NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Hearing loss in adults

Date of quality standards advisory committee post-consultation meeting:
4 April 2019

2 Introduction

The draft quality standard for hearing loss in adults was made available on the NICE website for a 4-week public consultation period between 12 February and 12 March 2019. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 16 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in Appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

4. Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- The quality standard was generally supported.
- The implementation of local referral pathways was supported to address the significant UK variation in primary, community and secondary care for hearing loss.
- Reference to dementia, cognitive impairment and learning disability as equality and diversity considerations were supported.
- The statements need to reflect patient choice.

Consultation comments on data collection

- Significant variation was reported across CCG areas.
- The structure measure data sources were supported.
- Hearing loss is included in annual GP health checks for people with learning disabilities however it was felt GPs need to be adequately trained to ensure that the format of the checks are suitable to support all people.

Consultation comments on resource impact

- CCG resources to deliver hearing loss care are limited with multiple and competing priorities.
- The current statements will not provide cost saving for the local services but there will be overall cost savings and reduced morbidity.
- Currently there is limited availability of nurses to undertake ear care.
- The need for GP training and education on diagnosing and managing hearing loss was highlighted.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Adults with earwax contributing to hearing loss or other symptoms, or preventing ear examination, have earwax removal in primary care or community ear care services.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Significant variation in practice was reported.
- Locally agreed referral pathways being in place with trained healthcare professionals and access to the correct equipment was supported.
- Referral pathways should also be included in the statement's measures.
- Amend the statement from 'care services' to 'settings' so that referrals to an outpatients or an acute hospital do not happen unless clinically necessary.
- Include a waiting time limit in this statement as timely ear wax removal can reduce hearing problems.
- Care home access to ear wax removal services needs to be improved by NHS commissioners and service providers.
- Clear patient information about local ear wax removal services is needed. Also, GPs and primary care nurses should be better informed about the importance of wax removal for hearing aid users and people attending audiology appointments.
- Manual ear wax removal can also be contraindicated for some patients.
- Health-related quality of life is difficult to measure as an outcome as people are unlikely to notice that the wax has impacted on their quality of life.

Consultation question 2 – data collection

Stakeholders made the following comments in relation to consultation question 2:

- There are no current local data systems and structures in place to collect data on ear wax removal so appropriate primary care and private providers will have to collect data.
- A joint audit by ENT and Audiology services could measure non-compliance by examining the number of unnecessary referrals they receive when wax removal has not been appropriately performed in primary care.

Consultation question 3 – resource impact

Stakeholders made the following comments in relation to consultation question 3:

- Appropriate funding is needed for wax management training and equipment in primary care or community ear care services. CCGs should refer to the 2016 NHS England Framework and learn from each other about more effectively implementing wax removal services into the audiology pathway.
- Training Associate Practitioners to be experts in ear wax removal may lead to potential savings.

5.2 Draft statement 2

Adults with sudden onset or rapid worsening of hearing loss are referred for immediate or urgent specialist medical care.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- The statement's referral criteria needs to be reviewed as it now differs from the updated British Society of Hearing Aid Audiologists guidance.
- Query raised on the rationale's inclusion of necrotising otitis externa as not being a typical risk of sudden onset of hearing loss. An alternative suggestion was to focus on the adult being seen by a specialist within 10 days. This could potentially save residual hearing.
- Simplify the language of the statement's supporting information and be clearer on the signs or symptoms that require an urgent referral.

- Improved awareness is needed for the public and primary and emergency care staff about the signs and symptoms of worsening hearing and the need for urgent referrals.
- There is a current lack of guidance on psychological support for those who experience sudden or progressive hearing loss. The traumatic nature of rapid worsening of hearing loss and worsening irreversible damage caused by waiting time needs to be emphasised in this statement.
- Add mastoiditis within the definitions section.
- Care home staff should be trained to recognise signs of hearing loss, including the need for urgent care in the case of sudden hearing loss. This should be added to as an equality and diversity consideration.
- Morbidity as the only outcome included in this statement was queried. Avoidable long-term disability was suggested as an additional outcome.

Consultation question 2 – data collection

Stakeholders made the following comment in relation to consultation question 2:

- This statement's measure does not specify where these people have initially presented so it may be difficult to collate data from different care services.

Consultation question 3 – resource impact

Stakeholders made the following comment in relation to consultation question 3:

- This statement's referral criteria may have a resource impact.

5.3 Draft statement 3

Adults presenting with hearing difficulties not caused by impacted earwax or acute infection are referred for an audiological assessment.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Significant national variation in access to audiology services was reported.
- Specify ‘at the first presentation’ in the statement. This could reduce the number of patients repeatedly attending their GP with hearing loss before being referred.
- Include self-referral to accelerate the time between complaint and diagnostic assessment and reduce GP time.
- It was highlighted that people with impacted earwax can be referred to audiology services.
- Refer to assistive listening devices not hearing aids.
- CCGs should be encouraged to promote good practice and innovations which aim to raise awareness of early diagnosis and hearing loss in general.
- Hearing assessments should be undertaken for adults with severe or profound learning disabilities. This should be added as an equality and diversity consideration.
- Include disability-adjusted life years (DALYs) as an outcome.

Consultation question 2 – data collection

Stakeholders made the following comments in relation to consultation question 2:

- Uptake rates of the validated self-reporting tools included was suggested as a useful measure.
- Referral time to Direct Access Audiology is available from NHS England’s Referral to Treatment (RTT) data.
- Local area data is available in the 2016 NHS England Commissioning Framework. A forthcoming JSNA guide should provide this too.
- Undetected hearing loss estimated data is available from the Projected Older People Population Information (POPPI) dataset.

Consultation question 3 – resource impact

Stakeholders made the following comments in relation to consultation question 3:

- Based on the current levels of funding, staffing resource and service level agreements it is unlikely that local resources would be able to achieve the hearing-specific health-related quality of life outcome.
- Healthcare professionals should have the appropriate training and knowledge to recognise hearing loss and communication difficulties. This will require significant time and resources.

5.4 Draft statement 4

Adults presenting with hearing loss affecting their ability to communicate and hear are offered hearing aids.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Refer to assistive listening devices not hearing aids.
- This statement must include another process measure for adults who are offered binaural aids but decline 1 or 2. This would reflect patient choice.
- Structure measure data source- Include local contract key performance indicators (KPIs) which include service specifications.

Consultation question 2 – data collection

Stakeholders made the following comments in relation to consultation question 2:

- A joint audit would be required with ENT and Audiology services which would require time and resources.
- The number of people who refuse hearing aids and their refusal reasons would be useful for future service improvements.

Consultation question 3 – resource impact

Stakeholders made the following comment in relation to consultation question 3:

- Significant barriers in hearing aid provision were reported. A new funding model (similar to the eye care voucher model) which supports integration between the NHS funded and private funded hearing care is needed.

Consultation question 4 – implementation

Stakeholders made the following comment in relation to consultation question 4:

- Onward referral systems are in place in all BSHAA Member service delivery practices in line with NICE Guidance NG98.

5.5 Draft statement 5

Adults with hearing aids have a face-to-face follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- The 2019 NHS Long Term Plan objectives highlight the importance of patient informed choice, technological innovation and the need to reduce NHS outpatient appointments. Not all adults with hearing aids will require or will want a follow-up appointment so the choice of face-to-face, via telephone or electronic communication should be offered. Community provision and other access adjustments should also be encouraged. This choice will potentially improve service efficiency and reduce non-attendance rates.
- An earlier follow-up time of 4 to 8 weeks was suggested.
- Hearing tests should be included in the follow-up appointment to ensure that there are no changes from the initial hearing test and assessment. Further deterioration should be addressed.

- Automatic data logging for monitoring purposes was supported but this will need patient consent in line with General Data Protection Regulation (GDPR).

Consultation question 2 – data collection

Stakeholders made the following comments in relation to consultation question 2:

- Audiology services could audit follow-up appointment choice.
- Additional data will be needed to properly assess the benefits and effectiveness of remote follow-up support.
- Some CCGs do not currently collect any data on numbers of hearing aids fitted locally.

Consultation question 3 – resource impact

Stakeholders made the following comments in relation to consultation question 3:

- Face-to-face follow-up appointments are not national current practice and therefore may have resource implications for both providers and commissioners. There will also be significant resource implications as the time needed for telephone and face-to-face appointments are significantly different. Resources could however be reduced by offering remote access.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Access to assistive listening devices
- Improved use and standardisation of patient reported outcome measures (PROMs)

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
1	Action on Hearing Loss	General	About us Action on Hearing Loss, formerly RNID, is the UK's largest charity working for people with deafness, hearing loss and tinnitus. 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, enabling them to take control of their lives and removing the barriers in their way. We give people support and care; develop technology, treatments, and campaign for equality. Throughout this response we use the terms 'people with hearing loss' to refer to people with all levels of hearing loss or deafness, which could be caused by various factors including age, genetic predisposition, exposure to loud sounds, complications at birth or other health problems. We use the term 'people who are deaf' to refer to people who are severely or profound deaf who use British Sign Language (BSL) as their first or preferred language and may consider themselves part of the Deaf community, with a shared history, language and culture. Introduction Action on Hearing Loss welcomes the opportunity to comment on NICE's hearing loss (adult onset) Quality standard. We welcome the 5 quality standard statements and in our response, we have provided feedback using the questions.
2	Action on Hearing Loss	General	We welcome this standard is inclusive of those with dementia, cognitive decline and learning disability, however, may be challenging to implement since some checks are carried out in primary care and the standard of care is likely to vary. One study found that the format of hearing checks carried out in GP surgeries are often inappropriate for people with learning disabilities.[2] Some GPs who were interviewed as part of this study were also reluctant to refer people with learning disabilities for a hearing test, due to misconceptions that diagnosis and treatment would be

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

[2] McShea L. (2015). Managing hearing loss in Primary care. Learning Disability Practice.18(10):18-23. doi:10.7748/ldp.18.10.18.s19

ID	Stakeholder	Statement number	Comments[1]
			ineffective. GPs should be adequately trained to ensure that the format of primary care hearing assessments are suitable for people with learning disabilities. People with learning disabilities should be provided with appropriate support to communicate well and understand information, in line with the Accessible Information Standard. [3] A reference to NHS England's Accessible Information Standard should be added to this section.
3	Action on Hearing Loss	General	80% of people living in care homes have hearing loss. Anecdotally, we have heard that audiology services cannot always offer domiciliary care due to staff shortages or financial constraints from CCGs. This therefore means that many people within care homes do not get the same access to the support they require for their hearing loss. CCHS therefore must work with local audiology and social care services to find ways of ensuring that people in care home are able to access support or their hearing loss. It is vital that NHS audiology services and local authorities work together to ensure that social care services for people with hearing loss can be accessed by all people that need it. The Commissioning Framework for Adult Hearing Loss Services[4] states that "commissioners should be open to new ideas about how to meet needs and deliver services wherever they come from, including working closely with other parts of the health and social care system". Commissioners should also refer to NHS England's forthcoming JSNA guide. [5] This guide has been co-produced by NHS England, the Local Government Association, the Association of Directors of Public Health and other stakeholders, and will be published later this year. The guide provides data; evidence and insight to help local authorities and NHS commissioners develop robust hearing needs assessments that properly reflect local needs.
4	British Society of Audiology	General	We do not feel the draft standards have addressed any of the key areas for quality improvement that we previously identified and submitted and as such there are significant gaps in the QS
5	Hearing Loss and Deafness Alliance	General	The Alliance welcomes the quality standard. We have some general comments which apply to all sections. - It is important that providers and commissioners are held to these so patients benefit and we would be interested in supporting the process post publication to ensure that this happens.

[3] NHS England (2017). Accessible Information Standard. DCB 1605. To find out more, please visit www.england.nhs.uk/accessibleinfo
[4] NHS England (2016) *Commissioning Services for People with Hearing Loss: A Framework for clinical commissioning groups*. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf
[5] NHS England et al. Forthcoming 2019. *Guidance for Local Authorities and NHS commissioners on assessing the hearing needs of local populations*.

