NCHA consultation response

Service Quality Committee Consultation Feedback

Onward Referral Guidance for Adult Audiology Patients

Introduction

We are currently seeking views on:

1. The overall content of the guidance
2. The detail provided within the guidance

This feedback document will help us to collate your opinions so that we can incorporate them into the next version.

Section 1: Consultation Questions

1. What do you think of the general approach taken in this document?

The NCHA welcomes the opportunity to review and provide feedback on this guidance.

We support all guidance that aids accurate and appropriate referrals. We base our feedback on the following evidence-based guidelines and technology assessment from NICE:

- NG98 – Hearing loss in adults: assessment and management, NICE 2018
- NG155 – Tinnitus: assessment and management, NICE 2020
- TA566 – Cochlear implants for children and adults with severe to profound deafness, NICE 2019

Regarding the general approach taken in the document, our feedback is as follows:

- The draft guidance copies the referral guidance from NG98 verbatim. The advantage is that this approach reduces the risk of variation in published guidance. However, it would be helpful to reference replicated text so that readers can refer to the original source, which has annexes with evidence

explaining the criteria in more detail. It is also essential to review NICE evidence and the context in which it presents criteria – e.g., 'consider – and update this BAA/BSHAA guidance as appropriate'.

- One downside of reproducing NICE guidelines this way is that NICE writes for a wider audience. It might help save time and reduce risk if the BAA/BSHAA guidance could be reframed and shortened for audiologists as the primary audience. For example, in our view, the guidance:
    - Could omit text targeted at GPs only
    - Could review the section on adults with suspected or diagnosed dementia as this replicates text from the NICE guideline for GPs and other healthcare professionals rather than audiologists

- It would also be helpful to read across relevant sections from NG155 and TA566 as part of this process.
- The document's flow might be improved if the checklist was at the start and further simplified, and additional information and guidance notes followed.

We would happily work with BAA and BSHAA colleagues and provide further feedback.

2. If you have any further comments on the document, please add them here:

Please see our high-level feedback responding to question one and further feedback in the table below. We would also welcome the opportunity to review the next iteration of this guidance if that would be helpful.

About You

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Section 2: Detailed Comments:

Please enter your detailed comments on the document in the table below

Page No.	Standard number	Text from Document	Suggested Text
3	Introduction	This guidance has been written in line with the following NICE guidance: NICE NG98 https://www.nice.org.uk/guidance/ng98/chapter/Recommendations NICE TA566 https://www.nice.org.uk/guidance/ta566	This guidance has been written in line with the following NICE guidelines (NG) and technology assessment (TA): • NG98 – Hearing loss in adults: assessment and management, NICE 2018 • NG155 – Tinnitus: assessment and management, NICE 2020 • TA566 – Cochlear implants for children and adults with severe to profound deafness, NICE 2019 In addition, we suggest that text replicated verbatim from NICE guidelines is referenced so that readers can refer to the evidence-based review that underpins the specific recommendation.
4	Scope	However, detailed guidance on pre-existing conditions, previous investigations and the **deterioration of hearing** are beyond the scope of this document.	Deterioration of hearing loss, based on the criteria within the guidance, is within the scope of the document. Therefore, it would be helpful to review and reframe this text. From a medical malpractice viewpoint, it is also important to clarify which guidance clinicians should refer to when making referral decisions on pre-existing conditions e.g., those that have clinically significant deterioration.
4	Regional Variation	Entire section	It would be helpful to differentiate referrable signs and symptoms from locally commissioned pathways.

			Otherwise, there could be a risk of confusing a clinical guidance document (referrable signs and symptoms based on the risk of pathology) with locally commissioned pathways and local non-evidence-based norms. For example: • Certain NICE criteria used in this guidance clearly state a need to refer to ENT. In these cases, unwarranted regional variation could present a risk to patients and medical malpractice risk for the audiologist. Therefore, it is not just best practice to ensure these referrals are made, but also fundamental for duty of care • We agree that in some regions, audiologists might provide wax management; in others, they might not. However, the NICE guideline aims to explicitly avoid referrals to ENT for certain patients with impacted wax. Hence, management of impacted earwax could have its own section and follow evidence-based criteria to minimise pressure on GPs and ENT colleagues • Many tinnitus cases, as set out in NG155, do not require a specialist (medical) service. So, reading across NG155 in the same context as the feedback above is essential. More clarity would have the added advantage of helping audiologists challenge unwarranted variation in patients' best interests.
5	Referral Pathway	Section on 'GP should'.	This section partly replicates text in NG98 section 1.1.1 but without the explicit cross-referencing and nuanced text in the

