of high impact will be flagged.
19	SH	British Society of Audiology	3	70	Initial assessment requires some clarification as it may be interpreted as the patients first point of contact regardless of setting or professional. (as above) Change bullet point wording to: *'Initial Assessment (first point of contact)'*	Thank you for your comment. The wording of this heading in the scope has been changed to 'Initial assessment (first presentation) and triage' to make this clear.
109	SH	Evident	3	71	In terms of audiological assessment in primary care, it would be helpful to review the hearing screening tools available and whether these should be routinely used for assessment.	Thank you for your comment. Screening is not within the scope of this guideline but a review of assessment tools used in primary care will be considered and may include these tests if the guideline committee thinks it appropriate.
137	SH	Hearing Link	3	71	It is important to agree where self-assessment of communication and relationship impact will be included,	Thank you for your comment. The patient's concerns will be raised at initial presentation and

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					ie are these best considered as audiological assessments, or clinical history? Unless this is done, there is a risk their value will not be fully appreciated in differential diagnosis and decision-making about onward referral.	this forms part of the clinical history overall assessment process for the purposes of this guideline.
187	SH	Action on Hearing Loss	3	71	The guideline should cover practices and screening questions that can be used in primary care as well as strictly audiological assessments – for example simply asking someone about their hearing, encouraging people to seek help, and providing written information can increase the numbers of people seeking help. Many non-audiological tests are used in primary care, such as a tuning fork or whisper test, and there is no consistency in which are used, so it would be very beneficial if this guideline could collate and summarise the evidence and give recommendations for what tests or screening tools GPs and other non-audiological health and social care professionals should use. This line should therefore be changed to: 'What practices, screening questions and assessments in addition to clinical history and examination should be carried out in primary care?'	Thank you for your comment. The guideline committee will consider initial assessment in general practice.
70	IND	IND	3	72	Add 'and AQP schemes'. This is possibly an important issue!	Thank you for your comment. Adjustments have been made to the scope and it now includes the following question on assessment and treatment by AQP providers: - Which causes of hearing difficulty can be identified and treated by direct access

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						audiology services (currently known as the 'any qualified provider' [AQP] scheme?
188	SH	Action on Hearing Loss	3	73	The mention of which causes of hearing loss can be identified and treated in primary could make specific mention of the management of ear wax, for which there is often not a well-defined local pathway (as is noted later in the scope).	Thank you for your comment. The guideline will cover the management of ear wax following feedback from stakeholders and there is now an additional question on 'How should earwax be treated?' Please note the wording of the questions within the scope is provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee.
7	NICE	Social Care	3	77	This could read as though people with more severe cognitive impairments are excluded – given it would also be difficult to identify hearing loss in this group why would that be the case? – Surely they should be included also.	Thank you for your comment. This question has been changed to 'In whom should hearing loss be suspected? For example people with dementia, mild cognitive impairment and learning difficulties.' The scoping group feels that it is appropriate to use the term mild cognitive impairment as it is a recognised medical term that precedes dementia. Please note the wording of the questions within the scope is provided as a guide to the areas to

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						be covered. The clinical questions will be refined and finalised by the guideline committee.
110	SH	Evident	3	77	It would also be helpful to consider how hearing services should be set up alongside mild cognitive impairment/dementia services, as this is essential for addressing this population of patients.	Thank you for your comment. The organisation and delivery of hearing loss services is outside the scope of this guideline.
125	SH	University of Manchester	3	77	Suggest re-wording: How can we ensure that hearing loss is not over-looked in people with mild cognitive impairment, dementia and learning difficulties?	Thank you for your comment. This question has been changed to 'In whom should hearing loss be suspected? For example people with dementia, mild cognitive impairment and learning difficulties.' Please note the wording of the questions within the scope is provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee.
189	SH	Action on Hearing Loss	3	77	This line asks how hearing loss is diagnosed in people with dementia. This should be widened to include people with other conditions that would affect diagnosis and management and who may need alternative forms of support - such as tinnitus, vestibular disorders, learning disabilities, dementia and sight loss. It should also cover what specialist management as well as diagnosis is needed for these groups. We'd recommend either listing these conditions by saying 'How can hearing loss be identified and managed in people with other conditions such as tinnitus, vestibular disorders, learning disabilities,	Thank you for your comment. This question has been changed to 'In whom should hearing loss be suspected? For example people with dementia, mild cognitive impairment and learning difficulties.' This is not an exhaustive list so the additional examples you mention may be identified in the review. The committee will consider the different needs of these groups when reviewing the evidence and

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					dementia or sight loss'.	making recommendations. Please note the wording of the questions within the scope is provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee.
87	SH	University of Southampton	3	78	Other comorbidities such as visual impairment are not mentioned.	Thank you for your comment. This question has been changed to 'In whom should hearing loss be suspected? For example people with dementia, mild cognitive impairment and learning difficulties.' This is not an exhaustive list so the additional examples you mention may be identified in the review. Please note the wording of the questions within the scope is provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee.
88	SH	University of Southampton	3	80	In addition scope to clarify who should be referred via the AQP pathway and who through the complex adults (non AQP) pathway.	Thank you for your comment. Service organisation and delivery is outside the scope of this guideline. The scope now includes a question on 'Which causes of hearing difficulty can be identified and treated by direct access audiology

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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						services (currently known as the 'any qualified provider' [AQP] scheme?' Please note the wording of the questions within the scope is provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee
138	SH	Hearing Link	3	80	The guideline should also recognise that referral direct to audiology services has in the past been made successfully from non-primary care (eg direct public access), and it would be timely to re-evaluate this route.	Thank you for your comment. Service organisation and delivery is outside the scope of this guideline.
190	SH	Action on Hearing Loss	3	80	A key issue should be added 'How to ensure appropriate triaging and referral pathways between primary care, audiology and ENT' – as well as the question of who should be referred, there is an issue in many areas around making sure all parties are aware of referral procedures and these are effectively followed, to ensure the patient gets the best care and resources are not wasted through wrong referrals and wasted appointments.	Thank you for your comment. This issue would fall under service organisation and delivery which is outside the scope of this guideline.
124	SH	University of Manchester	3	53 & 54	Suggest defining 'hearing loss' as hearing thresholds levels better than 25 dB HL between 250 Hz and 8000 Hz.	Thank you. Your comments will be considered by the guideline committee.
9	NICE	Social Care	4	General	Following on from the comment immediately above – should there be a question about how to take into account people's social circumstances when assessing their needs and determine the right treatment/response	Thank you for your comment. We will pass this on to the guideline committee for consideration when reviewing the evidence and making the