ID	Stakeholder	Statement number	Comments[1]
			- Some of the language on urgency of referral could be made clearer, and it would be helpful to check it all matches the actual guideline-see further specific comments below. - It is crucial to measure the actual numbers in the adult hearing pathways locally over estimated local adults with hearing loss so that there is a clear picture of unmet need and plans put in place to address this-see below for more detail.
6	Hearing Loss and Deafness Alliance	General	It is important and good to see that this standard refers to dementia, cognitive decline and learning disability, however, may be challenging to implement since some checks are carried out in primary care and the standard of care is likely to vary. Also there is significant evidence that hearing loss and dementia are not routinely diagnosed correctly and there is not standard protocol for assessing patients with dementia and hearing loss.
7	National Community Hearing Association	General	In response to question one and three (consultation document page 3), about whether the quality standard accurately reflects the key areas for quality improvement and whether these are achievable given the resources available: • Statements 1 to 4: when read in detail, do reflect the key areas for quality improvement. Yes all these are achievable within the resources available. We provide specific feedback on each statement below. • Statement 5: it is unlikely that the original NICE guideline or original Equality Impact Assessment have been reviewed. In our view this standard must be updated. In its current form it is also not achievable given current funding, capacity and workforce issues in audiology. We provide specific feedback in our response to Statement 5. In response to question two (consultation document page 3), about whether local systems and structures are in place to collect data for the proposed quality statements: • Not in all cases. In our view some of proposed data collection methods can be simplified and improved. We provide feedback on specific statements in our response below.
8	British Association of Audiovestibular Physicians	General	The five quality standards suggested are key areas for quality improvements relevant to assessing and managing hearing loss in adults. BAAP fully endorse this quality standard.
9	ENT UK	General	The quality measures are very difficult to achieve for most of the statements and review of electronic records, the

ID	Stakeholder	Statement number	Comments[1]
			means stated in most of the statements, will not be an adequate means to assess outcomes. There is, unfortunately, a wide variation in the knowledge for diagnosing and treating hearing problems in the community. In order to improve standards overall, it will be necessary to address the lack of training that medical students and primary care practitioners receive in this area. Furthermore many practices do not appear to have adequate equipment to accurately differentiate between different causes of hearing loss. NICE should introduce a standard in assessing all cases of hearing loss that required the use of a modern Otoscope with fibreoptic lighting or equivalent for good visualisation of the tympanic membrane and the mandatory use of tuning forks (256 or 512Hz) in all cases. All primary care practitioners should be required to gain adequate competency in the interpretation of Tympanic membrane abnormalities and the outcomes of the Tuning Fork tests through adequate training.
10	ENT UK	General	It would be helpful to have a statement related to those who are severe to profoundly deaf and who may not be benefiting from hearing aids. Ideally the quality standards ought to state that such patients should be referred to a cochlear implant centre for further assessment. This could be statement 5
11	ENT UK	General	Should the quality standards specify that patients identified as having external or middle ear disease during a hearing assessment or hearing aid fitting appointment should be referred to a local ENT surgeon? This does not necessarily relate to hearing loss but is an important component of good quality ear care.
12	NHSE	Question 1	Important that health systems identify adults with learning disabilities, to highlight potential vulnerabilities and possible need for reasonable adjustments to the care pathway offered Sensory impairments may have been missed in childhood and contributing to the clinical presentation/perceived level of functioning leading to diagnostic overshadowing Awareness of high prevalence of sensory impairments in people with learning disabilities Access to point of contact technology for screening, early intervention (currently being developed) (JOH)
13	Royal College of Nursing	Question 1	“Does this draft quality standard accurately reflect the key areas for quality improvement?” Yes very useful guideline

ID	Stakeholder	Statement number	Comments[1]
14	NHSE	Question 2	It is included in Annual Health Checks (financially incentivised scheme for General Practice) to encourage health checks, health promotion and health screens for people with learning disabilities. It is currently available from age 14+ (JOH)
15	Royal College of Nursing	Question 2	"Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?" Not able to comment due to our national rather than locality specific role
16	Action on Hearing Loss	Question 2	We welcome that the standard will be monitored on activity as well as quality, however we have concerns that data collection and outcomes collection varies considerably across CCG areas and are aware that some CCGs do not collect any data at all on the numbers of hearing aids fitted locally. NHS England's Commissioning Framework for adult hearing services states "contracts for hearing services that do not include service specifications and outcome measures should be avoided". The Framework also recommends that commissioning hearing aids services should be outcomes focused, which will "have a positive impact in terms of access, choice, quality and other related outcomes that benefit the services user and assure CCGs that services are providing good value for money".[6] CCGs should therefore be encouraged to implement this framework and collect and publish useful outcomes data in order for this statement to be effective.
17	British Association of Audiovestibular Physicians	Question 2	The structures for required local data collection should be in place and the information can be obtained through for example service specifications, referral pathways, clinical protocols, audits of case records and training records.
18	NHS Clinical Commissioners	Question 3	Clinical Commissioning Groups (CCGs) welcome the identification of good practice examples and recognise the value of NICE quality standards which draw upon a comprehensive evidence base to identify key areas for quality improvement within particular pathways. However, it is also important to acknowledge that the ability of CCGs to implement such quality standards can be constrained by the limited resource available to them, and their need to balance multiple, competing priorities. Unfortunately the NHS does not have unlimited resources and ensuring patients get the best possible care against a

[6] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

ID	Stakeholder	Statement number	Comments[1]
			backdrop of spiralling demands, competing priorities and increasing financial pressures is one of the biggest issues CCGs face. With huge pressures being felt across the whole health and care system, the NHS has to review services to ensure they are sustainable and improve the health of the wider population. Clinical commissioners have a responsibility to consider the needs of their whole populations, reduce inequalities and improve quality of care while making the most effective use of the limited NHS pound. NICE quality standards must therefore be considered within this context.
19	British Association of Audiovestibular Physicians	Question 3	The statements are achievable by local services. The suggested quality standards will not provide cost saving for the local services but there will be overall cost savings and reduced morbidity. For example; the quality statement for earwax removal require appropriately trained health professionals and equipment to remove earwax in primary/community care and may involve additional costs if not already in place. However, the suggested quality standard will provide general cost savings for example related to reduction in wasted appointments due to earwax preventing proper assessment, reduction in ear infections requiring medical treatment and prevention of inappropriate use of specialist services. Sudden or rapidly progressive hearing loss is a medical emergency, however unfortunately still not always promptly referred for specialist care leading to increased morbidity.
20	British Association of Audiovestibular Physicians	Question 3	The suggested quality standards will all provide general cost saving related to reduction in additional health, social care and economic costs (i.e. social benefit system cost and lost income/tax revenues).
21	British Society of Hearing Aid Audiologists	Question 3	Not able to address this question as we do not have knowledge of the local systems and structures for proposed quality measures.
22	British Academy of Audiology	Question 3	Within NHS, yes, but patients will not all present to NHS services.
23	British Academy of Audiology	Question 3	No, resources are not currently in place to deal with wax removal or face to face follow ups. Within Wales, there is currently a Welsh Government Task and Finish Group working on wax removal pathways to try and address this issue. We only have enough staff to cover the waiting lists on which there are government waiting times – this does not currently include follow ups.
24	Royal College of Nursing	Question 3	“Do you think each of the statements in this draft quality standard would be achievable by local services given the

ID	Stakeholder	Statement number	Comments[1]
			net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment." There are workforce issues in the availability of nurses to undertake ear care. The RCN are aware that the recruitment, retention and return of nurses to general practice nursing in England (2017) revealed that a third expressed an intention to retire by 2020. If this figure is extrapolated to the 23,100 headcount of GPNs nationally (NHS Digital, Sept 2016) it would imply that over 8,000 may leave the workforce in the next three years. https://www.england.nhs.uk/wp-content/uploads/2018/01/general-practice-nursing-ten-point-plan-v17.pdf
25	Action on Hearing Loss	Question 3	We recommend that the NICE guideline, The Action Plan on Hearing Loss and the Commissioning Framework for Adult Hearing Loss Services is included within the RCGP curriculum to provide GPs with more information about the impacts of hearing loss; the benefits of addressing hearing loss early and accessing support and management that is available on the NHS. The standard of training and education of GPs is monitored by the General Medical Council (GMC), and the curriculum and assessment are developed by RCGP, but the content of GP training is determined locally by individual Deaneries, Local Education, and Training Boards, and so varies across the UK. The RCGP curriculum for the 'Care of People with ENT, Oral and Facial Problems' gives examples of how to apply the competencies a GP needs to have to cases of people with hearing loss. For example, it states that doctors should ensure they can communicate with the patient, that they should "appreciate the impact of hearing loss on quality of life", including its "isolating effect", and that they should find out and gain experience of the services available for people with hearing loss[7]. However, GPs may have little specific training on diagnosing and managing hearing loss, and they may not know the latest research, such as on the link between hearing loss and dementia. The RCGP curriculum provides very little detail in these areas, and apart from a link to ENT UK and a link to a website with one e-learning module, it does not reference any other information or guidance.
26	ENT UK	1	The rationale for this statement is fine. The main concern the group had was that dewaxing is increasingly not

[7] RCGP. (2015). RCGP Curriculum: Professional and Clinical Modules. Available at: www.rcgp.org.uk/~/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-3-15-ENT-Oral-and-Facial-Problems.ashx

ID	Stakeholder	Statement number	Comments[1]
			delivered by NHS health care professionals. Without a change in the way this type of service is commissioned, dewaxing services will continue to devolve to the private sector.
27	ENT UK	1	GPs often struggle to adequately visualise the ear canal and tympanic membrane partly because of poor equipment and partly because of inexperience. This makes appropriate diagnosis difficult, not just of ear wax but of other types of pathology.
28	Action on Hearing Loss	1	It is extremely difficult to collect the numerator and denominator data for the process quality measure. Similarly a quality of life measure to assess the benefit of ear wax removal will be very difficult to administer and it may not be possible to identify an appropriate tool. The providers of ear wax removal are extremely diverse and often in the private sector compounding these issues.
29	British Society of Hearing Aid Audiologists	1	This is an important area for improvement, given the unwarranted variation across England, with widely different practice geographically. In many locations, the NHS only provides earwax removal through ENT services which is a widely inefficient and unnecessary arrangement causing long delays for individuals, and taking up important and expensive appointment time with scarce clinicians whose skills should be reserved for more specialist care. In those areas without community based arrangements, earwax removal is unlikely to satisfy the requirement for simple and timely access. Where it is provided through primary care (either NHS community-based clinics or commissioned from private providers) the service is often provide in same day clinics. Referral pathways are limited, which adds cost burden onto individuals who may have to seek private wax services. for others they may not realise it is possible to pay for treatment if they don't require hearing support. How can individuals be sure of the level of training for ear care practitioners in the private sector?
30	British Academy of Audiology	1	Many people wouldn't always think of Audiology being primary care. Need to make it clear that Audiologists are possibly best qualified/best placed to do this (wax removal)?
31	British Academy of Audiology	1	Difficult to measure health-related QoL as, from experience, wax impedes proper examination more often than it causes additional hearing loss. Patients are therefore unlikely to feel/notice that this has impacted on their quality of life. The same goes for when it affects hearing aid use - patients aren't always aware wax is the cause and therefore wouldn't attribute it to reduced QoL.
32	British Academy of Audiology	1	"Ear irrigation may be contraindicated for some patients" - as can manual removal.