			original NICE guideline. This guidance for GPs could be omitted and we believe it would be safer to do so. If the text for GPs is to be included, then the NICE text should be amended to provide more accurate information for GPs. For example, the original NICE guideline recommended excluding impacted wax as a cause of adult hearing loss. However, if a GP found impacted earwax, they could still arrange an audiology visit. A GP should reach this conclusion if they read NICE NG98 short-form section 1.1 alongside section 1.2, but not when reading this draft guidance.
5	Referral pathway	Section on 'audiology professional shall'.	In our view, this section could be shortened and better aligned with NICE guidelines, helping audiologists reduce risk. It would also be helpful to review how prescriptive this guidance should be with regarding the level of detail required in a referral. We would also welcome a discussion on informed consent, including advice for professionals on informing a GP when the patient has not provided consent for referral, as suggested in the draft guidance.
5	Referral pathways	Where any onward referrals have have been made to specialist opinion or investigions ….	1) Remove duplicate 'have' 2) Correct typo – should read 'investigations'
6	Referral pathways	Requesting MRI scanning in the case of an asymmetrical sensorineural hearing loss.	Please see our feedback to question one about the benefit of reordering the guidance. For example, clinically significant asymmetry is undefined here but defined on page 11. However, if the checklist came first, notes could be added to direct busy clinicians to more detail in the following pages, as required.

6	Referral pathways	Where any of the signs or symptoms listed in the criteria for referral below have not been dealt with previously or not satisfactorily treated/managed and are outside scope of practice then referral for a medical opinion should be made.	We agree with the principle but would welcome discussion about this section. For example, there are scenarios, especially with ENT colleagues under significant pressure, where seeking clarification (such as a copy of discharge letters) from a GP might be the optimal approach.
6	Referral pathways	Referral for a medical opinion should not normally delay impression taking or hearing aid provision.	Again, we agree with the principle but would welcome a discussion about this section. For example, there is scope to provide more guidance on scenarios here.
6	When a referral may not be required	The patient has made an informed and competent decision and declined a referral. In this case, the audiology clinician must make appropriate records of the basis on which this decision has been reached. They must ensure that informed consent has been obtained from the patient or their carer or other competent advisor on the basis of sufficient information including associated risks, and the records confirm all the necessary considerations about patient's best interests.	As noted above, we would welcome a discussion on informed consent and record keeping about medically indicated referral. For example, whether such guidance would be better suited to separate advice on informed consent, which is consistent with other regulations and professional standards for HCPC and RCCP registrants etc.
9	Specialist referrals	Specialist referrals – entire section	The referral criteria in this and other sections appear to be copied verbatim from NG98. Therefore, it is vital to set out why NICE used the term 'consider' rather than 'refer' and to update advice for audiologists accordingly. We would like to discuss this as, in our view, clearer evidence-based guidance can be given to audiologists on specific criteria. For example, when reviewing NG98 with audiology experience rather than GP experience, it is possible to reframe certain NICE criteria and reduce the risk of false positive referrals.

10	Adults with suspected dementia	Consider referring adults with diagnosed or suspected dementia…	Please see our feedback to question one.
11	Post audiology assessment referrals	Referral for implantable devices such as…	This section appears to replicate sections of NG98 but out of context. It would be helpful to review the flow of guidance and consider reframing certain sections with the audiologist as the main guidance user. For example, this section starts by replicating a section from NG98 and then includes CI eligibility criteria based on NICE TA in the section below, yet this could be simplified further, removing duplication and reducing the risk of confusion.
12	Appendix – specialist referral	Unexplained unilateral or asymmetric hearing loss	This and other sections in the checklist should be checked against the referenced NICE guidelines to ensure consistency. For example, an audiologist should only refer clinically significant asymmetric hearing losses to ENT et al. In contrast, a GP might not have the equipment to determine this and should refer to an audiologist in the first instance in most cases. The evidence provided with NICE guidelines also explains why it used the term 'consider' and the NICE response to consultation feedback offers further context.
13	Appendix – specialist referral	Persistent tinnitus that is: • Unilateral • Pulsatile • Has significantly changed in nature • Is causing distress	We recommend that the NICE guideline on tinnitus is read across to this guidance.