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					for them?	recommendations.
25	SH	British Society of Audiology	4	85-88	3.1 whilst it is recognised that the lists of tests is not intended to be exhaustive, it is recommended that electrophysiological tests be included here (a key category of diagnostic hearing test, particularly in those unable/unwilling to carry out more standard tests). *3.1 How should hearing and individual communication needs be assessed? For example, history, examination, pure tone audiometry, tympanometry, electrophysiological tests, speech and hearing in noise tests, patient-reported quality of life, needs and goal-setting (individual management plans).*	Thank you for your comment. As you have noted, the list is not intended to be exhaustive and is provided as an example of the tests to be considered. The committee will determine which tests will be considered, in high street providers or community settings and advise accordingly.
26	SH	British Society of Audiology	4	85-88	3.1 is a expansive question – it may be better to split into 2 questions, one directed at hearing and one at assessing individual needs.	Thank you for your comment. The committee will consider this when refining the review question.
28	SH	British Society of Audiology	4	89-92	With a minor amendment, question 3.2 would cover question 3.3 We suggest that question 3.3 is deleted and 3.2 amended to: *'Which tests and investigations should be used in medical services to assess the underlying case of hearing loss including sudden onset sensorineural hearing loss.'*	Thank you for your comment. The tests and investigations may be different. The scoping group agreed to keep the questions separate to recognise the particular issues and importance of identifying the cause sudden-onset sensorineural hearing loss in the scope.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
129	SH	University of Manchester	4	89-92	Suggest combining questions: which tests and investigations should be used in medical services to assess the underlying cause of hearing loss, including sudden-onset sensorineural hearing loss?	Thank you for your comment. The tests and investigations may be different. The scoping group agreed to keep the questions separate to recognise the particular issues and importance of identifying the cause of sudden-onset sensorineural hearing loss in the scope.
51	SH	NIHR Nottingham Hearing Biomedical Research Unit	4	98-99	Should be made clear this refers to both pre- and post-clinical assessment/intervention.	Thank you for your comment. The scoping group considers that it is important that hearing loss is identified first.
52	SH	NIHR Nottingham Hearing Biomedical Research Unit	4	100-101	In addition to '1 vs 2 aids', this question should be extended to include "What is the effectiveness and cost-effectiveness of hearing aids?' in light of some CCGs considering restricting hearing aid provision to those with mild and /or moderate hearing loss.	Thank you for your comment. The scoping group did not consider this issue to be a priority for the guideline to address.
53	SH	NIHR Nottingham Hearing Biomedical Research Unit	4	104-105	Although hearing aids are the main management option of people with adult onset hearing loss, other devices, such as Bone anchored hearing aids and cochlear implants should also be considered.	Thank you for your comment. Due to the wide scope of this guideline and the limited time and resources this question was not prioritised by the scoping group. The guideline will signpost to the Cochlear implants for children and adults with severe to profound deafness (2009) NICE technology appraisal guidance TA166, and Auditory brain stem implants (2005) NICE interventional procedure IP108.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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161	SH	National Community Hearing Association	4	91-92 and 102-103	Idiopathic sudden-onset sensorineural hearing loss is featured in this scope, but age related and noise induced hearing loss are not mentioned. Given over 95% of people that present with hearing loss are likely to have age-related hearing loss, noise-induced hearing loss or earwax, whereas only 0.005% to 0.02% of the population might have idiopathic sudden-onset hearing loss[xii] and there is already guidance on this topic by the American Academy of Otolaryngology head and neck surgery[xiii], we are concerned that there is a disproportionate emphasis on this condition. We have the following questions: Is the focus on this condition consistent with lines 57 and 58 of the draft scope? Is this a condition being prioritised by an interest group or a committee member with a special interest? Is this a case of falling into the old 'sub-specialty' magnification trap? We would ask the committee to consider whether they might instead consider medical and non-medical causes of hearing loss as useful typologies when carrying out their research. This should, to a large extent, determine whether a person is referred to an audiologist (non-medical) or ENT/audiovestibular doctor (medical) and thus help address other questions raised.	Thanks for your comment. Age-related and noise-induced hearing loss are covered implicitly and we did not think it necessary to make this explicit. Sudden-onset sensorineural hearing loss was considered important to highlight separately because of the particular issues and urgency relating to this condition. It is not possible to refer to other non-NICE guidance within NICE guidelines and the scoping group felt there is a need for NICE guidance on this topic. Referral to medical/non-medical services is covered by the following questions: - Which causes of hearing difficulty can be identified and treated in primary care? - Who should be referred to audiovestibular medicine or ear, nose and throat (ENT) surgery for medical assessment? - Which causes of hearing difficulty can be identified and treated by direct access audiology services (currently known as the 'any qualified provider' [AQP] scheme? Please note the wording of the questions within the scope are provided as a guide to the areas to

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						be covered. The clinical questions will be refined and finalised by the guideline committee.
24	SH	British Society of Audiology	4	83	Change in wording in order to acknowledge the holistic assessment approach used in Audiology (to enable identification of individual need) – this is more than about a hearing test. (as above) Change bullet point wording to: • *Holistic* assessment in audiology(community or secondary care settings)* ** including identification of individual communication needs*	Thank you for your comment. We do not feel it is necessary to include this level of detail in the heading.
127	SH	University of Manchester	4	83	Suggest adding the following questions: • To which services should audiology to able to directly refer patients? • What aspects of history taking should be included in an assessment?	Thank you for your comment. The first issue you raise would fall under service organisation and delivery, which is outside the scope of this guideline. History taking is included within assessment questions and will be considered by the committee. The second issue was not considered by the scoping group to be a priority for the guideline to address.
213	SH	British Society of Hearing Aid Audiologists	4	83	Classification of hearing loss in different categories, should added here as currently used classification system only involves using pure tone audiogram (PTA) results whereas true hearing ability may only be reflected by a combination of measures.	Thank you for your comment. The current classification system uses a battery of tests. The guidelines will advise on the most effective 'combination of measures' or battery of tests.
8	NICE	Social Care	4	85	Having referred to people with cognitive impairments	Thank you for your comment. We can confirm that

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					above, no reference is made to that when looking at the assessment of hearing and communication	this will be included on our reviews. The current questions in the scope are draft top line questions and not an exhaustive list.
89	SH	University of Southampton	4	85	There is scope to refer more explicitly to the 4 guiding principles outlined in the British Society of Audiology Guiding Principles for adult aural rehabilitation (2012) and utilise the terminology used which describes a more collaborative approach including the communication partner. A key issue is how these guiding principles can be incorporated into audiological assessment and rehabilitation.	Thank you for your comment. It is not possible to refer to non-NICE guidance within the guideline.
128	SH	University of Manchester	4	85	Suggest splitting question: • How should hearing loss be diagnosed? • How should communication needs be assessed?	Thank you for your comment. The scoping group felt it is appropriate to keep these 2 questions together, but the suggestion has been noted and will be considered by the guideline committee.
214	SH	British Society of Hearing Aid Audiologists	4	85	The majority of individuals present with communication difficulties, (e.g. difficulty of understanding conversations in a noisy environment), not hearing difficulties per se. Current assessment based on the PTA is limited as a tool in evaluating the problem presented by the individual. Greater emphasis should be placed on the ability of the chosen evaluation methods to address the problem and offer the most applicable support interventions. Current understanding of evidence is relatively weak and inhibits takeup of more meaningful assessment tools.	Thank you for your comment. The guideline committee will consider this when reviewing the evidence.
48	SH	NIHR Nottingham	4	87	'tests' or 'assessment' needs to be inserted after 'hearing in noise.	Thank you for your comment. This now reads

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
		Hearing Biomedical Research Unit				'speech and hearing in noise tests'.
49	SH	NIHR Nottingham Hearing Biomedical Research Unit	4	88	Other means of assessment such as 'involvement of communication partners and readiness or motivation to take action (i.e an intervention)' should be included as recent research suggests these are important in help-seeking, takeup and use of hearing aids.	Thank you for your comment. It is not the intention of the proposed question to address this issue. The scoping group considered that this is part of consideration by a specialist rather than for recommendations for the GP.
120	SH	Sense	4	89	Addition of: 'when assessing communication needs, what non-audiological information (such as additional vision impairment) should be obtained'?	Thank you for your comment. The particular needs of people with sight loss and hearing loss will be considered as part of the equality impact assessment therefore a separate question is not required.
215	SH	British Society of Hearing Aid Audiologists	4	89	The subject under consideration here should also consider who can order these investigations. For example, some NHS departments are successfully using audiologists to order MRI for asymmetrical hearing loss. This saved precious time of both ENT team members and patients	Thank you for your comment. Workforce considerations and the roles and responsibilities of staff involved in delivering hearing loss services is outside of the scope of this guideline.
77	SH	ENT UK	4	91	Suggest we specify both unilateral and bilateral sudden sensorineural loss as the investigation and management differs between the two.	Thank you for your comment. The committee will consider both unilateral and bilateral sudden sensorineural hearing loss.
90	SH	University of Southampton	4	93	The draft scope doesn't consider how candidacy for hearing aids should be determined. We feel this is important to address current inconsistencies in provision.	Thank you for your comment. The scoping group did not consider this issue a priority for the guideline to address. However the guideline does