ID	Stakeholder	Statement number	Comments[1]
33	British Academy of Audiology	1	Availability of equipment and training does not guarantee good service for patients if no appointments actually happen. Pathways should be included in the measures here. At the moment a lot of patients are paying for wax removal – is this to be included?
34	British Academy of Audiology	1	Wax removal services can only reduce the problems associated with wax if it can be removed in a timely way. I would like to see a limit on the acceptable time a patient will wait for wax removal.
35	British Academy of Audiology	1	The location of the appointment is less important than the availability of the service. Our patients would be quite happy to travel to 'secondary care' audiology sites for wax removal if it were available.
36	British Academy of Audiology	1	The key here is patients being able to 'access' wax management in a timely and consistent manner. This could be in Primary or Community (Audiology/Nurse led). The issue at the moment is each GP Practice can work alone and define its own rules/pathways and approach to wax so each patient gets a very different experience and outcome as a result. There is large variability in practice across local GP surgery's (within the same commissioning locality) and nationally, possibly in part due to uncertainty as to whether wax management is included in the General Medical Service Contract. NICE supports a good wax pathway and goes a long way to presenting the clinical reasons for its need. Although I wonder if the message to the GP consortiums and Commissioners needs to be stronger in that each commissioning locality should be expected to have: • A defined wax management pathway (models can vary) • Provide timely care (set expected time to management as Hanna suggests) • Including an agreed spell of trying to self-manage wax (with drops for set time) but then agreement to offer removal if drops are ineffective • Cost effective (not using ENT unnecessarily) • Reduced variability (so all patients in the defined locality access very similar wax management pathways regardless of GP Practice) • With the wax pathway having confirmed funding, targets and support from local commissioners and stakeholders (ENT/Audiology/Nurse leds teams etc)

ID	Stakeholder	Statement number	Comments[1]
			NICE Quality Standards are chosen because there is concern over 'variation in care'. Patients should be able to depend on a locally standardised agreed local pathway to avoid further examples of the below. 'The NICE committee noted that, in its experience, there is an increasing trend for GP surgeries not to treat patients with uncomplicated earwax in the surgery but to routinely refer them elsewhere or give them long courses of ear drops which, used on their own, are ineffective.'
37	British Academy of Audiology	1	Agree with comment how would this be measured? Not sure it is possible to accurately measure this Are trained in earwax removal methods (typo) I think comment is right about contra indication perhaps needs to say unless there are contra indications suggest removal by ENT specialist nurse/doctor
38	British Academy of Audiology	1	Full stop after cough not needed (typo)
39	British Society of Audiology	1- Question 2	May be difficult to measure as would need collation of data from all Primary care providers, as well as Private providers that provide this service.
40	British Society of Audiology	1	In order for this QS to be achieved there would need to be an increase in the accessibility in equipment and training in Primary Care. It is apparent that a large proportion of GP practices do not provide this service.
41	Hearing Loss and Deafness Alliance	1	It is good to see the focus on "Adults with earwax contributing to hearing loss or other symptoms, or preventing ear examination, have earwax removal in primary care or community ear care services." However, there is huge variation of service provision across the UK for wax removal, with some GP surgeries no longer providing any wax removal services. Because of this variation, as well as confusion over the methods available locally by professionals and the public, it may be difficult to measure this. Clear local information should be provided on what wax removal services are available, including the most appropriate method of removal for an individual. This should help to mitigate confusion for someone accessing wax removal services locally and reduce repeat appointments with the GP, ENT and audiology. A key element is ensuring that GPs and nurses in primary care are well informed about the importance of wax removal for hearing aid users and people attending audiology appointments. We also welcome that reference is made to ensuring that locally agreed pathways for wax removal are in place, as well as trained healthcare professionals and equipment are

ID	Stakeholder	Statement number	Comments[1]
			provided. We recommend that CCGs look to sources such as NHS England´s framework and learn from each other regarding implementing wax removal services into the audiology pathway more effective. For example NHS England's commissioning framework for adult hearing loss refers to a redesigned direct access hearing services, which is inclusive of wax removal in Coventry and Rugby CCG. Implementation within audiology services found effective outcome measures, improved patient experience and enabled acute and community services to operate alongside each other. y.
42	RCGP	1	Hearing loss caused by impacted can also interfere with employment. It is important that alternative community arrangements are in place commissioned by the CCG independent of GP practices who may not be able to offer removal pf was due to manpower issues
43	Royal Berkshire NHS Foundation Trust	1	Wax is a healthcare issue and patients should be able to 'access' wax management in a timely and consistent manner. This could be in Primary care, such as Alliances between GP practices (sharing trained staff?) or Community (Audiology/Nurse led) but the local pathway needs to be clear to GP's and patients. The issue at the moment is each GP Practice can work alone and define its own rules/pathways and approach to wax so each patient gets a very different experience and outcome as a result. This is understandable as there are pressures on GP's and nursing, some practices will not have nurses who are trained on wax management or nurses who refuse to train in this area. There is an expense to training a new nurse if one leaves, and the demand is high for the nurse led time in modern GP surgeries, particularly small ones. Funding is also an issue in part due to uncertainty as to whether wax management is included in the General Medical Service Contract. As a result there is large variability in practice across local GP surgery's (within the same commissioning locality) and nationally, as it's unclear who will resource pathways. NICE NG98 supports a good wax pathway and goes a long way to presenting the clinical reasons for its need. Although we wonder if the direction to the GP consortiums and Commissioners needs to be stronger in that each commissioning locality should be expected to have: • A defined wax management pathway (models can vary i.e. GP alliance collaborations/community pathway?) • Provide timely care (set expected time to management)

ID	Stakeholder	Statement number	Comments[1]
			• Include an agreed spell of trying to self-manage wax (with drops for set time) but then agreement to offer removal if drops are ineffective • Cost effective (not using ENT unnecessarily) • Reduced variability (so all patients in the defined locality access very similar wax management pathways regardless of GP Practice) • With the wax pathway having confirmed resourcing agreed and funding. Possibly targets and support from local commissioners and stakeholders (ENT/Audiology/Nurse led teams etc) NICE Quality Standards are chosen because there is concern over 'variation in care'. Patients should be able to depend on a locally standardised agreed local pathway to avoid further examples of the below. 'The NICE committee noted that, in its experience, there is an increasing trend for GP surgeries not to treat patients with uncomplicated earwax in the surgery but to routinely refer them elsewhere or give them long courses of ear drops which, used on their own, are ineffective.'
44	National Community Hearing Association	1	We strongly support statement 1. We would however suggest the wording is changed to make this clearer as follows: From • "Adults with earwax contributing to hearing loss or other symptoms, or preventing ear examination, have earwax removal in primary care or community ear care services" To • "Adults with earwax contributing to hearing loss, other symptoms, or preventing ear examination, have earwax removal in a primary care or community care setting – i.e. are not referred to an outpatients or an acute hospital unless clinically necessary" Explanation if required:

ID	Stakeholder	Statement number	Comments[1]
			This is in line with the NHS Long Term Plan to explicitly reduce the pressure on hospital capacity and significantly reduce the number of outpatient visits. However, even before publication of the Long Term Plan it was important – for both patients and the NHS – that adults with impacted earwax were not referred to ENT unless it was clinically necessary. This still holds true as follows: § For patients with earwax, this will help avoid unnecessary visits to hospital and therefore reduce the cost and anxiety associated with hospital visits. § For other patients, e.g. those with life-threatening conditions who need to see an ENT surgeon, it will mean more timely care because ENT slots are not being used for routine aural care § For the NHS, it will help ensure resources are used appropriately. Each year NHS trusts in England record over 350,000 annual visits by adults for "clearance of external auditory canal". The majority of these visits will be to manage earwax, and this is also likely to underestimate the actual activity because not all of it is recorded. Managing this caseload in primary and community care settings can reduce costs and free up scarce hospital capacity, resulting in significant economic savings and system benefits for the NHS. It is important to note however that statement 3 conflicts with statement 1 in a practical – real world – setting (please see our feedback on statement 3).
45	National Community Hearing Association	1	The proposal for measurement is unlikely to have the desired impact. We would be happy to explain why in detail if that would be helpful. Here we provide a brief summary and some alternative suggestions: Summary § the original NICE guideline NG98 (pp. 102-136 full version) aimed to reduce unnecessary referrals to ENT and improve access to evidence-based/cost-effective treatments for earwax § statement 1 builds on that NICE guideline recommendation § the proposals for measurement however overlook these objectives and the data outputs are unlikely to help infer whether these objectives are being met

ID	Stakeholder	Statement number	Comments[1]
			Measurement § instead of focussing on training of healthcare professionals or equipment, it would be more helpful to focus on where these services have been commissioned in line with the NICE guideline (NG98) § the commissioned service would include a specification – covering access, locations, quality control (staff training, clinical governance, training criteria, equipment etc) § at present earwax services are not always explicitly commissioned and rely on ad hoc arrangements which explains the root cause of significant unwarranted variation in this area We therefore suggest the following alternative: § Structure: a) Evidence of locally commissioned earwax management services in a primary and/or community settings Data source: local data collection, for example, local commissioning region publishing which earwax services it has commissioned for the population b) Evidence of quality earwax management services available locally – including suitably qualified and trained healthcare professionals and appropriate equipment Data source: local data collection, for example, service specifications § Process a) Proportion of attendances where a patient is referred to secondary care for management of earwax Numerator: number of adults referred to secondary care for management of earwax Denominator: number local of adults aged 50 and older*

ID	Stakeholder	Statement number	Comments[1]
			Explanation Useful data collection for earwax management is likely to be costly and complex, and of limited value – e.g. most people already self-manage by visiting a pharmacy (the data support this, when looking at incidence estimates vs. recorded ENT and GP activity). The goal here is to encourage the NHS to ensure people can access quality care closer to home and to avoid ENT visits for earwax management unless clinically necessary. The pragmatic way to do this is to measure how many people are referred to ENT/secondary care for wax management, and focus attention of tackling unnecessary referrals – i.e. the number should be reduced over time if the NICE guideline recommendation is implemented. The measure can therefore be simplified by local regions assessing how many adults are referred to secondary care (ENT) for earwax management and then benchmarking their local data to other regions, whilst controlling for age of the local adult population*. This should help local NHS regions to explore the root cause of variation and possible solutions where unwarranted variation exists – e.g. commissioning a primary or community based service with a service specification to reduce excessive referrals to ENT, or ensuring local services are referring to ENT where it might be warranted. This process approach would be consistent with health quality management principles. [*Adults aged 50 and older is suggested because impacted earwax is highly correlated with age, with very young people (not in scope) or older people (in scope) much more likely to need support with impacted wax – i.e. to control for variation due to local demographics, although an age of 60 or 70 might be equally helpful, controlling for age is likely to be an important consideration]
46	National Community Hearing Association	1	We agree that "housebound people with hearing loss might also have limited access to hearing care services". This however is due to suboptimal commissioning standards – e.g. commissioning without performing a joint strategic needs assessment and/or Equality Impact Assessment. The current text risks, inadvertently, misinforming the reader that there are limited options to address this inequality and this should therefore be addressed. There are specialist providers that offer home care and also increasingly offer earwax management services. The availability of these services should be noted in this section.

ID	Stakeholder	Statement number	Comments[1]
47	Hearing Loss and Deafness Alliance	1	Evidence shows that over 80% of older people living in care homes need support for their hearing loss to maximise their independence and wellbeing, but hearing loss often goes undiagnosed or is not properly managed. The focus on people who live in care homes should have the same access to health and social care as people living independently is therefore really helpful. However access to domiciliary care varies across the country. Wax can cause temporary hearing loss, is also a major cause of hearing aid malfunction and excessive wax can delay access to assessment and management of permanent hearing loss and this needs more focus and a more flexible response. For example District Nurses and other health professionals already carry out ear canal irrigation in care home settings. In addition, NHS hearing services could offer ear canal irrigation as part of their outreach services to care homes which would all help address this.
48	Action on Hearing Loss	1	**The statement that people who live in care homes should have the same access to health and social care as people living independently is welcomed**. Evidence shows that over 80% of older people living in care homes need support for their hearing loss to maximise their independence and wellbeing, but hearing loss often goes undiagnosed or is not properly managed[8]. We are aware that access to domiciliary care varies across the country. Wax can cause temporary hearing loss, is also a major cause of hearing aid malfunction and excessive wax can delay access to assessment and management of permanent hearing loss. Local authorities and NHS commissioners and providers should consider innovative ways of improving the way older people living in care homes access ear wax removal services. For example, in some areas, District Nurses and other health professionals already carry out ear canal irrigation in care home settings. In addition, NHS hearing services could offer ear canal irrigation as part of their outreach services to care homes.
49	Birmingham University Hospitals NHS Foundation Trust	1 – Question 2	This refers to audience descriptor: We could measure non-compliance by primary care of this guideline by auditing numbers of referrals that come through where wax removal has not been performed appropriately. This would need to be a joint audit with ENT and Audiology but would require time and resources.
50	British Academy of Audiology	1- Question 2	There should be a defined Wax Pathway with expected timeframes and outcomes. There maybe be funding issues arising from this as traditionally it was absorbed by GP. Wax could be therefore be seen as a new funding pressure.

[8] Echalier, 2012. *A World of Silence*. Available from: http://www.actiononhearingloss.org.uk/-/media/ahl/documents/research-and-policy/reports/care-home-report.pdf

ID	Stakeholder	Statement number	Comments[1]
			There are a lot of patients who will request wax management, some linked with hearing aids/hearing assessment, but many unrelated to hearing services. As a result wax is likely to represent an activity pressure on those services (GP, community nurse, community Audiology) selected to remove stubborn wax (not cleared through drops). Therefore, care must be taken not to underestimate support and funding to a that service. For instance, it is unsustainable to bundle wax management into current Audiology hearing services without support. Similarly, a GP or community nurse model would need adequate time and funding to prevent wax becoming an unsustainable burden that negatively impacts other care.
51	Royal Berkshire NHS Foundation Trust	1- Question 2	There should be a defined Wax Pathway with expected timeframes and outcomes. There may be funding issues arising from this as traditionally it was absorbed by GP. Wax could be therefore be seen as a new funding pressure into CCG's/ICS. There are a lot of patients who will request wax management, some linked with hearing aids/hearing assessment, but many unrelated to hearing services. As a result wax is likely to represent an activity pressure on those services (GP, community nurse, community Audiology) selected to remove stubborn wax (not cleared through drops). Therefore, care must be taken not to underestimate resources so that GP surgeries and the wax pathway are supported.
52	Wales Audiology Heads of Service	1- Question 2	This statement may be hard to measure because: There are no local systems and structures in place to collect data on ear wax removal. Currently there is no obligation on GPs to provide wax removal for their patients and many do not do so. In a small number of areas Audiology Services are starting to provide this service. A Welsh Task and Finish Group is currently looking at pathways for ear wax removal and will be reporting to Welsh Government & by Health Circular to Health Boards in the summer providing recommendations for pathways and training. After the T & F group has reported measurement would be feasible once Health Boards have complied with the recommendations, but there would be significant cost implications for training and provision of equipment. One Health Board Audiology service has suggested that local ENT/audiology departments could run a microsuction/manual dewaxing course
53	British Society of Hearing Aid Audiologists	1- Question 2	We are unaware of any accurate data set reporting the provision of earwax removal services, and whether these are community or hospital based, or what waiting times services are operating with. We need clarity of what services commissioners are making provision for, and whether these will be subject to Any Qualified Provider contracts so that individuals have a choice of provider and location at their convenience.

ID	Stakeholder	Statement number	Comments[1]
			Many GPs have withdrawn from offering wax removal services. There is no agreement of which clinical profession/ what training is required for wax removal.
54	British Academy of Audiology	1- Question 3	Resources and achievability can only really be understand when a locality understands size of issue and the relative split envisaged between primary care and community ear care services (GP, Nurse led, Audiology). Achievability will be directly linked to resources which will likely be linked to sensible funding to ensure sustainability
55	Royal Berkshire NHS Foundation Trust	1- Question 3	Resources and achievability can only really be understood when the demand for the service is understood locally and the model and/or relative split envisaged between primary care and community ear care services (GP, Nurse led, Audiology) agreed. Achievability will be directly linked to a robust plan and resources
56	Wales Audiology Heads of Service	1- Question 3	Achievable once Primary Care Audiology funding is obtained by all Health Boards. Potential cost savings - Training Associate practitioners (band 4) to become experts in wax removal
57	British Society of Hearing Aid Audiologists	1- Question 3	There is limited capacity or funding to make this a readily available service. Equipment, training and clinic space will need to be funded if the service is to be delivered universally within community-based facilities What training and qualification provisions are there for staff?
58	ENT UK	2	The 'quality statement' at the start of this statement is misleading. It refers to sudden onset or rapidly worsening idiopathic sensorineural hearing loss. Sudden onset conductive hearing losses are not an emergency. The statement should therefore be modified to clarify this. The rationale is also unclear. The definition of sudden hearing loss and rapid onset hearing loss should be set out at the beginning of this section. Furthermore it is not appropriate to state that sudden hearing losses can, in some cases, lead to death. The risk groups mentioned as possible causes of death generally do not cause death. They also generally present with slower onset hearing losses, conductive hearing losses or with other more obvious non-hearing related symptoms
59	ENT UK	2	For clarities sake, it might be better to separate sudden onset idiopathic sensorineural hearing losses from rapid onset sensorineural hearing losses as they are managed differently (perhaps as separate statements). Similarly the differential diagnosis of sudden sensorineural hearing losses include many different conditions eg. Meneire's disease, vestibular schwannoma etc. Should there not be some guidance about excluding these conditions before diagnosing idiopathic sudden sensorineural hearing loss.
60	ENT UK	2	Most of the group agreed that sudden hearing losses should be treated even if they present up to 6 weeks after

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			onset. Some felt that treatment should be attempted after even longer periods.
61	ENT UK	2	We agreed that sudden and rapid onset sensorineural hearing losses should be referred to ENT or AV medicine, not to the emergency department. Emergency departments do not have the expertise or facility to diagnose and treat these types of hearing loss. They should refer anybody with a sudden sensorineural hearing loss (as determined by clinical examination and tuning fork tests) to ENT or AV Medicine.
62	ENT UK	2	It does not state how patients with sudden and rapid onset hearing loss should be managed once seen by ENT or AV Medicine. Patients should be offered oral steroids and have intratympanic steroids available as a treatment either as a primary modality or for rescue following failed oral steroid therapy.
63	ENT UK	2	The main problem with diagnosing sudden and rapidly progressive sensorineural hearing losses is making a correct diagnosis. In the community, which is where many of these patients present, there is a lack of expertise in carrying out tuning fork tests adequately in order to differentiate between conductive and sensorineural hearing losses, not to mention an absence of the appropriate tuning forks. There is also poor appreciation of the urgency to treat sudden sensorineural hearing losses. Any pathway needs to clearly state that both Rinne's and Webers tuning fork tests (using either a 256Hz or a 512Hz fork) should be carried out and if they indicate a sensorineural hearing loss then an urgent referral should be made. There is a major education issue here.
64	ENT UK	2	There is a risk of ENT and AV Medicine departments being swamped with inappropriate sudden hearing loss referrals that turn out to be acute middle ear problems or even longer term problems. Again, this is an education issue but very difficult to improve in the short to medium term as knowledge in primary care is not consistent.
65	ENT UK	2	Again the process quality measures will be virtually impossible to achieve. It will be very difficult to know the total numbers of patients who have had a sudden or rapid onset sensorneural hearing loss, some of whom will not see a doctor in a timely fashion or may not be referred to ENT or AV Medicine services in a timely fashion. It will also be difficult to collect the data on numbers of patients referred for treatment without very robust, national audit processes in place.
66	ENT UK	2	It is unclear how morbidity data for sudden and rapid onset hearing losses will be collected and what tool would be used. Many of the tools for measuring the morbidity of single sided deafness are complex and time consuming to carry out.
67	Action on Hearing Loss	2	We welcome the rationale to statement 2; however, more education is needed about urgent referrals to the public as well as within primary and emergency care.

ID	Stakeholder	Statement number	Comments[1]
			Anecdotally, we have received some reports from individuals delaying treatment for sudden onset hearing loss because it were believed that the underlying cause was a common cold or flu causing congestion. Subsequently, the issue was not treated urgently and the individual was later diagnosed with sensorineural hearing loss. The NICE guideline recognises that there are 'several clinical guidelines for GPs and audiologists outlining the circumstances in which they should consider referral for more specialist medical care, for example, the British Academy of Audiologists' Guidance for Audiologists and for Primary Care, which reflect a broad clinical consensus. Whilst most of the recommendations made reflect current practice, there remains variation and not all clinicians would currently be aware of all the signs and symptoms, which lead to an urgent referral. The quality standard and NICE guideline for hearing loss will help to overcome these variations by setting out clear national guidance- CCGs should therefore work with local audiology services and primary care staff are full aware of local pathways and policies for sudden hearing loss.
68	Action on Hearing Loss	2	It is estimated that over 80% of older people living in care homes need support for their hearing loss to maximise their independence and wellbeing, but this often goes undiagnosed or is not properly managed[9]. Care home staff should be trained to recognise signs of hearing loss, including the need for urgent care in the case of sudden hearing loss. This should be added to equality and diversity section within standard 2.
69	Birmingham University Hospitals NHS Foundation Trust	2- Question 3	This refers to audience descriptor: Audiology have procedures in place to refer directly to the ENT casualty clinic if they have a patient with sudden hearing loss. Any monitoring of this would need to be completed by ENT which would require time and resources.
70	British Academy of Audiology	2	I am a little confused at the mix of emphasis here (i.e. in the list of conditions which carry risk of non-identification). Necrotising otitis externa can be deadly, but there would also be a history of recent untreatable otitis externa. Not your typical case of SSNHL; the primary differential symptom being pain. I would have thought the primary rationale would be that there is the potential for saving residual hearing if seen by a specialist within 10 days.
71	British Academy of Audiology	2- Question 2	The measure does not specify where these patients have initially presented. They may attend NHS audiology services, A&E, GP, high street audiologist… It may be difficult to gather together numbers from all these different locations.
72	British Academy of	2	Unsure of the term 'morbidity' here. Does it imply that the only outcome we are trying to avoid is death? I think the

[9] Echalier, 2012. *A World of Silence*. Available from: http://www.actiononhearingloss.org.uk/-/media/ahl/documents/research-and-policy/reports/care-home-report.pdf

ID	Stakeholder	Statement number	Comments[1]
	Audiology		QS should aim to minimise any avoidable long term disability.
73	British Academy of Audiology	2	Sudden hearing loss that has developed (typo) Add mastoiditis?
74	Hearing Loss and Deafness Alliance	2	We welcome the rationale to statement 2; however, more education is needed about urgent referrals to the public as well as within primary and emergency care. The guideline recognises that there are 'several clinical guidelines for GPs and audiologists outlining the circumstances in which they should consider referral for more specialist medical care, for example, the British Academy of Audiologists' Guidance for Audiologists and for Primary Care, which reflect a broad clinical consensus. Whilst most of the recommendations made reflect current practice, there remains variation and not all clinicians would currently be aware of all the signs and symptoms, which lead to an urgent referral. The quality standard and NICE guideline for hearing loss will help to overcome these variations by setting out clear national guidance- CCGs should therefore work with local audiology services and primary care staff are full aware of local pathways and policies for sudden hearing loss.
75	Hearing Loss and Deafness Alliance	2	Care home staff should be trained to recognise signs of hearing loss, including the need for urgent care in the case of sudden hearing loss. This should be added to equality and diversity section within standard 2.
76	RCGP	2	It is helpful that definitions are provided on what constitutes urgent referral. The important principle here is that services need to be responsive to demand from these patients who need to be seen quickly.
77	National Community Hearing Association	2	We support this statement. On pages 9 and 10 the statement repeats the applicable definitions used in the NICE guideline. These are clear and correct. Stakeholders however have reported, and we agree, that text on pages 7 to 9 is less clear and this might result in confusion and human error. It would be helpful if NICE can review the text on pages 7 to 9 with the goal of making this easier to read/digest and thus reducing the risk of misreading and human error – e.g. simplify the language used and be clearer on the signs/symptoms that warrant an urgent referral because not everybody will read the detail or refer back to NG98.
78	National Association of Deafened People	2	We are concerned this statement does not take into account traumatic nature of rapid worsening of hearing loss and worsening irreversible damage caused by wait . All patients in this group need urgent assessment. 2 weeks is a long time.