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						include a question on tools to help people decide between the different management strategies available including hearing aids.
130	SH	University of Manchester	4	93	Suggest adding questions: • What is the evidence behind different management strategies? • What constitutes patient centred care and which components of patient centred care are supported by an evidence-base? • How does choice of hearing aid prescription effect patient outcomes? • What is the clinical and cost-effectiveness of using Real Ear Measures when verifying hearing aid fittings? • What is the clinical and cost-effectiveness of noise management technologies? (E.g. FM, ALDs, Hearing aid features). • What dimensions of effectiveness should be measured, what tools should be used, and when should they be used? • Which outcome measures are most appropriate for each patient group? • What patient characteristics would indicate a unilateral fitting in the first instance and when would a change to bilateral fitting be most appropriate? • What are the key components of a hearing aid	Thank you for your comment and suggested additional questions. These will be noted and considered by the guideline committee if they fall within the scope of the guideline and emerge from any of the questions listed in the scope document.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					fitting which ensure a successful outcome for the patient (e.g. time spent with patient, written information, verbal information, verification approach, measurement outcome, group rehab, family support, qualification of audiologist/hearing aid dispenser).	
134	SH	University of Manchester	4	93	Suggest new question: What tools and management strategies are available to adults who have a hearing loss?	Thank you for your suggestion. This question is already covered by the following question: - What tools (for example, patient-centred decision aids) help people with hearing difficulty choose between different management strategies, including: (combinations of) hearing tactics, lip reading, hearing aids, assistive listening devices, communication training, counselling? Please note the wording of the questions within the scope are provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee
149	SH	Royal College of general Practitioners	4	93	Can the supply of hearing aid batteries be clarified as currently there is an administrative burden on practices as they store and supply batteries?	Thank you for your comment. The scoping group did not consider this issue a priority for the guideline to address.
50	SH	NIHR	4	97	Include 'Bone anchored hearing aids' and 'cochlear	Thank you for your comment. This topic was not

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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		Nottingham Hearing Biomedical Research Unit			implants' – see point 15 also.	considered by the scoping group to be a high priority for the guideline to address as it would not affect a large number of people as implantable devices are not standard issue. This guideline will cross-refer to related NICE guidance where available.
191	SH	Action on Hearing Loss	4	98	Another question should be added here to examine the evidence behind a practice that happens in some areas where complex patients have access to different support options compared with non-complex patients. Add: 'What support and equipment should be available to patients with complex or non-complex hearing loss?'. This will allow the group to examine any evidence of particular equipment or support being more beneficial for one group compared with another.	Thank you for your comment. The guideline has included a question on support and information needs and will be considered as part of this where the information is available.
192	SH	Action on Hearing Loss	4	99	Reference should be made here to the NHS England Accessible Information Standard, which requires all NHS services (including audiology) to identify, record, share and meet the communication needs of people with hearing loss, sight loss and learning disabilities. We suggest adding another point to ask 'What will services need to do to meet the NHS Accessible Information Standard'.	Thank you for your comment. We do not feel it is necessary to reference the NHS England Accessible Information Standard in the scope as this would fall under service delivery which is outside the scope of this guideline.
29	SH	British Society of Audiology	4	100	4.3 Improvement to wording (effectiveness currently occurs twice in sentence, and no mention of clinical effectiveness)	Thank you for your suggestion. This has been changed in the scope document.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					4.3 What is the clinical and cost effectiveness of 1 hearing aid compared with 2.	
91	SH	University of Southampton	4	100	We feel it would be helpful to evaluate the clinical effectiveness of different approaches to hearing aid fitting e.g. auto fit, real ear measurements, speech mapping etc.	Thank you for your comment. The scoping group did not consider this issue a priority question for the guideline to address.
131	SH	University of Manchester	4	100	Suggest re-wording: Are there any patient populations who should not be considered for 2 hearing aids?	Thank you for your comment. We feel the current wording of the question is adequate and the committee will review and finalise the question to be addressed.
216	SH	British Society of Hearing Aid Audiologists	4	100	The question about the evidence for unilateral versus bilateral hearing aid provision is important, but must be considered in the context of real-world benefits of confidence and wellbeing engaging in everyday activities.	Thank you for bringing this to our attention. We will pass this on to the guideline committee for consideration when reviewing the evidence and drafting the recommendations.
78	SH	ENT UK	4	102	Again specify unilateral and bilateral sudden loss as the treatment differs	Thank you for your comment. The question implicitly addresses both unilateral and bilateral sudden sensorineural hearing loss and the guideline committee will consider the issue you have raised when drafting the review protocol.
31	SH	British Society of Audiology	4	104	On-going hearing aid support (eg, access to help, self-management materials and volunteer peer support) may impact on sustained benefit following hearing aid fitting and is worthy of close scrutiny. Add question:	Thank you for your comment. Question 4.7 has been amended to the following, which addresses the point you have raised: - What is the clinical and cost effectiveness of aftercare to support continuing use of devices?

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					'What are the most clinically and cost effective means of providing on-going support for hearing aid use? '	Please note the wording of the questions within the scope are provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee
32	SH	British Society of Audiology	4	104	Whilst hearing aid provision is the most common intervention it would be useful to adjust the scope, expanding question 4.5 to look beyond only those patients fitted with hearing aids. Amendment of wording suggested: *'How and when should people with hearing related communication needs be monitored and followed up.?'*	Thank you for your comment. This change has been made and the question amended to: - How and when should people with hearing-related communication needs (including those with hearing aids) be monitored and followed up? Please note the wording of the questions within the scope are provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee
71	IND	IND	4	104	Delete the word 'prescribed' as it implies more accuracy in fitting that can be warranted.	Thank you for your comment. This question has now been amended to: - How and when should people with hearing-related communication needs (including those with hearing aids) be monitored and followed up? Please note the wording of the questions within

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						the scope are provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee
92	SH	University of Southampton	4	104	There is scope to consider how ongoing support post follow-up should be delivered. This is important for supporting self-management and longer term hearing aid use.	Thank you for your comment. Question 4.7 has been amended to the following, which addresses the point you have raised: - What is the clinical and cost effectiveness of aftercare to support continuing use of devices? Please note the wording of the questions within the scope are provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee.
33	SH	British Society of Audiology	4	106	Currently there is no question on the important issue of the fitting and verification of hearing aids. Add question: *'What are the optimal processes for the fitting and verification of hearing aids?'*	Thank you for your comment. The scoping group did not consider this issue a priority question for the guideline to address. However a question has been included on monitoring and aftercare to support use of devices which may include this issue,
34	SH	British Society of Audiology	4	106	Just looking at 2 features of hearing aid technology limits the scope and potential benefit. This is potentially an extensive question, but clinical practice would benefit on	Thank you for your comment. While we recognise that there may be other features of hearing aid

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					guidance on the most useful technologies from the range available. Suggest amended question: *'What are the most clinically and cost effective features of hearing aid technology?'*	technology that it would be useful to review, we need to limit the scope and it was felt that guidance in the 2 areas identified: hearing aid microphones and digital noise reduction technologies, would be the most useful as one of the main issues for people who use hearing aids is distracting background noise. These areas were therefore prioritised for inclusion within the guideline.
54	SH	NIHR Nottingham Hearing Biomedical Research Unit	4	106	The technologies mentioned here are very specific. There are increasingly new technological developments,generally named 'hearables' (currently a systematic review is assessing the quality of the evidence for these, and another horizon scanning review is looking at new and emerging technologies). The review should broaden this, so the guidance is up–to-date.	Thank you for your comment. While we recognise that there may be other features of hearing aid technology that it would be useful to review, we need to limit the scope and it was felt that guidance in the 2 areas identified (hearing aid microphones and digital noise reduction technologies) would be the most useful as one of the main issues for people who use hearing aids is distracting background noise. These areas were therefore prioritised for inclusion within the guideline.
55	SH	NIHR Nottingham Hearing Biomedical Research Unit	4	106	There is no question on the important issue of the fitting and verification of hearing aids. Suggest including this.	Thank you for your comment. The scoping group did not consider this issue a priority question for the guideline to address. However the issue may be picked up in the following questions:

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						- What is the clinical and cost effectiveness of aftercare to support continuing use of devices? - How and when should people with hearing-related communication needs (including those with hearing aids) be monitored and followed up?
93	SH	University of Southampton	4	106	In addition we feel that the provision of and clinical and cost effectiveness of blue tooth accessories for NHS digital hearing aids should be included. Current provision of these is highly variable being neither part of social services provision nor Audiology provision.	Thank you for your comment. The scoping group did not consider this issue a priority for the guideline to address.
132	SH	University of Manchester	4	106	Suggest rewording this question: What are the most clinically and cost effective features of generic DSP hearing aid features?	Thank you for your suggestion. The scoping group would prefer to keep the original wording of the question.
139	SH	Hearing Link	4	106	If the effectiveness of hearing aid technologies are to be investigated, then so too should the effectiveness of assistive technologies designed to be used with and without hearing aids	Thank you for your comment. We have added the following question to address the point you have raised: - What is the clinical and cost effectiveness of assistive listening devices (such as loops to support use of audiovisual devices)? Please note the wording of the questions within the scope are provided as a guide to the areas to