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			With causes that include trauma, intracranial infection and tumours. it can frequently be a symptom of a serious condition. And a contrast enhanced CT scan will either give the diagnosis or at least exclude the more acute serious causes. Lack of guidance on psychological support for those who experience sudden or progressive hearing loss. Late Deafened report which was co – written by NADP has shown patients are not offered mental health support
79	National Association of Deafened People	2	Most of the patients are not aware they need to act swiftly with worsening of their hearing, better awareness is needed among patients and medical staff. A&E departments need to have clear pathway procedure in case of sudden hearing loss. Given WHO guidance on prevention of noise induced hearing loss, it is advisable NHS supports the efforts to educate general public on importance of getting hearing checked, even if hearing loss may seem to be reversed after short period. The damage may already have been done.
80	British Society of Hearing Aid Audiologists	2- Question 2	We do not have knowledge of the local systems and structures for proposed quality measures. However, we are aware that there is no national comparison of the extent to which individuals presenting with difficult but routine hearing loss are referred inappropriately into complex pathways. The data required to assess the effectiveness of urgent referral for sudden hearing loss would be similar to that required for monitoring the appropriate use of referral pathways.
81	British Society of Hearing Aid Audiologists	2- Question 2	Yes, the local systems and structures are in place for the basic data collection. If not, it should be fairly straight forward to organise. However, more evidence is required to identify and address the variation in levels of referral into complex pathways.
82	Wales Audiology Heads of Service	2- Question 2	Data is not currently collected locally or on an all Wales basis but local Healthcare pathways are in place or being developed in Welsh Health Boards so it would be quite feasible to use these to collect the data required
83	Wales Audiology Heads of Service	2- Question 3	Health Pathways can easily be put in place for GPs and other professionals to access specialist care, with ENT services accepting immediate referrals Potential cost savings - GPs could take immediate action and prescribe oral steroids to ensure that these are being administered in a timely fashion to help aid in possible recovery of hearing

ID	Stakeholder	Statement number	Comments[1]
	ENT UK	3	The rationale is fine. Again the quality measures are very difficult to achieve. How do we know how many people there are in any given community with hearing loss.
84	Action on Hearing Loss	3	We welcome the quality standard that "adults presenting with hearing difficulties not caused by impacted wax or acute infection are referred for an assessment." This statement may be a challenging to implement for GPs, since evidence suggests that often GPs can act as a barrier to people accessing audiology services. On average, adults with hearing loss wait 10 years before seeking medical advice, and when they do visit their GP, 30 to 45 percent are not referred for a hearing assessment[10]. This indicates that there is a significant unmet need. Approximately only two fifths of people who need hearing aids have them[11]. We also refer to further challenges concerning equality and diversity and better training for GPs related to hearing loss. In addition, there is also considerable variation across England in access to audiology services. The NHS England Atlas of Variation shows an 11-fold variation in the rate of audiology assessments,[12] suggesting that there is significant variation in referrals made by GPs for people with hearing loss[13]. In recognition of this, early diagnosis and management of hearing loss has been identified as a key objective in the Action Plan for Hearing Loss[14]. CCGs should overcome challenges users should refer to the Commissioning Framework for Adult Hearing Loss Services[15], which states that "GPs and other health and social care professionals should regularly check people's hearing as they get older (10, 23) to encourage people to seek help, and to ensure they get a prompt referral on to audiology

[10] Davis et al (2007) Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. Health Technology Assessment 11:1–294; 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

[11] Health Survey England (2014): VOL 1 | CHAPTER 4: HEARING. The Health and Social Care Information Centre. Available at: http://www.hscic.gov.uk/catalogue/PUB19295/HSE2014-ch4-hear.pdf; 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; European Hearing Instrument Manufacturers Association (2015) Eurotrak Survey 2015; Davis and Smith (2013) Adult hearing screening: health policy issues--what happens next? Am J Audiol. 22(1):167-70.

[12] Public Health England (2013). NHS Atlas of Variation in Diagnostic Services: Reducing unwarranted variation to increase value and improve quality.

[13] Davis et al (2012). Diagnosing patients with age-related hearing loss and tinnitus: Supporting GP clinical engagement through innovation and pathway redesign in audiology services. International Journal of Otolaryngology, available at: http://www.hindawi.com/journals/ijoto/2012/290291/

[14] NHS England and Department of Health (2015) Action Plan on Hearing Loss. London: NHS England and Department of Health. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/03/act-plan-hearing-loss-upd.pdf

[15] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

ID	Stakeholder	Statement number	Comments[1]
			services". The Framework also recommends that "CCGs should plan to ensure services tackle unmet need and ensure that GPs are aware of the evidence and national guidance, as well as local referral pathways". Further guidance on referral is available from the British Academy of Audiology at http://www.baaudiology.org/index.php/download_file/view/302/178/ , and professional practice guidance from the British Society of Hearing Aid Audiologists can be found at http://www.bshaa.com/Publications/BSHAA, which should be included within 'tools and resources' under the section 'Putting the guideline into practice' on page 11 of the short version of the guideline. Furthermore, users should also refer to the Action Plan on Hearing Loss[8], which urges health professionals to recognise communication needs and offer appropriate support in accessing other health and public services to people with hearing loss.
85	Action on Hearing Loss	3	An increasing body of evidence suggests that early intervention and support for hearing loss may reduce the risk and impact of dementia. Hearing aids may have an important role to play in reducing the risk of cognitive decline and the onset of dementia, but despite this, we know that less than two-fifths of people who need hearing aids have them. Hearing aids are most effective when fitted early, but evidence suggests that people wait up to ten years on average before seeking help for their hearing loss and the average age for referral is in the mid-70s. [16] Good health and social care practitioners awareness of hearing loss, hearing aids and role of the GP in referring adults for a hearing assessment is therefore crucial for ensuring early diagnosis and prompt access to treatment. Commissioners and health and social care professionals implementing this Quality Statement should refer to NICE's recently published Hearing Loss in Adults: Assessment and Management Guideline which provides clear guidance on the best approaches for diagnosing and managing loss. The Guideline highlights that delays in referral for hearing difficulties will reduce people's ability to "function at work and home" and make it harder for them to look after their own health. Commissioners should also refer to NHS England's forthcoming JSNA guide. This guide has been co-produced by NHS England, the Local Government Association, the Association of Directors of Public Health and

[16] Davis et al, 2007. Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. *Health Technology Assessment* 11: 1–294.

ID	Stakeholder	Statement number	Comments[1]
			other stakeholders, and will be published later this year. The guide provides data; evidence and insight to help local authorities and NHS commissioners develop robust hearing needs assessments that properly reflect local needs.
86	Action on Hearing Loss	3	CCGs should be encouraged to promote good practice and innovations aimed at raising awareness of hearing loss and the early diagnosis of hearing loss.
87	British Society of Hearing Aid Audiologists	3	This statement should embrace self-referral as well as from GPs who generally add little to pathway and may pose a barrier, preventing individuals from being assessed by an audiologist, The quality statement is not properly focused on measuring the true impact of hearing loss. The use of QALY and DALY in the statement is restricted to assessment of satisfaction with hearing aids which is irrelevant in assessing the social need, but nevertheless important in assessing the effectiveness of the support provided. The quality statement should differentiate between these two measurements. The statement should refer to tools which genuinely assess the need, such as the Hearing Handicap Inventory for the Elderly (HHIE), and within dementia services such as the Mini Mental Health State Exam (MMHSE). BSHAA recommend the use of alternative appropriate measurement functions. DALYs- Murray 1994 Bulletin of the World Health Organisation. 1994;72(3):429-45 DALYs and QALYs – Sassi 2006 Health Policy Plan. 2006 Sep;21(5):402-8. Epub 2006 Jul 28 The Guidelines Manual-Process and Methods (PMG6) Nov 2012, NICE, HMSO MMHSE – COCHRANE REVIEW 2015 HHIE - Ventry 1982 Ear and Hearing. 1982 May-Jun;3(3):128-34. Gold, M.R., Stevenson, D. and Fryback, D.G. (2002) HALYS and QALYS and DALYS, Oh My: similarities and differences in summary measures of population Health. Annual Review of Public Health 23 , 115-34. QALYs - . National Institute for Health and Care Excellence. September 2013.
88	British Society of Hearing Aid Audiologists	3	To meet this statement, Local Service Level Agreements need to include standardised referral assessments criteria, with particular regard to the socio-interpersonal-economic costs of mild hearing impairment. It's likely that there would be cost and resource impacts to achieving this. Also need to differentiate the measurement of the social impact of hearing loss, from measurement of the effectiveness of the provided intervention in delivering the intended benefits, including satisfaction measures and measures of the successful adoption rates. With a large range of useful measurement tools, some indication of adoption rates for different measurement

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			vehicles would be helpful.
89	Birmingham University Hospitals NHS Foundation Trust	3- Question 3	This refers to audience descriptor: Not sure how easy this would be for us to monitor as this is the responsibility of primary care. It would also require significant time and resources to ensure healthcare professionals have the appropriate training and knowledge to recognise hearing loss and communication difficulties.
90	British Academy of Audiology	3	"Devices" not "aids".
91	British Academy of Audiology	3	Some outcome collection difficulties hard to comment on - GPs consulted?
92	British Academy of Audiology	3	Pleased to see need for hearing assessment in adults with cognitive needs raised – it would be a very useful addition to include a sentence emphasising the fact that hearing assessment is possible in these populations so that referrers are not tempted not to make the referral for those with severe or profound learning disabilities under the mistaken belief that hearing can't be assessed in that group
93	British Academy of Audiology	3	Yes, although statement 3 could go further in terms of ensuring good services for adults with learning disabilities etc.
94	British Academy of Audiology	3	Replace 'are referred for' with 'receive'. Many patients now self-refer (e.g. primary care services in Wales), so this specification for someone to refer them is outdated.
95	British Academy of Audiology	3	Structure: Does not specify where the patients initially present. Should also specify 'at the first presentation' – this QS should aim to reduce the number of patients repeatedly attending GP with hearing loss before receiving an Audiology appointment.
96	British Academy of Audiology	3	Numerator: Replace 'are referred for' with 'receive'
97	British Academy of Audiology	3	Replace 'are referred for' with 'receive'
98	British Academy of Audiology	3	Add 'devices' and possibly add in 'assistive listening device'?
99	British Society of Audiology	3	GP referral pathways have been in place for a long time. We would suggest the availability of self-referral which would enable adults with hearing difficulties to self-refer thereby accelerating the time between complaint and diagnostic assessment and freeing up GP time. This service model has already been put in place in primary care in

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			some areas of Wales.
100	Hearing Loss and Deafness Alliance	3	We welcome the quality standard that "adults presenting with hearing difficulties not caused by impacted wax or acute infection are referred for an assessment." However evidence suggests that often GPs can act as a barrier to people accessing audiology services. On average, adults with hearing loss wait 10 years before seeking medical advice, and when they do visit their GP, 30 to 45 percent are not referred for a hearing assessment. In recognition of this, early diagnosis and management of hearing loss has been identified as a key objective in the Action Plan for Hearing Loss. CCGs should overcome challenges users should refer to the Commissioning Framework for Adult Hearing Loss Services, which states that "GPs and other health and social care professionals should regularly check people's hearing as they get older (10, 23) to encourage people to seek help, and to ensure they get a prompt referral on to audiology services". The Framework also recommends that "CCGs should plan to ensure services tackle
101	Hearing Loss and Deafness Alliance	3	Commissioners and health and social care professionals implementing this Quality Statement should refer to NICE's recently published Hearing Loss in Adults: Assessment and Management Guideline which provides clear guidance on the best approaches for diagnosing and managing loss. The Guideline highlights that delays in referral for hearing difficulties will reduce people's ability to "function at work and home" and make it harder for them to look after their own health. Commissioners should also refer to NHS England's forthcoming JSNA guide. This guide has been co-produced by NHS England, the Local Government Association, the Association of Directors of Public Health and other stakeholders, and will be published later this year. The guide provides data; evidence and insight to help local authorities and NHS commissioners develop robust hearing needs assessments that properly reflect local needs
102	National Community Hearing Association	3	We fully support adults being encouraged to visit an audiologist for a hearing assessment. The current statement however § is based on historical and outdated models of care § is likely to conflict with statement 1 in a real world setting Adults with earwax can, where services have been commissioned, be referred directly to audiology. Audiologists can then manage earwax (i.e. deliver on Statement 1 to manage earwax removal in primary or community settings). To make this quality statement align with the objectives set out in Statement 1 and Statement 2, we would suggest

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			a change of wording: From • "Adults presenting with hearing difficulties not caused by impacted earwax or acute infection are referred for an audiological assessment" To • "Adults presenting with hearing difficulties not caused by acute infection or that is not of urgent or sudden onset, are referred for an audiological assessment" We also suggest § that all references to impacted earwax in statement 3 (pages 11 to 13) are edited to make clear that people with impacted earwax can be referred to audiology services
103	National Community Hearing Association	3	The NICE guideline for adult hearing loss (NG98) acknowledges that unaddressed adult hearing loss is a major and growing public health issue. The same NICE guideline shows hearing assessments and hearing aids are very cost-effective. This collectively resulted in NICE recommending the NHS should do more to encourage hearing tests. We strongly supported the NICE review of evidence and new economic analysis led by NICE, and therefore NICE's recommendation. The problem with the proposed measure for this particular quality statement however is that, at best, it will only capture information on those people that report a hearing difficulty to a healthcare professionals (typically their GP). This represents a minority of people with hearing loss. This means the data are likely to continue misleading decision makers about the underlying public health risk due to unsupported hearing loss. It is for this reason we strongly recommend keeping the numerator but changing the denominator from § the number of adults presenting with hearing difficulties not caused by impacted earwax or acute infection to § per 1,000* local adults estimated to have a hearing loss

ID	Stakeholder	Statement number	Comments[1]
			That is (number adults referred to audiology)/(local adults with hearing loss/1000*) Data sources: For the numerator (number of audiological assessments): we would strongly encourage the use of direct access audiology RTT data which NHS England collects and publishes here: https://www.england.nhs.uk/statistics/statistical-work-areas/direct-access-audiology/. This is already collected and reported, and has a methodology that has been approved and that can be audited etc. For the alternative denominator (number of local adults estimated to have a hearing loss): this data is readily available – including from the POPPI dataset and NHS England Commissioning Framework. In addition to this, although NICE does not refer to unpublished documents, NHS England, the Local Government Association and Association of Directors of Public Health (ADPH), supported by the NCHA and Action on Hearing Loss, have also produced a JSNA guide (which includes data tool) to support local decision making. This JSNA guide will be aligned with the POPPI dataset – i.e. the denominator we suggest is easy to obtain from several sources and consistent. Advantages: This will be low cost to collect and monitor, will avoid duplication and help infer some information on the proportion of adults not seeking help. These data already exist, so guidance on how to use the datasets for this purpose is what is required. The NCHA, working with colleagues across sectors (including the ADPH), would be able to support this process if NICE recommended the proposed numerator and denominator above. The data output would then provide a mechanism by which to benchmark one region to another, and applying health quality management principles help investigate the root cause of variation. This would also help focus the system in general on tackling unaddressed hearing loss in accordance with the recommendations set out in the NICE guideline NG98.

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			[*if the catchment area is at an integrated care system level, 1,000 might need to be changed to 10,000. If it is at a GP level, 100 might be more appropriate than 1,000]
104	Hearing Loss and Deafness Alliance	3- Question 2	A focus on referrals is crucial but this should also be measured. The system should be looking at the adults referred to direct access audiology divided by local adults with hearing loss. It is important to note that you can get the first part of this from NHS England data (RTT data). The second part of this data should be available from the NHS England commissioning framework (and soon to be published JSNA guide) This will allow a measure of uptake and geographical variation to some degree. We feel this should be done in addition to the data you have proposed (that is because the data you have proposed only includes people presenting with a problem that are referred, and many people do not present in the first instance and this is a public health issue that the NICE guideline itself supports addressing. unmet need and ensure that GPs are aware of the evidence and national guidance, as well as local referral pathways".
105	Wales Audiology Heads of Service	3- Question 2	Direct referral to audiology is already in place within Wales for all over 16 years of age and data is already collected for Welsh Government Quality Standards audits and ENT Planned Care Board
106	British Society of Hearing Aid Audiologists	3- Question 3	It is unlikely that local resources would be able to achieve the outcome measurement HALYs as detailed, given current levels of funding, staffing resources, and service level agreements Alternative support from external providers ~ the independent and voluntary sectors, may be able to complement statutory provision to meet service delivery expectations. Resources would also need to be allocated and maintained towards training in earwax removal methods, standards for assessment training, and hearing loss awareness for healthcare providers in primary care settings
107	Wales Audiology Heads of Service	3- Question 3	Already in place Potential cost savings - Primary Care Audiology Services using Advanced Practitioners in place of GPs saves money overall for the NHS but requires transfer of funding from Primary Care budgets to Audiology, which is unlikely to happen
108	British Society of Hearing Aid Audiologists	3- Question 4	Onward Referral systems are in place in all BSHAA Member service delivery practices to NICE Guidance NG98 1.1 to 1.1.7
109	ENT UK	4	The rationale is fine. Again the quality measures are very difficult to achieve as per statement 3.
110	ENT UK	4	Who is going to complete and then analyse the quality of life assessments to measure outcomes.

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111	ENT UK	4	There are no criteria stated for who should receive a hearing aid. Further more, hearing aids are not the only hearing rehabilitation device eg. BAHA, middle ear implants, cochlear implants. There is no reference to these (see below re: cochlear implants)
112	Action on Hearing Loss	4	We welcome the quality standard that states, "Adults with hearing loss affecting their ability to communicate and hear are offered hearing aids." Furthermore, we welcome that the statement refers to the benefit of wearing binaural hearing aids where clinically appropriate. There is huge variation in what services are being delivered within audiology across the country, with some areas decommissioning or rationing hearing aids due to financial constraints within CCGs areas. Hearing aids are seen as an "easy" target for decommissioning due to lack of awareness of the impact of hearing loss and the benefit of hearing aids despite the extensive clinical evidence, professional opinion and national policy prioritising hearing loss and the benefits of hearing aids. 16 CCGs across the country have proposed to decommission hearing aid provision for people with mild and moderate hearing loss and other CCGs areas are not providing bilateral hearing aids. In 2015, North Staffordshire CCG became the first CCG to no longer provide NHS hearing aids to people with mild hearing loss, and require people with moderate hearing loss to undergo an eligibility test before gaining access. North Staffordshire CCG is expected to review their policy on hearing aids once the NICE guidelines on hearing loss are published – we are still waiting for this review. The proposals made to decommission hearing aids are extremely concerning, since hearing aids are the "only viable treatment option"[17] for people with mild and moderate hearing loss. In addition, hearing aids are cost effective. A hearing aid costs the NHS £90, and on average £390 for all of a person's appointments, two hearing aids and repairs for three years[18]. This small cost per person enables the NHS to deliver huge benefits in terms of quality of life and reduces the need for more costly interventions in the future. As summarised by Access Economics (2006), "the literature shows that hearing aids yield significant benefits for relatively low investments".[19] NHS England state that

[17] Chisholm et al. (2007). A systematic review of health-related quality of life and hearing aids: Final report of the American Academy of Audiology task force on the health-related quality of life benefits of amplification in adults. Journal of American Academy of Audiology, 18:151-183
[18] Monitor and NHS England. (2013). National tariff information workbook 2014/15. Available at: https://www.gov.uk/government/publications/national-tariff-information-workbook-201415
[19] Access Economics. (2006) Listen Hear: The economic impact and cost of hearing loss in Australia. Canberra: Access Economics

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			the benefits of providing hearing aids outweigh the costs, and that hearing aids provided through the NHS are cost effective[20]. In contrast, purchasing a set of hearing aids privately costs £3,000 on average, [21] which is beyond the savings of 55% of UK households.[22]
113	British Society of Hearing Aid Audiologists	4	Yes, it does. However, local arrangements often present unhelpful barriers which discourage individuals from accessing services. There is a strong body of evidence provided in the commissioning framework for hearing loss, which shows that services are not as accessible as they should be and that in some cases, attitudes of other clinicians do not always lead to referral into the appropriate pathway. There are also excellent examples showing that self-referral into an audiology pathway should be more widely available, removing the need for referral by GP. It would be useful to note that individuals should not be discouraged by local services (or any other health professionals) from getting help for hearing difficulties even where the hearing loss is due to the natural ageing process and is an expected level of difficulty for the individual's age. This is because hearing aids can significantly improve quality of life especially in retirement years. It may also be useful to collect data on the number of individuals who refuse hearing aids and their reasons why. This may provide information for future service improvements. Currently there is an unacceptable geographic variation in the number of referrals being made into complex pathways, leading to higher costs and unnecessary delays in treatment. Many such referrals are driven by financial rather than clinical decisions, because the tariff for routine assessment does not adequately cover the cost of more comprehensive assessment (well within the scope of practice of audiologists) which some individuals will benefit from when they present with a more difficult need.
114	Birmingham University	4	This refers to audience descriptor:

[20] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf
[21] Which? (2018). Hearing aid prices - Which? Available at: https://www.which.co.uk/reviews/hearing-aid-providers/article/how-to-get-the-best-hearing-aid/hearing-aid-prices
[22] Department for Work and Pensions (2014): Family Resources Survey: financial year 2013/14. Available at: https://www.gov.uk/government/statistics/family-resources-survey-financial-year-201314

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	Hospitals NHS Foundation Trust		This is completed routinely by audiologists and ENT- a joint audit would be required with ENT and Audiology, and would require time and resources.
115	British Academy of Audiology	4	Shouldn't this be "devices" as opposed to "aids"?
116	British Academy of Audiology	4	This may seem the easiest way of monitoring whether services offer binaural provision, but it is not entirely accurate and disregards patient choice. Include another metric - those offered 1/2 but decline (either 1 or 2)?
117	British Academy of Audiology	4	Process: Hearing aids are not compulsory! You cannot use having a hearing aid as a measure of a hearing aid having been offered. The patient has the right to decline!!
118	British Academy of Audiology	4	should it not be hearing devices or assistive listening devices where appropriate?
119	British Society of Audiology	4	In the measurement of this QS patient choice about using Hearing Aids should be taken into account. Presently the measurement is just how many patients are fitted rather than how many are offered and take up; how many are offered and refuse; how many are offered and choose to delay; how many are offered but take up hearings aids privately.
120	British Society of Audiology	4	There is no acknowledgement of other management options for adult permanent hearing loss other than hearing aids, such as access to assistive listening devices, hearing tactics etc. and the need for these to be standardised
121	Hearing Loss and Deafness Alliance	4	“Adults with hearing loss affecting their ability to communicate and hear are offered hearing aids” is important and welcome. NHS England state that the benefits of providing hearing aids outweigh the costs, and that hearing aids provided through the NHS are cost effective. NICE should make this clearer in the guidance. This advice then needs monitoring as there is huge variation in what services are being delivered within audiology across the country, with some areas decommissioning or rationing hearing aids due to financial constraints within CCGs areas. Hearing aids are seen as an “easy” target for decommissioning due to lack of awareness of the impact of hearing loss and the benefit of hearing aids despite the extensive clinical evidence, professional opinion and national policy prioritising hearing loss and the benefits of hearing aids. 16 CCGs across the country have proposed to decommission hearing aid provision for people with mild and moderate hearing loss and other CCGs areas are not providing bilateral hearing aids.
122	National Community Hearing Association	4	We support statement 4.