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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						be covered. The clinical questions will be refined and finalised by the guideline committee.
193	SH	Action on Hearing Loss	4	106	Another issue should be added here: 'What are the cost and clinical effectiveness of different ways to deliver aftercare (hearing aid maintenance and support)'. Our survey of audiology departments[1] found a great deal of variation in how aftercare was being delivered, and often patients say that more support would help, so an evidence-based recommendation on this would be very useful.	Thank you for your comment. Question 4.7 has been amended to the following, which addresses the point you have raised: - What is the clinical and cost effectiveness of aftercare to support continuing use of devices? Please note the wording of the questions within the scope are provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee.
30	SH	British Society of Audiology	4	108	Device provision is an intervention method yet question 4.7 implies that intervention methods do not include devices. Also, for clarification it would be helpful to provide some examples of interventions (instrumental and non-instrumental). Re-wording of question 4.7 is suggested to: *'What is the clinical and cost effectiveness of different*	Thank you for your comment. Question 4.7 has been amended to the following: 'What is the clinical and cost effectiveness of after care to support continuing use of devices?' to clarify the precise point we wish to address. Please note the wording of the questions within the scope are provided as a guide to the areas to

[1] Lowe, C (2015) Under Pressure: NHS Audiology across the UK, available at www.actiononhearingloss.org.uk/underpressure

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					instrumental interventions (hearing aids and assistive listening devices) and non-instrumental interventions (eg, hearing tactics, lip reading, communication training, counselling) for people with hearing related communication needs? Interventions may also vary in their efficacy as adjuncts for others. Subsequent sub-questions for the above could address: *'What package of interventions are most clinically and cost effective for people with hearing related communication needs?'*	be covered. The clinical questions will be refined and finalised by the guideline committee.
56	SH	NIHR Nottingham Hearing Biomedical Research Unit	4	108	'intervention methods' is unclear as hearing aids or other devices are interventions. Suggested wording: "..effectiveness of non-device methods (e.g. communication strategies, auditory training, lip reading, peer/volunteer support) and their impact on continuing use of hearing aids and other listening devices (e.g. assistive listening devices, BAHA, CI)".	Thank you for your comment. Question 4.7 has been amended to the following: 'What is the clinical and cost effectiveness of after care to support continuing use of devices?' to clarify the precise point we wish to address. Please note the wording of the questions within the scope are provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee.
72	IND	IND	4	108	After 'intervention methods' add e.g. ..... to give the reader some idea of what these are	Thank you for your comment. Question 4.7 has been amended to the following: 'What is the clinical and cost effectiveness of aftercare to support continuing use of devices?' to clarify the

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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						precise point we wish to address. Please note the wording of the questions within the scope are provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee.
133	SH	University of Manchester	4	108	Suggest replacing 'intervention' with 'management' for consistency.	Thank you for your comment. Question 4.7 has been amended to the following: 'What is the clinical and cost effectiveness of aftercare to support continuing use of devices?' to clarify the precise point we wish to address. Please note the wording of the questions within the scope are provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee.
194	SH	Action on Hearing Loss	4	108	Where it says 'intervention methods' here the scope could make clear that this means hearing aids, other technology, and other support.	Thank you for your comment. Question 4.7 has been amended to the following: 'What is the clinical and cost effectiveness of aftercare to support continuing use of devices?' to clarify the precise point we wish to address. Please note the wording of the questions within the scope are provided as a guide to the areas to

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						be covered. The clinical questions will be refined and finalised by the guideline committee.
94	SH	University of Southampton	4	109	The draft scope doesn't consider what outcome measures should be used to evaluate the quality of provision.	Thank you for your comment. The list of outcomes in the scope is not an exhaustive list. The guideline committee will finalise this list based on the final list of clinical questions.
121	SH	Sense	4	109	Addition of: '4.8 What is the clinical and cost effectiveness of providing additional assistive technologies e.g streamers'	Thank you for your comment. The followingquestion on assistive listening devices has been included in the scope: - What is the clinical and cost effectiveness of assistive listening devices (such as loops to support use of audiovisual devices)? The clinical questions will be refined and finalised by the guideline committee.
195	SH	Action on Hearing Loss	4	109	Another question should be added here. Although cochlear implants provision itself is out of scope as there is NICE guidance on cochlear implants themselves, there are issues among audiologists around the understanding and levels of referral from audiology to cochlear implant centres. A survey of audiologists found a lack of training and availability of information on cochlear implants, and	Thank you for your comment. The scoping group did not consider this issue a priority for the guideline to address.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					that less than half felt confident that they understood the referral criteria for cochlear implants[2]. This issue should be covered in this guideline development, by adding the line 'What is required to ensure audiologists can refer on appropriate candidates to cochlear implant centres?'.	
35	SH	British Society of Audiology	4	112	A variety of questionnaire based outcome measurement tools are in use in auditory rehabilitation to guide the management of individual patients and to determine the efficacy of interventions for cohorts of patients. Add question: *'What outcome measurement tools would be of most use (in clinical practice) and how should they be optimally used to help determine the efficacy of rehabilitative interventions?'*	Thank you for your comment. The scoping group did not consider this issue a priority for the guideline to address.
144	NICE	QS	5	125-127	How will TA166 be incorporated unchanged in this guideline given that the guideline does not cover children?	Thank you for your comment. TA166 has now been removed from this section and instead highlighted in the NICE pathway section, which sets out related guidance that this guideline will link to.
27	SH	British Society of Audiology	5	85	To recognise a holistic approach to assessment, providing identification of individual needs, we suggest	Thank you for your comment. We do not consider it necessary to make this change in the scope.

[2] Crook, 2015. Conference presentation, Audiologists referring for implantable devices. Bending the Spend Conference. London, 13 October 2015.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					the following change of wording (underlined). *'How should hearing and <u>individual</u> communication be assessed? For example, history, examination, pure tone audiometry, tympanometry, electrophysiological tests, hearing speech in noise tests, patient reported quality of life, impact of hearing loss, motivation/readiness for intervention, role of communication partners, needs and goal setting (<u>individual</u> management plans) .'*	
57	SH	NIHR Nottingham Hearing Biomedical Research Unit	5	113	A variety of questionnaire based outcome measurement tools are in use in auditory rehabilitation to guide the management of individual patients and to determine the efficacy of interventions for cohorts of patients. Suggest add question: 'What are the outcome measurement tools that would be of most use (in clinical practice) and how should they be optimally used to help determine the efficacy of rehabilitative interventions?'	Thank you for your comment. The scoping group did not consider this issue a priority for the guideline to address.
217	SH	British Society of Hearing Aid Audiologists	5	113	Health related quality of life should give some consideration to the secondary effect on quality of life of significant others (spouses, partners, carers)	Thank you for your comment. The guideline committee will consider this and identify relevant outcomes for individual reviews in the process of drafting the review protocols.
36	SH	British Society	5	116	HRQoL is relevant but we know that measures of this	Thank you for your comment. The scoping group