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			The statement, rationale, quality measures and other sections are sound. We would recommend that for data sources the following text is incorporated: key performance indicators (KPIs) from local contracts that have service specifications This is because many contracts include this data and it can be monitored – e.g. commissioners pay providers based on this variable so both commissioners and providers have an incentive to collect and report data on whether people are fitted with one or two hearing aids. This will also help stakeholders view and understand, and then address, any unwarranted variation.
123	Wales Audiology Heads of Service	4- Question 2	In Wales Quality Standards for Adult Rehabilitation are audited every two years and data is collected about proportion of patients being offered unilateral/bilateral hearing aids. Most departments offer bilateral fitting as standard for bilateral hearing loss.
124	Wales Audiology Heads of Service	4- Question 3	Already in place for most, but some cost implications for services which are currently unable to provide 2 hearing aids.
125	British Society of Hearing Aid Audiologists	4- Question 3	This is an important quality standard, but we know that currently only around one third of people with hearing loss are seeking help/ and/or being provided with hearing aids. We also know that commissioners are placing significant barriers in the way of provision, including decommissioning, restricting to a single aid and not providing adequate support for habituation which reduces the level of benefits and successful adoption. The capacity and funding to meet this requirement would be significantly enhanced by developing a new funding model which supports integration between the NHS funded and private funded hearing care, similar to the voucher model adopted in eye care.
126	ENT UK	5	Does statement 5 need to be a statement in its own right? It should be a given that patients will have a follow up and could be stated as part of statement 4.
127	Action on Hearing Loss	5	Whilst we support that the quality standard statement that "adults with hearing aids have a face-to-face follow up audiology appointment 6-12 weeks after the hearing aids are fitted" this statement should be changed to reflect the NICE guidance on follow up appointments and should read "adults with hearing aids are offered a face to face follow up audiology appointment 6-12 weeks after the hearing aids are fitted." The NICE guidance also states that there should be "the option to attend this appointment by telephone or electronic communication if the person

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			prefers." We believe that follow ups should be offered to all, with the choice over whether the individual would like to have the appointment face-to-face, via telephone or electronic communication. Where some patients may decline or be reluctant to attend a follow up, they should be encouraged to attend and informed of the benefits of follow up. Care and consideration however should be taken when arranging a follow up for the individual – communication needs should be considered as well as whether the person is likely to require reinstruction or hearing aid adjustment, which is not possible over the phone. There are however newer models of hearing aids that can be altered remotely or via a user app and so some adjustments can be made prior to a follow up where needed- variation over the use of such devices will vary across the country. The NHS Commissioning framework for adult hearing loss states that "A follow-up appointment should be undertaken within 10 weeks of fitting (unless there are clear documented, clinical reasons to do otherwise, or if the service user chooses to wait beyond this period) in order to determine whether needs have been met. " The framework also states that service users should be "offered a choice of a face to face or non-face to face follow-up (using a variety of mediums, for example, telephone, internet or written review). " A quicker follow-up appointment may be necessary in advance of the service user's' pre-booked follow-up appointment (for example, if the service user is experiencing difficulty with their aids) and this should be offered within five working days of the request from the service user.
128	Action on Hearing Loss	5	A challenge may arise in ensuring CCGs are aware of the importance of follow ups and that they are routinely offered to all those who are provided with hearing aids, alternative listening devices or other support. Research shows that follow up provision varies considerably across England. Research from our 'Under Pressure' report found that only 49% of NHS audiology services offer patients face to face follow up appointments[23] and some areas are not contractually required to provide a follow up appointment.[24] CCGs are facing financial pressures and access to follow ups and aftercare services may be seen as a burden to audiology services, preventing them from seeing

[23] Lowe C. (2015). Under Pressure. London: Action on Hearing Loss. Available from: https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/under-pressure-report/
[24] Monitor. (2015). NHS adult hearing services in England: exploring how choice is working for patients. London: Monitor

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			newly referred patients which too can lead to the reduction or cutting of follow up and aftercare provided. Evidence confirms that given good support, follow up and rehabilitation, high levels of hearing aid use and satisfaction can be achieved at low costs[25] and improves people's quality of life, safety and independence.[26] The fitting of hearing aids, although a key component of managing hearing loss, should not be provided in isolation. As detailed in the full draft guideline, not providing a follow up "can result in people giving up using their hearing aids and may consequently have a negative impact on their quality of life over time as their ability to communicate and participate in everyday situations declines". In reality, often people who stop wearing their hearing aids do so because the device has stopped working; they are having issues with managing, using or inserting the hearing aid or they are uncomfortable, which are all issues that can usually be resolved in follow up appointments. Those with hearing loss should be informed that they are entitled to have a follow up and know how to access the service if they have any questions or problems. The Commissioning Framework for Adult Hearing Loss Services states that "follow-up and other support after the initial hearing aid fitting has been shown to improve satisfaction with hearing aid and increase hearing aid use".[27] Services therefore must be encouraged by their CCG to offer follow up appointment in a variety of ways including face to face, telephone and electronic communication. There is variation in how CCGs gather and collect data. We welcome that the standard recommends the use of NHS

[25] Abrams H, Chisolm TH, McArdle R, et al. (2002). A cost utility analysis of adult group audiologic rehabilitation: are the benefits worth the costs? Journal of Rehabilitation Research and Development, 39(5):549-558

[26] Yueh B, Souza PE, McDowell JA, et al. (2001). Randomized trial of amplification strategies. Archives of Otolaryngology Head & Neck Surgery,127(10):1197-204; Cacciatore, et al. (1999). Quality of life determinants and hearing function in an elderly population: Osservatorio Geriatrico Campano Study Group. Gerontology 45:323-323; Mulrow CD, Aguilar C, Endicott JE, et al (1990) Quality-of-life changes and hearing impairment. A randomized trial. Ann Intern Med. 1:113(3):188-94; Chisolm TH, Johnson CE, Danhauer JL, et al. (2007) A systematic review of health-related quality of life and hearing aids: final report of the American Academy of Audiology Task Force on the Health-Related Quality of Life Benefits of Amplification in Adults. Journal of the American Academy of Audiology, 18(2):151-83; Kochkin S. (2005). The impact of untreated hearing loss on household income. Better Hearing Institute

[27] 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. doi: 10.1371/journal.pone.0031831; European Hearing Instrument Manufacturers Association. (2015). Eurotrak Survey 2015; Abrams H, Chisolm TH, McArdle R. (2002). A cost utility analysis of adult group audiologic rehabilitation: are the benefits worth the costs? Journal of Rehabilitation Research and Development 39(5): 549-558

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			England´s Adult Hearing Service Specifications (2016) for outcomes data collection as detailed within NHS England's Commissioning Framework for adult hearing services. [28] Furthermore, CCGs should be encouraged to publish outcomes data to demonstrate activity and patient satisfaction with local audiology services.
129	British Society of Hearing Aid Audiologists	5	No. The follow up should be set at a shorter time period after fitting- suggested 4/8 weeks as target. Experience indicates that higher levels of satisfaction with and benefits available from adoption of hearing instruments is increased with stronger support for habituation and follow-up in the early stages of adoption. It is important that access to such follow-up appointments is convenient to the individuals and should wherever possible be community based. With increasing advances in technology, more follow-up appointments will be supportable by remote telecare, provided that the choice of instrument supports remote adjustment, and that the individuals are properly involved in and supported through the consultation.
130	British Society of Hearing Aid Audiologists	5	An earlier follow up time has the potential to Improve an individual's usage of the aids and satisfaction with them by offering easier correction of misuse, encourage turnaround of non-use while there is still willingness from the individual. There is no additional time required though there may be a short term catch-up and investment required to adjust to the quality improvement. The potential benefits to the individual over the medium to long term offer significant cost savings in other health costs as shown by various studies. It should be possible for individuals to seek additional follow-up / fitting appointments to help in the habituation process, and of necessary to pay a top-up fee for private consultation, without having to begin a brand new pathway and purchase instruments privately.
131	Birmingham University Hospitals NHS Foundation Trust	5	This refers to audience descriptor: Currently patients in our service are offered a choice between telephone/face to face follow up. This could again be monitored by an Audiology audit although would require time and resources.
132	British Academy of Audiology	5	This QS is not supportive of new technology. Individual patient preference or an individualised care plan. Not all patients require or desire an in person follow up and this was noted in the NICE guidance The guidance says: 1.7.1 Offer adults with hearing aids a face-to-face follow up audiology appointment 6 to 12 weeks after the hearing aids are fitted, with the option to attend this appointment by telephone or electronic communication if the person

[28] NHS England, 2016. Commissioning services for people with hearing loss; a framework for Clinical Commissioning Groups (CCGs). Available from: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

ID	Stakeholder	Statement number	Comments[1]
			prefers. With new methods of remote consultation and remote hearing technology adjustments as well as patient access to Apps that allow self-tuning to set a criterion that is stating only a face to face follow up is acceptable is short-sighted and not in line with the guidance that was published. The QS would have significant resource implications as time allowed for telephone and face to face appointments are significantly different.
133	British Academy of Audiology	5	I am sort of in agreement with this one, although with younger patients potentially coming through with milder losses, I am doubtful whether face-to-face follow-up is always required. Some form of follow-up obviously is, but in some ways, with the current focus by hearing aid manufacturers on telecare, this is possibly a bit outdated.
134	British Academy of Audiology	5	– I would argue that further review / support is frequently required for individuals with cognitive needs – this would be worth adding along the lines of "further reviews should be offered as required taking into account the person's ability to manage their amplification" perhaps?
135	British Academy of Audiology	5	It is important for NICE to support the use of Follow Up in Adult Hearing Care as it helps improve outcomes and hearing aid use. Similarly, the NICE recommendation to have access to face-face follow up for patients who want and need them should not be diluted. However, the blanket statement of Quality Statement 5 does not align itself well with a number of NHS and wider Healthcare modernisation initiatives including the NHS Long Term Plan, 2019. • Patients benefit from being empowered to make their own informed choice on management (including options of face-face follow up along with alternatives or no follow up at ll.) • Alternative forms of Follow up are often preferable to patients with long term conditions such as hearing loss. NHS long term plan section (5.8 Long Term Plan). Reducing need to attended busy healthcare sites. • Effective use of resources for follow up can allow 'richer face-face appointments' to patients who want them or need them. NHS long term plan section 5.8 Long term Plan • NHS England is keen to encourage virtual clinics, telehealth and Apps. 5.24, Long term Plan • Most Follow Up elements recommended in NG98 1.7.1 and 1.7..2 can be administered through alternative methods such as Apps, virtual clinics, phone or postal follow ups. Therefore, would it be possible to amend the NICE Quality statement to include the benefits of informed 'follow up choice' and allow for modern pathway redesign to incorporate remote options and new technology.
136	British Academy of	5	There should be a documentation that the options for Follow Up have been offered and the IMP will state the follow

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	Audiology		up the patient chooses. If issues are highlighted through an alternative follow up method (skype call/post/App) the clinician should encourage and facilitate a face to face follow up within ?? weeks. It is important to note that Community provision and other service adjustments to help those less mobile (domiciliary visit/home volunteers) should be encouraged, so that access is not one of the reasons to decline face-face attendance for follow up.
137	British Academy of Audiology	5	I don't think face to face follow up is always appropriate/possible so just follow up
138	British Academy of Audiology	5	I think we need to stress face to face isn't always possible or appropriate and that there are other methods of follow up- telephone, email, telehealth systems etc.
139	British Society of Audiology	5	The QS seems over emphasis the need for a follow up to be face to face. People with hearing loss may be better supported by a range of follow up option including the option of a face-to face- follow up. For example with the development of telehealth and remote hearing aid programming people may want to feed back the problems they are having in real time rather than wait for a follow up, or via other methods e.g. telephone follow up The proportion of adults continuing to wear hearing aids at review stage would still be a valid measure
140	British Society of Audiology	5	The utilisation of other methods other than face to face follow ups potentially have efficiency and cost savings
141	Hearing Loss and Deafness Alliance	5	It is important that the NICE guideline, The Action Plan on Hearing Loss and the Commissioning Framework for Adult Hearing Loss Services is included within the RCGP curriculum to provide GPs with more information about the impacts of hearing loss; the benefits of addressing hearing loss early and accessing support and management that is available on the NHS. This framework is now an important part of the implementation of policy around hearing loss and therefore crucial that it is referenced.
142	Hearing Loss and Deafness Alliance	5	"adults with hearing aids have a face-to-face follow up audiology appointment 6-12 weeks after the hearing aids are fitted" should be changed to reflect the NICE guidance on follow up appointments and should read "adults with hearing aids are offered a face to face follow up audiology appointment 6-12 weeks after the hearing aids are fitted." The NICE guidance also states that there should be "the option to attend this appointment by telephone or electronic communication if the person prefers." We believe that follow ups should be offered to all, with the choice over whether the individual would like to have the appointment face-to-face, via telephone or electronic communication. Where some patients may decline or be reluctant to attend a follow up, they should be encouraged

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			to attend and informed of the benefits of follow up. Care and consideration however should be taken when arranging a follow up for the individual –communication needs should be considered as well as whether the person is likely to require reinstruction or hearing aid adjustment, which is not possible over the phone. There are however newer models of hearing aids that can be altered remotely or via a user app and so some adjustments can be made prior to a follow up where needed- variation over the use of such devices will vary across the country. The NHS Commissioning framework for adult hearing loss states that "A follow-up appointment should be undertaken within 10 weeks of fitting (unless there are clear documented, clinical reasons to do otherwise, or if the service user chooses to wait beyond this period) in order to determine whether needs have been met. " The framework also states that service users should be "offered a choice of a face to face or non-face to face follow-up (using a variety of mediums, for example, telephone, internet or written review). " A quicker follow-up appointment may be necessary in advance of the service user's' pre-booked follow-up appointment (for example, if the service user is experiencing difficulty with their aids) and this should be offered within five working days of the request from the service user.)
143	National Cochlear Implant Users Association	5	We are disappointed that the draft QS5 only addresses the immediately post-fitment part of the after care process. In the NCIUA's response to your original consultation we explained that "It is important to recognise that many CI users, and virtually all users of Bone Conduction devices will have started their journey into deafness with a relatively low level of hearing loss, for which hearing aids are an appropriate solution, but that over time their hearing will continue to decline to the point at which they should be assessed against the appropriate criteria for provision of CIs and Bone Conduction devices, e.g. TAG 166. The only reliable way in which these assessments can be triggered is if the audiology team responsible for the provision of hearing aids is required as part of the Guidelines to regularly assess the patient's hearing loss going forwards, so that the patient can be given appropriate advice [and onward referral if appropriate] as their hearing continues to decline. We recommend that the "Monitoring and follow-up" requirements summarised in paragraphs 32-34 of your "Full list of recommendations" should be extended to highlight the need for regular follow up on those patients where the rate of decline of their hearing means that they may soon need to consider options such as a CI or Bone Conduction device."

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			NICE's response to this comment was to say that "Thank you for your comment. The committee has recommended that hearing services consider creating a system to recall people with hearing devices for regular reassessment." We had expected that QS5 would include a requirement aimed at ensuring that HA users would be checked periodically to detect further deterioration in their hearing and trigger appropriate action, and are concerned to see that the draft QS does not address this key area of potential improvement.
144	NHSE	5	'Adults with hearing aids have a face-to-face follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted.' This is not widespread practice currently and may have resource implications for both providers and commissioners. (RP)
145	Royal Berkshire NHS Foundation Trust	5	It is important for NICE to support the use of Follow Up in Adult Hearing Care as it helps improve outcomes and hearing aid use. However, each patient is different and there are reasons why patients will not want or need a face-to-face Follow Up. Previous hearing aid use, age, family support can reduce the desire for face-face follow up in a number of patients and therefore informed patient choice should be encouraged. It is important to note that Community provision and other service adjustments to help those less mobile (domiciliary visit/home volunteers) should be encouraged, so that access is not one of the reasons to decline face-face attendance for follow up. As a result, we propose that NICE highlight the importance of face-face Follow Up for those who need it but reflect the modernisation of healthcare practice particularly that set out in the NHS Long Term Plan, 2019. This will help future proof the NICE statement and also account for current NHS drives for patient choice and efficiency of services. For instance: 'Adults with hearing aids have a face-to-face follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted adjusted to': 'All adults with hearing aids are offered the informed option of a face-to-face follow up, or if they prefer a remote follow through another source, with the option of organising a face-face follow up if required (within 3 weeks of request)' This would be more in-keeping with a number of NHS goals to modernise outpatient services. 1: Informed patient choice on their continuing health care pathway. Option to be seen face-to-face ensured to

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			promote good outcomes and compliance, while allowing them the options of remote follow up. 2: Empower patients to take control of their own follow up plan and encourage the use of technology (only if it suits the patient) (such as Apps). This is particularly pertinent for long term conditions such as hearing loss. NHS long term plan section 5.8 3: Allow richer face-face appointments to patients who want them or need them. Allowing more time to these patients rather than using activity to see patients who would rather not have had the further appointment. NHS long term plan section 5.8 4: Allow technology and enable 'different ways of doing things' to help redesign clinical pathways, such as the use of virtual clinics, telehealth and Apps. 5.24 5: Allow patients the flexibility to use different methods of follow up to be seen closer to home or even better from home. Virtual clinics, phone and post follow ups. (p91 Long term plan) 6: Enable sustainability and modernisation and redesign of outpatient services to reduce unwanted face-face attendances over the coming years. (1.48 long term plan). There is a 'strong patient pull' for the use of technology to achieve this and a focus on digitally enabled care widely accessible (NHS long term plan) It is important to clarify that the most Follow Up elements recommended in NG98 1.7.1 and 1.7..2 can be administered through alternative methods, be that Apps, virtual skype clinics, phone or postal follow ups. Insertion of the device is one area where face-face follow up is particularly important and for patients where this in question, the option of face-face follow up should be encouraged by the clinician offering follow up options. There should be a documentation that the options for Follow Up have been offered and the IMP will state the follow up the patient chooses. Patients should be made aware of the option to request a face-face follow up if their initial choice of remote follow up does not cover their needs. Likewise, if issues are highlighted through an alternative follow up method (skype call/post/App) the clinician should encourage and facilitate a face to face follow up within 3 weeks.
146	National Community Hearing Association	5	We cannot support statement 5 in its current form. For avoidance of doubt, we strongly support § the need to offer every patient fitted with hearing aids a follow-up appointment § any drive to address the unjustifiable approach where providers fit hearing aids but do not offer follow-up care – as we set out in our response to the previous consultation this is a problem that has been left unaddressed for three decades

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			§ viewing the proportion of adults that continue to wear their hearing aids at a review as a useful outcome (page 18) § etc. The reason we cannot support statement 5, is because suggesting "face-to-face" follow-up should be the default § is not based on evidence § ignores the actual NICE guideline (see NG98 full version), the consultation responses to NG98, the Equality Impact Assessment for NG98 (which explains issues with stating face-to-face follow-up for all), and the responses to proposals for this Quality Standard § least important, but significant, it also ignores key objectives set out in the NHS Long Term Plan and overlooks technological advances in hearing care – e.g. the NHS Long Term Plan is clear that the NHS must reduce outpatient activity and embrace technological innovation to do this, and despite advances in teleaudiology which make this increasingly viable for follow-up this quality statement is insisting on an old world view. Looking at this in its entirety, statement 5 suggests that Committee members might be keen to have this as a norm but the NICE guideline does not support this and nor does the original Equality Impact Assessment. The NCHA, and other stakeholders, have set out in great detail why NICE should not suggest face-to-face follow-up visit is the default (see stakeholder comments on face-to-face following in the feedback to NG98). Instead, as per the NICE guideline and Equality Impact Assessment NG98, the patient should be given a choice of how they want to access their follow-up visit. This way, experienced users might want to use alternatives to a face-to-face visit, freeing up clinical time to provide people that need it via multiple face-to-face visits etc. We would be happy to discuss this in more detail but, for brevity here, the statement in its current form is not acceptable and should be changed From § Adults with hearing aids have a face-to-face follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted To § All adults with hearing aids have a follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted, and are offered a choice of how they would like to access this service – e.g. face-to-face, teleaudiology or

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			other non-face-to-face options Other text related to face-to-face follow-up (page 1, and pages 17-20) should be updated accordingly.
147	National Association of Deafened People	5	We welcome quality assessment at follow up as a positive step forward. NADP feels, we are missing important component of follow up assessment : hearing test during visits. Individuals should have their hearing tested during follow up to ensure there are no changes to initial hearing test and assessment. We note mention of use of automatic data logging for monitoring purposes, however we are missing advice to obtain patients consent prior to activating data logging. This is serious omission given GDPR in force in UK. However, data logging may have potential to help spot serious issues with hearing loss, such as fluctuations and further hearing loss. Use of data logging to measure how many hours patient wears hearing aids should lead to further assessment and fine tuning.
148	Wales Audiology Heads of Service	5- Question 2	Data is collected every 2 years for Wales Adult Rehab Quality Standards on whether follow up is offered – although not currently specified as face-to-face follow up. However not all services in Wales achieve the aim of review within 6-12 weeks after hearing aid fitting due to resource difficulties. There is no standard statement relating to measuring outcomes of intervention. Inclusion of "hearing aid use" outcomes would be helpful with associated interventions to improve hearing aid use Systems for measuring outcome for this standard are not in place for 6-12 week follow up but would be feasible to introduce using electronic completion, but with resource implications, including set up
149	British Society of Hearing Aid Audiologists	5- Question 2	Structures should already be in place for basic measurement. Additional data will be required to progress to remotely supported follow-up in which the benefits and effectiveness of remote support are properly assessed. More information is also required to support an effective equality impact measurement and the impact that different access arrangements have on the equality of provision to different demographic groups.
150	British Academy of Audiology	5- Question 3	The Do Not Attend (DNA) rate will be higher if face-face follow ups are made routine. Whereas if the patient has the option of informed choice for their follow up plan, the likely hood DNA will be reduced.

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			Effective and clever use of resources, including virtual clinics is a thread discussed in the NHS Long Term Plan (2019)
151	Royal Berkshire NHS Foundation Trust	5- Question 3	The NHS sets out the need to use resources wisely in the NHS Long Term Plan (2019), in a sustainable manner and optimising the tax payer's investment (chapter 6, p100). Therefore, a blanket requirement for follow up post hearing aid fitting might be seen as counter intuitive to these drivers. The importance of follow up must be maintained with a strong recommendation as it is important for outcomes, although there can be flexibility. Therefore, reducing unnecessary encounters for patients who do not want them, reducing increased DNA's that result from blanket follow up provision and preserving clinical time for quality face-face follow up when required or patients request. The above will also minimise unnecessary footfall to busy acute and community hospital sites which is another area highlighted in recent NHS forward plans.
152	Wales Audiology Heads of Service	5- Question 3	Not all services carry out face-to-face follow ups so resource implications for staffing Resource implications could be mitigated by using group reviews and remote access (e.g. skype, remote programming, Patients Know Best (PKB))

Registered stakeholders who submitted comments at consultation

- Action on Hearing Loss
- Birmingham University Hospitals NHS Foundation Trust
- British Academy of Audiology
- British Association of Audiovestibular Physicians
- British Society of Audiology

- British Society of Hearing Aid Audiologists
- ENT UK
- Hearing Loss and Deaf Alliance
- National Association for Deafened People
- National Cochlear Implant Users Association
- National Community Hearing Association
- NHS Clinical Commissioners
- NHS England
- Royal Berkshire NHS Hospital Trusts
- Royal College of General Practitioners
- Royal College of Nursing
- Wales Audiology Heads of Service