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
		of Audiology			rarely show the benefits of hearing interventions. In addition, include *'hearing-specific health related quality of life' (for example the HHIE)*	agreed to leave this outcome worded as it currently is, but the guideline committee will consider this and identify relevant outcomes for individual review in the process of drafting the review protocols.
58	SH	NIHR Nottingham Hearing Biomedical Research Unit	5	116	HRQoL is relevant but we know that measures of this rarely show the benefits of hearing interventions. In addition, include 'hearing-specific health related quality of life' (such as the HHIE).	Thank you for your comment. The scoping group agreed to leave this outcome worded as it currently is, but the guideline committee will consider this and identify relevant outcomes for individual review in the process of drafting the review protocols.
140	SH	Hearing Link	5	116	'Health-related quality of life' is often overly focussed on physical health. It is important that mental health and social well-being be included here.	Thank you for your comment. The guideline committee will consider this and identify relevant outcomes for individual reviews in the process of drafting the review protocols.
196	SH	Action on Hearing Loss	5	116	Many measures of health-related quality of life are not sensitive to quality of life changes caused by hearing loss, because they do not take into account reductions in communication, isolation or some mental health issues. The term 'health-related' should therefore be removed here, leaving simply 'quality of life'.	Thank you for your comment. The scoping group agreed to leave this outcome worded as it currently is, but the guideline committee will consider this and identify relevant outcomes for individual review in the process of drafting the review protocols.
164	SH	National Community Hearing Association	5	117	Considering the guideline scope and review questions, we agree it is important to include the positive predictive value of signs and symptoms as an outcome. NICE might find that the UK Screening Committee's review helpful on	Thank you for your comment.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					this particular point[xiv].	
37	SH	British Society of Audiology	5	120	The scope veers between a focus on hearing aids and being broader than this intervention method. Should 'interventions' or 'hearing devices' be used here?	The outcome now reads 'use of hearing aids'. The guideline committee will consider how to best interpret this outcome for individual reviews in the process of drafting the review protocols.
165	SH	National Community Hearing Association	5	120	We do not think a main outcome can be as ambiguous as "*Appropriate use of hearing aids".* In our view this should be changed to *"Continued use and benefit from hearing aids"*	Thank you for your suggestion. 'Appropriate' has been deleted so the outcome now reads 'use of hearing aids'. The guideline committee will consider how to best interpret this outcome for individual reviews in the process of drafting the review protocols.
197	SH	Action on Hearing Loss	5	120	It is not clear here what 'appropriate' use of hearing aids means. People do not use their hearing aids if they do not gain benefit from them, and even if they only use hearing aids for specific tasks or for a short amount of time they still gain benefit, so remove the word 'appropriate'. Also awareness and understanding of hearing aids and wider technology and support (such as assistive devices available from social services or lipreading classes) are important here, so alter the line to 'Understanding and use of hearing aids and other technology and support'.	Thank you for your suggestion. 'Appropriate' has been deleted so the outcome now reads 'use of hearing aids'. The guideline committee will consider how to best interpret this outcome for individual reviews in the process of drafting the review protocols.
218	SH	British Society of Hearing Aid Audiologists	5	120	The term appropriate use of hearing aids is very paternalistic, and impossible to determine generally as it is highly dependent on individual lifestyle preferences. If	Thank you for your suggestion. 'Appropriate' has been deleted so the outcome now reads 'use of hearing aids'. The guideline committee will

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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					an individual's hearing-loss prevents them from living their preferred actively engaged lifestyle with confidence, but is able to maintain that by wearing hearing aids when required, but the lack of hearing support would lead to exclusion from these activities, then the only meaningful application of "appropriate" would be "when required".	consider how to best interpret this outcome for individual reviews in the process of drafting the review protocols.
38	SH	British Society of Audiology	5	121	There are a variety of validated outcome measurement tools in use, only one of which is the Glasgow hearing aid benefit profile. Delete *'Glasgow hearing aid benefit profile'* and replace with *'validated outcome measurement tools'*	Thank you for your comment. Glasgow hearing aid benefit profile has been replaced with the more generic 'validated hearing-specific self-report benefit measures'.
59	SH	NIHR Nottingham Hearing Biomedical Research Unit	5	121	GHABP is too narrow as this is only one of a number of measures used. Suggest changing to 'self-report questionnaire outcome measures'	Thank you for your comment. Glasgow hearing aid benefit profile has been replaced with the more generic 'validated hearing-specific self-report benefit measures'.
73	IND	IND	5	121	The Glasgow hearing aid benefit profile is a tool not an outcome, the results from this would be an outcome.	Thank you for your comment. Glasgow hearing aid benefit profile has been replaced with the more generic 'validated hearing-specific self-report benefit measures'.
95	SH	University of Southampton	5	121	What is the justification for the use of GHABP as a main outcome and not other validated measures?	Thank you for your comment. Glasgow hearing aid benefit profile has been replaced with the more generic 'validated hearing-specific self-report benefit measures'.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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135	SH	University of Manchester	5	121	Suggest changing to: Validated hearing self-report measures.	Thank you for your comment. Glasgow hearing aid benefit profile has been replaced with the more generic 'validated hearing-specific self-report benefit measures'.
141	SH	Hearing Link	5	121	Many other tests exist for this domain; this item should be broadened to include them.	Thank you for your comment. Glasgow hearing aid benefit profile has been replaced with the more generic 'validated hearing-specific self-report benefit measures'.
166	SH	National Community Hearing Association	5	121	Glasgow hearing aid benefit profile is one of a number of tools that are used. We do not know of any literature that suggests this is better than any other validated tool. We think it is therefore important to seek expert input on this before proceeding with any literature review.	Thank you for your comment. Glasgow hearing aid benefit profile has been replaced with the more generic 'validated hearing-specific self-report benefit measures'.
198	SH	Action on Hearing Loss	5	121	GHABP is one outcome tool, but other verified tools are available and used by many services and in research, such as COSI and IOI-HA. We would recommend keeping it broad and including these other outcomes tools to ensure all the relevant evidence is included.	Thank you for your comment. Glasgow hearing aid benefit profile has been replaced with the more generic 'validated hearing-specific self-report benefit measures'.
219	SH	British Society of Hearing Aid Audiologists	5	121	The Glasgow hearing aid benefit profile isnot the only proven and valuable hearing aid benefit questionnaires. The guidance should be open kinded about choiceof tests at this stage. e.g. there are at least two other research based questionnaires that are widely used by professionals and should be considered Client Oriented Scale of Improvement (COSI) and Speech Spatial and Qualities of Hearing Scale (SSQ)	Thank you for your comment. Glasgow hearing aid benefit profile has been replaced with the more generic 'validated hearing-specific self-report benefit measures'.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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207	SH	British Academy of Audiology	5	121	There are more outcome measure than Glasgow hearing aid benefit profile. This only looks at handicap, disability, use and satisfaction. What about tools to measure reduction of social isolation?	Thank you for your comment. Glasgow hearing aid benefit profile has been replaced with the more generic 'validated hearing-specific self-report benefit measures'.
79	SH	ENT UK	5	125	? also Nice guidance on bone anchored hearing aids – used in single sided deafness.	Thank you for your comment. We are not aware of this guidance.
177	SH	British Tinnitus Association	6	144	For many people, tinnitus may be related to hearing loss. Some studies have looked at the effect of hearing aids on every-day life for the tinnitus patient e.g. how a hearing aid may help reduce tinnitus and improve quality of life. Other studies have more strongly suggested that for a significant number of people, hearing aids do reduce the effect of tinnitus. Bilateral hearing aids (one on each ear) have been shown to be more beneficial than using only one aid.	Thank you for your comment. This guideline will not be covering tinnitus without hearing loss.
169	SH	National Community Hearing Association	7	160-164	"*Hearing loss is a major health issue that affects over 11 million people in the UK. It is estimated that, by 2035, there will be more than 15.6 million people with hearing loss in the UK – a fifth of the population. According to the World Health Organization (WHO), by 2030 hearing loss will be in the top 10 disease burdens in the UK, above diabetes and cataracts*." Changed to *"Adult hearing loss is a major public health issue that*	Thank you for your comment. The figures included in the scope are published and widely quoted. We have read the section of the website you refer to with interest and will look into this data more thoroughly with the guideline committee during the development phase with a view to quoting more up to date figures in the final guideline document.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					affects 8.8 million adults in England – 1 in 5 adults[xv]. It is estimated that by 2037 there will be 12.9 million adults with hearing loss in England[xvi]. Adult hearing loss is now the 6th leading cause of years lived with disability in England[xvii]". This is based on number of adults with hearing loss/number of adults. The statistic NICE uses is based on adults with hearing loss/total population. Given scope of the guidance, we suspect focussing on adults is best. The projections for 2035 are for the UK and are unlikely to control for gender. Our suggested changes control for gender and age (see referenced endnotes for more details).	
179	SH	British Tinnitus Association	7	155	In the context section there is no mention of the information and support offered to patients. From our experience we know that many people with hearing loss do not wear their hearing aids either because they are uncomfortable or are perceived as not to work by patients. We would like the importance of discourse with audiologists to be recognised in the context of assessment and management of hearing loss.	Thank you for your comment. We recognise this is an important issue and this will be commented on within the guideline. The guideline will specifically look at support as part of the following question: - What are the information, support and advice needs of people with hearing loss and their families and carers? Please note the wording of the questions within the scope are provided as a guide to the areas to

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						be covered. The clinical questions will be refined and finalised by the guideline committee
82	SH	ENT UK	7	156	The pathway although in theory looks fine in reality this is not that different from what we now have in place and it is not working. As is pointed out in paragraph 3.1 45% of those presenting with hearing loss to the GP are not being referred to secondary care and access to GP services may well be a major cause of the 10 year delay in receiving treatment. It seems to me that primary care needs support and if more prompt treatment is to be achieved then this will need to be addressed and much input here will be needed from GP's and providers of hearing tests in the community.	Thank you for your comment. Your feedback will be considered by the team responsible for the NICE pathway and any necessary amendments will be made.
199	SH	Action on Hearing Loss	7	157	The hearing loss pathway diagram under 'Hearing loss overview' is missing some elements. It should include aftercare (repairs, maintenance and support) and referral on to other local services (eg social services for equipment and support, lipreading classes, counselling etc). Given that many GPs and other services now provide simple hearing checks or screens for hearing loss, the second boxes could also be altered to say 'Initial hearing check, assessment and treatment in primary care'. Another box could also be added before this entitled 'Awareness and help seeking', to recognise the role of online hearing checks and people being encouraged to seek help by families, care staff, GPs or other clinicians, as well as the role of public health messages.	Thank you for your comment. Your feedback will be considered by the team responsible for the NICE pathway and any necessary amendments will be made.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

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220	SH	British Society of Hearing Aid Audiologists	7	165	The £24.8 bn cost to the economy is not solely caused by inability to work. Causes include higher levels of unemployment, people unable to fulfil their potential and occupied in less demanding and lower paid roles because of difficulty engaging fully in work related activities, conversations and meetings. This distinction is important, because it is not the hearing loss, but the communication/ participation difficulties that are usually the cause.	Thank you for your comment. The report from which this statistic was taken is the 'Commission on Hearing Loss: Final Report' from the International Longevity Centre UK (2014). The statistic is based on rates of unemployment amongst people with hearing loss, however the report does state that the cost may be higher if levels of underemployment are also taken into account. The text has been changed to the following to reflect the points made: 'It is estimated that, in 2013, the UK economy lost more than £24.8 billion in potential output because of high unemployment rates amongst people with hearing loss. The cost may be higher if rates of underemployment are also taken into account. These high rates of unemployment and underemployment reflect the communication and participation difficulties experienced by people with hearing loss.'
60	SH	NIHR Nottingham Hearing Biomedical Research Unit	7	169	Add 'use of' prior to hearing aids.	Thank you for your comment. This change has been made.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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200	SH	Action on Hearing Loss	7	169	Where the document states 'it is thought that hearing aids may reduce these risks', this is not correct – there is now good evidence that using hearing aids does reduce these risks[3].	Thank you for your comment. The text has been amended to 'Research also suggests that use of hearing aids reduces these risks.'
178	SH	British Tinnitus Association	7	185	We feel there should also be reference to combination aids. Combination aids not only amplify sounds, but also provide extra low level sound in order to try to help the habituation process (getting used to the tinnitus sound).	Thank you for your comment. These guidelines will not be covering tinnitus where the management differs from the management of hearing loss alone.
173	SH	National Community Hearing Association	8	186-192	Earwax is mentioned on line 187. Occlusive earwax should be considered in the review questions, see comment 13.	Thank you for your comment. The management of ear wax will be covered within the guideline and a question has been added as follows: 'How should earwax be treated?' Please note the wording of the questions within the scope is provided as a guide to the areas to be covered. The clinical questions will be refined and finalised by the guideline committee.
172	SH	National Community	8	180-185	"*… The main referral pathway for an adult with hearing loss who meets the national 'direct referral' criteria set out*	Thank you for your comment. The text has been

[3] Saito H, Nishiwaki Y, Michikawa T, Kikuchi Y, Mizutari K, Takebayashi T and Ogawa, K, 2010. Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. Journal of the American Geriatrics Society, 58 (1), 93-7; Mulrow CD, Tuley MR and Aguilar C, 1992. Sustained benefits of hearing aids. Journal of Speech and Hearing Research 35 (6), 1402-5; National Council on the Aging 2000. The consequences of untreated hearing loss in older persons. Head and Neck Nursing, 18 (1), 12-16; Acar B, Yurekli MF, Babademez MA, Karabulut H and Karasen RM, 2011. Effects of hearing aids on cognitive functions and depressive signs in elderly people. Archives of Gerontology and Geriatrics, 52 (3): 250-2.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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ID	Type	Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
		Hearing Association			*by the British Academy of Audiology is direct from GP to audiology services. …*" It is important to note that the British Society of Hearing Aid Audiologists (BSHAA) have the same referral criteria as the British Academy of Audiology[xviii], we would there recommend changing this to include the BSHAA "*… The main referral pathway for an adult with hearing loss who meets the national 'direct referral' criteria set out by the British Academy of Audiology and British Society of Hearing Aid Audiologists is direct from GP to audiology services. …*"	amended to include the BSHAA.
171	SH	National Community Hearing Association	8	172-174	"*On average there is a 10-year delay in people seeking help for their hearing loss, and 45% of people who do report hearing loss to their GP are not referred to NHS hearing services*." This statistic is based on Davis et al. 2007. The primary research was actually carried on in the 1990s – before digital hearing aids were introduced in the NHS. For example audiology activity increased 142% between 2003 and 20013[xix] – i.e. after the introduction of digital aids, it is unlikely GP referral was not influenced. The rate of onward referral by GPs also requires further examination.	Thank you for highlighting these issues and bringing them to our attention. We will pass this on to the guideline committee who will discuss this when reviewing the evidence and making the recommendations.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					We include an extract from the history of hearing care© (researched by H. Sandhu on behalf of the NCHA) here. But please note Benova's 2014 paper is based on data from the Wave 2 study conducted some years earlier, i.e. this section of the history is simplified for the general reader: *"In 1988 the RNID challenged the need to see an ENT doctor before being fitted with an NHS hearing aid because it caused unnecessary delays[1]. In response "Provision of hearing aids: Does specialist assessment cause delay?" was published in the BMJ in 1989[2]. The article argued that the "main cause for delay in treating impaired hearing is the failure by patients to seek help promptly"[1]. This resulted in several letters to the editor of the BMA in 1989 with ENT doctors and others agreeing that whilst people might delay coming forward, once they did, having to wait to see an ENT doctor still unnecessarily extended the time it took them to receive treatment[3]. In 1998 the RNID commissioned a MORI poll that showed that 22% if people over 50 had had a hearing test in the last 10 years compared to 87% that had a sight test[4] – suggesting a lack of public awareness about hearing assessments. In 1999 the RNID reported that only 60% of people with hearing difficulty actually tried to get help and of those that did c.67% were referred[5].* *In 2000 the Audit Commission would add that a reason*	

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					for unmet hearing need was that people did not seek help in the first place[6]. It was not until 2014, however, that a peer-reviewed article with a large sample size (N=8,680) finally confirmed that the main reason for delay was that people did not report their hearing loss to a health care professional. The paper noted ▪ *"Among the older population in England, nearly half of self-perceived hearing difficulty is unreported to health professionals, and therefore remains untreated"[7]* ▪ *45% of people aged 65 and over reported hearing difficulties but just 46% of this group told a health professional[7]* ▪ *of those that told a health professional 73% were referred to a hearing specialist[7]* *System leaders have long stated their objective is to improve early diagnosis and treatment of hearing loss[8-16]. This research suggests that in order to achieve these goals public awareness campaigns, local services and demedicalisation will be required to normalise hearing care in the same way that seeing an optician or dentist has been."[xx]*	
181	SH	University of Southampton	8	3.2	Related to comment 1, it would be worth stating clearly within 3.2 that current practice for management/onward referral/urgency of treatment at primary care level for sudden onset sensorineural hearing loss is variable.	Thank you for your comment. The text has been amended as follows to reflect the point: 'The investigation and management pathways for people with hearing loss vary, and many people

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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						face delays in treatment and inappropriate management. This is a particular issue in relation to sudden onset sensorineural hearing loss which requires urgent treatment.'
221	SH	British Society of Hearing Aid Audiologists	8	172	Evidence suggests that people often present multiple times to GP before further referral to audiology services, contributing to the delay in treatment.	Thank you highlighting this issue. The guideline committee will discuss this when making the recommendations.
61	SH	NIHR Nottingham Hearing Biomedical Research Unit	8	173	The study (Davis et al , 2007) that these figures refer to are relevant to a sample of 55-74 year olds, rather than all people who report hearing loss.	Thank you for your comment. This has been clarified in the text which now reads as follows: 'One study found that on average there is a 10-year delay in people aged 55–74 seeking help for their hearing loss, and 45% of people who do report hearing loss to their GP are not referred to NHS hearing services.'
222	SH	British Society of Hearing Aid Audiologists	8	174	This paragraph should draw attention to the fact that timely support can slow the further deterioration of hearing and ireduce its impact by enabling people to continue engaging in normal social, domestic and work activities.	Thank you for your comment. This information is not appropriate for this section which is about key facts and figures relating to hearing loss.
201	SH	Action on Hearing Loss	8	175	This should read 'In 2015, the Department of Health and NHS England developed the Action Plan on Hearing Loss…'.	Thank you for your comment. This change has been made.
223	SH	British Society	8	178	It is helpful to draw attention to the effect of hearing loss	Thank you for your comment. This information is

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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		of Hearing Aid Audiologists			on communication and the cognitive process. Loss of discrimination between consonant sounds tends to be the early effect of hearing loss. The cognitive process seeks to compensate by interpolating the most likely missing sounds. Sustained conversations become exhausting and frustrating, and this often leads to misunderstanding, strained relationships and withdrawal.	not appropriate for this section which is about key facts and figures relating to hearing loss.
224	SH	British Society of Hearing Aid Audiologists	8	182	Should acknowledge the role of British Society of Hearing Aid Audiologists (BSHAA)as well as BAA. BSHAA is the only professional body recognised by Health and Care Professional Council for the only group ofaudiologists with statutory rather than voluntary registration. BSHAA has a direct referral criteria for people receiving hearing healthcare services from its 1600+members. However, there is no contradictions in the criteria proposed by two professional bodies so, it will be appropriate to change the sentence to *"The main referral pathway for an adult with hearing loss who 183 meets the national 'direct referral' criteria set out by the British Academy of 184 Audiology and British Society of Hearing Aid Audiologists" is direct from GP to audiology services"*	Thank you for your comment. The text has been amended to include the BSHAA.
62	SH	NIHR Nottingham Hearing Biomedical	8	196	See comment 1, in addition, 'participation restrictions (previously known as handicap) ' should be included. This is a domain in the GHABP and also the subject of the most commonly used self-report outcome measure in	Thank you for your comment. The text has been amended to reflect this point and now reads:

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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		Research Unit			hearing research (hearing handicap inventory for the elderly/adult)	'It may also include clinic-based assessment of ability to understand speech in a noisy environment, and self-report measures related to disability and participation limitations.'
96	SH	University of Southampton	8	197	We feel that the reference to AQP should clarify what audiology services are covered under AQP and what isn't.	Thank you for your comment. We do not feel this detail is needed within the scope. However identification and treatment of hearing difficulties by AQP providers will be covered within the guideline.
174	SH	National Community Hearing Association	8	197	*"In some parts of England this is through 'the any qualified provider' (AQP) scheme."* This is not an accurate statement. Based on Monitor's – the NHS regulator's - review of adult hearing care, we recommend this is changed to *"In 60% of England this is through 'the any qualified provider' (AQP) commissioning"*[xxi]	Thank you for your comment. We feel the current statement is accurate and appropriate.
175	SH	National Community Hearing Association	9	201-209	This is an important part of this draft scope. However, the variation in services is not limited to one or two hearing aids. In July 2015 the NCHA performed a national project that involved sending a Freedom of Information (FoI) request to every CCG and NHS provider in England. We found unwarranted variation in prices paid, bilateral fitting rates, ENT to audiology	Thank you for your comment. Stakeholders will be informed if it is decided to undertake a call for evidence.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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					referral rates and service specifications. If it would be helpful, we would willingly share our FoI data with the committee.	
202	SH	Action on Hearing Loss	9	207-9	We welcome the recognition of the importance of proper support here, the wider evidence and our research with people with hearing loss shows that follow up and support are important. However, the line should read 'in some cases hearing aids are tried but discontinued…' rather than 'in many cases', as evidence shows that only around 1 in 10 people do not continue to use and get benefit from their hearing aids[4].	Thank you for your comment. 'In many cases' has been replaced with 'in some cases' to reflect the point.
39	SH	British Society of Audiology	9	200	Remove 'new' , not appropriate.	Thank you for your comment. 'New' has been replaced by 'independent'.
63	SH	NIHR Nottingham Hearing Biomedical Research Unit	9	200	Remove 'new'	Thank you for your comment. 'New' has been replaced by 'independent'.
225	SH	British Society of Hearing Aid	9	200	audiology services on the high street are not new- independent providers have existed for a long time and	Thank you for your comment. 'New' has been replaced by 'independent'.

[4] See for example: Perez E and Edmonds BA, 2012. A Systematic Review of Studies Measuring and Reporting Hearing Aid Usage in Older Adults since 1999: A Descriptive Summary of Measurement Tools. PLoS ONE 7 (3), e31831; Monitor, 2015. NHS adult hearing services in England: exploring how choice is working for patients, London: Monitor. This figure is also substantiated by numerous individual audits undertaken by audiology departments.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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		Audiologists			are fully regulated. The only "new" element is that under AQP, they may now choose to offer their services as part of the NHS offer. Replace the word "new" with "independent".	
226	SH	British Society of Hearing Aid Audiologists	9	201	This paragraph should also add. Many hearing aids now include programmes allowing two hearing aids to interact so that they can help reduce the masking effects of noise. More consistent and appropriate advice and guidance should be provided to enable users to benefit fully from these facilities.	Thank you for your comment. This level of detail is not required in this section of the scope.
40	SH	British Society of Audiology	9	207	Change 'many' (which sounds like the majority i.e. >50%) to 'some'.	Thank you for your comment. 'In many cases' has been replaced with 'in some cases' to reflect the point.
64	SH	NIHR Nottingham Hearing Biomedical Research Unit	9	207	Change 'many' (which sounds like the majority i.e. >50%) to 'some'.	Thank you for your comment. 'In many cases' has been replaced with 'in some cases' to reflect the point.
74	IND	IND	9	209	Add to end of sentence 'or that the hearing aids have not been fitted appropriately'	Thank you for your comment. The committee will take this into account.
203	SH	Action on Hearing Loss	9	213	This should read 'correct routes of referral and…' as there are different correct routes for different people.	Thank you for your comment. This change has been made.
76	IND	IND	9	216	Why is the AQP scheme set out as Policy when it is an accepted practice? This section should be referred to in the beginning of the document as indicated in previous comments	Thank you for your comment. We think it is clear that the AQP scheme is fully established and accepted practice, but we also think it is appropriate to highlight it in the policy section.

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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41	SH	British Society of Audiology	10	220	Replace 'it' with 'the provider' to prevent confusion with it meaning hearing loss	Thank you for your comment. 'It' has been replaced with 'the provider' as suggested to avoid confusion.
204	SH	Action on Hearing Loss	10	223	This will need to be updated to reference the forthcoming guidance for commissioners being developed by NHS England, the 'Commissioning Framework on hearing services', being published in May 2016.	Thank you for your comment. This reference has been added as suggested.
211	SH	British Academy of Audiology	12	GENERAL	In the section that starts other tests are also used we should include Speech in noise tests as these are more common and used as part of diagnosis and treatment planning. Other tests are also used, for example speech in noise tests, tympanometry and otoscopy.	Thank you for your comment. The scoping group considers otoscopy as part of examination and not a test. Otherwise, we think it is clear that the committee will be considering the most useful battery of tests to evaluate a patient's needs and that these include speech in noise tests and tympanometry as well as other tools.

[i] NCHA (May 2016, forthcoming), History of Hearing Care, www.the-ncha.com this section of the website will be based on hand search of archives, review of grey and published literature We would be happy to forward the committee any section of the history of hearing care in an accessible format – e.g. word

[ii] * Not all earwax will result in an individual seeking help from a health care professional. The actual prevalence of earwax varies with age: 0 to 16 years: 10% to 43%. 16 to 59 years of age: 2% to 5%. ≥60: 16% to 57% [Ref: Cited in: The safety and effectiveness of different methods of ear wax removal: a systematic review and economic evaluation. Clegg et al. Health Technology Assessment]

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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[iii] The safety and effectiveness of different methods of ear wax removal: a systematic review and economic evaluation. Clegg et al. Health Technology Assessment

[iv] 1.Johnson, Grover and Martin, 1984. A survey of NHS hearing aid services. RNID. London
RNID.
2. RNID, Age Concern and the British Association of the Hard of Hearing, 1986. Conference Papers presented at the Breaking the Sound Barrier event.
3. Technical Department Report". RNID, London; RNID, Age Concern and British Association of the Hard of Hearing (1986) Breaking the Sound Barrier
4. RNID 1988. Hearing aids the case for change. London
5. RNID 1999 "Waiting to hear? A report on waiting times for hearing tests" RNID, London
6. Audit Commission, (2000). "Fully equipped: the provision of equipment to older or disabled people by the NHS and social services in England and Wales" Audit Commission, London
7. Bhatt L, Martin M, King A, Grover B. A fact-finding survey of hearing aid services in trust and
non-trust NHS Hospitals. Science and Technology Unit, RNID 1993. London. cited in Jayarajan, V. and Rangan, S. 2000. Evaluation of hearing-aid provision in adults. Journal of Audiological Medicine, 9(1), pp. 25-34
8. Jayarajan, V. and Rangan, S. 2000. Evaluation of hearing-aid provision in adults. Journal of Audiological Medicine, 9(1), pp. 25-34
9. Matthews, L. (2011) "Seen but not heard: People with hearing loss are not receiving the support they need". London, RNID; Action on Hearing Loss (2011) "Hearing Matters", London.
10. Edmond, 2011. Hear me out. Audiology services in Scotland – services provided, patients' experience and needs. RNID Scotland.
11. Lowe, C (2015) "Under Pressure: NHS Audiology Across the UK." London, Action on Hearing Loss.
12. Monitor, 2015. NHS adult hearing services in England: exploring how choice is working for patients

[v] Department of Health, March 2007. Improving Access to Audiology Services in England; Department of Health, 2009. Best Practice Guidance. Hearing Services for Older People; NHS Improvement, 2011. The best of clinical pathway redesign. Practical examples delivering benefits to patients;
Department of Health, 2011. Liberating the NHS: Greater choice and control. Government response. Extending patient choice of provider (Any qualified provider);
Department of Health, 2011. Liberating the NHS: Greater choice and control. Equality analysis. Extending patient choice of provider (Any qualified provider); Department of Health, 2012. Any Qualified Provider Adult Hearing Services Implementation Packs. London: Department of Health

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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[vi] RNID, 1988. Hearing Aids the Case for Change; RNID. 1989. Hearing Aids – The Developing Debate. The RNID's Refined Views; RNID, 1999. Waiting to Hear? A report on waiting times for hearing tests; Action on Hearing Loss, 2011. Hearing Matters; Action on Hearing Loss, 2011. Annual Report and Financial Statements; Action on Hearing Loss, 2012. Annual Report and Financial Statements for the year ended March 2012

[vii] Monitor, 2015. NHS adult hearing services in England: exploring how choice is working for patients

[viii] NCHA, (May 2016, forthcoming), Causes of Hearing Loss. www.the-ncha.com this section of the website will include a table with a list of causes of hearing loss and prevalence of each condition. We would be happy to forward the committee any section of the website in an accessible format – e.g. word, excel etc.

[ix] Monitor, 2015. NHS adult hearing services in England: exploring how choice is working for patients

[x] NCHA, (May 2016, forthcoming), Hearing Map. www.the-ncha.com this section of the website will include prevalence data and a paper explaining in detail how calculations have been made. We would be happy to forward the committee any section of the website in an accessible format – e.g. word, excel etc. We would also be happy to forward the committee master excel sheets so that analysts can review how we calculated prevalence

[xi] Sandhu, HS (2015) analysis for forthcoming *History of Hearing Care*. Primary sources used for analysis: Royal College of Physicians of London. Hearing and balance disorders. Achieving excellence in diagnosis and management. Report of a Working Party and Health and Social Care Information Centre, 2015. NHS Hospital & Community Health Service (HCHS) monthly workforce statistics - Provisional Statistics. NCHA, (May 2016, forthcoming), History of Hearing Care. www.the-ncha.com, We would be happy to forward the committee any section of the website in an accessible format.

[xii] American Academy of Otolaryngology head and neck surgery, 2012. AAO-HNSF Clinical Practice Guideline: Sudden Hearing Loss; NCHA, (May 2016, forthcoming), Causes of Hearing Loss. www.the-ncha.com this section of the website will include a table with a list of causes of hearing loss and prevalence of each condition. We would be happy to forward the committee any section of the website in an accessible format – e.g. word, excel etc.

[xiii] American Academy of Otolaryngology head and neck surgery, 2012. AAO-HNSF Clinical Practice Guideline: Sudden Hearing Loss. http://www.entnet.org/sites/default/files/March2012_SuddenHearingLossFactSheet.pdf, accessed 26 April 2016

[xiv] Spiby, 2015, Screening for Hearing Loss in Older Adults, External review against programme appraisal criteria for the UK National Screening Committee (UK NSC). UK National Screening Committee

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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[xv] Please note this guidance is for adult hearing loss. The 1 in 6 figure is based on [adults with hearing loss/population] whereas [adults with hearing loss/adult population] results in an average prevalence of 20%. The range across CCG areas is 10% to >26%. NICE can cite: NCHA, (May 2016, forthcoming), Hearing Map. www.the-ncha.com this section of the website will include prevalence data and a paper explaining in detail how calculations have been made. We would be happy to forward the committee any section of the website in an accessible format – e.g. word, excel etc. We would also be happy to forward the committee master excel sheets so that analysts can review how we calculated prevalence and for the committee to run its own analysis and cite NICE.

[xvi] NCHA, (May 2016, forthcoming), Hearing Map. www.the-ncha.com this section of the website will include prevalence data and a paper explaining in detail how calculations have been made. We would be happy to forward the committee any section of the website in an accessible format – e.g. word, excel etc. We would also be happy to forward the committee master excel sheets so that analysts can review how we calculated prevalence and for the committee to run its own analysis and cite NICE.

[xvii] Vos et al. 2015. Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. http://dx.doi.org/10.1016/S0140-6736(15)60692-4

[xviii] See pages 27 and 28of Department of Health, 2012, Adult Hearing AQP Implementation Pack
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/475660/DH_-__Adult_Hearing_Implementation_Pack.pdf

[xix] NCHA (May 2016, forthcoming), Growth in NHS Audiology, www.the-ncha.com this section of the website will share H. Sandhu, NCHA analysis of DH reference cost data. We would be happy to forward the committee any section of the history of hearing care in an accessible format – e.g. word, excel etc.

[xx] . 1. RNID, 1988. Hearing aids the case for change. 2. Watson, C and Crowther, J. 1989. Provision of hearing aids: Does specialist assessment cause delay? BMJ. Vol. 299. 3. Browning et al. 1989 Provision of hearing aids. BMJ: British Medical Journal, 299(6700), pp. 678-678. 4. RNID, 1998. It's time for a hearing test 5. RNID, 1999. Waiting to hear 6. Audit Commission, 2000. "Fully equipped: the provision of equipment to older or disabled people by the NHS and social services in England and Wales" Audit Commission, London 7. Benova, L. et al 2013. Socioeconomic Position and Health-Seeking Behaviour for Hearing Loss Among Older Adults in England. *Journals of Gerontology, Series B: Psychological Sciences and Social Sciences* 8. Stephens, S. D. G., 1982. Letters to the Editor. What should be done about hearing impairments?

Hearing Loss

Consultation on draft scope
Stakeholder comments table
29 March 2016 – 26 April 2016

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Journal of the Royal Society of Medicine, 75, pp. 137 9. RNID, 1988. Hearing Aids the Case for Change. 10. RNID. 1989. Hearing Aids – The Developing Debate. The RNID's Refined Views. 11. RNID, 1988. It's time for a hearing test. A report on hearing tests, ear health and public attitudes 12. Department of Health, March 2007. Improving Access to Audiology Services in England. 13. Action on Hearing Loss, 2011. Hearing Matters 14. Department of Health, 2012. Any Qualified Provider Adult Hearing Services Implementation Packs. London: Department of Health.15. NHS England and Age UK, 2015. A practical guide to healthy ageing. p.14 http://www.england.nhs.uk/wp-content/uploads/2015/01/pract-guid-hlthy-age.pdf Accessed 1 February 2015. 16. NHS England and Department of Health, 2015. Action Plan on Hearing Loss

[xxi] Monitor, 2015. NHS adult hearing services in England: exploring how choice is working for patients