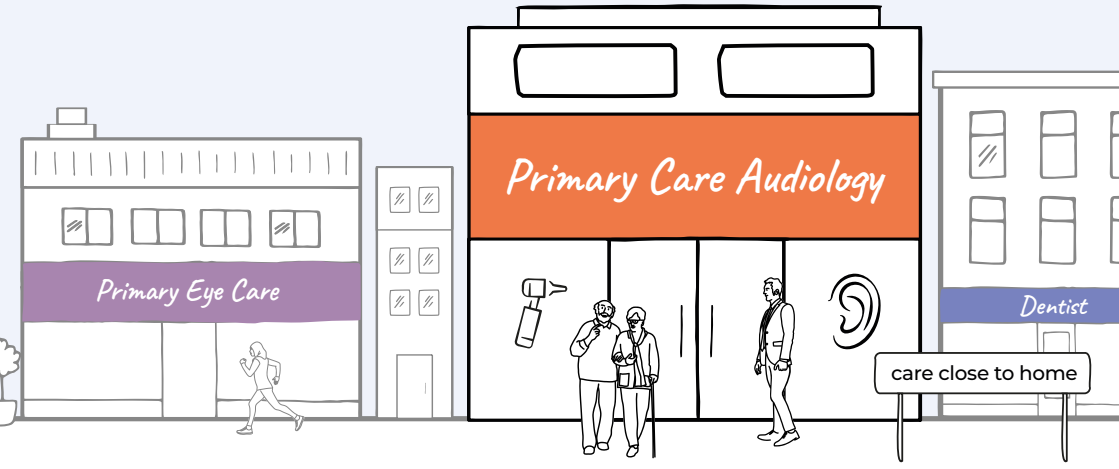
NCHA

The Association for
Primary Care
Audiology Providers

Primary care audiology – accessible ear and hearing care for all



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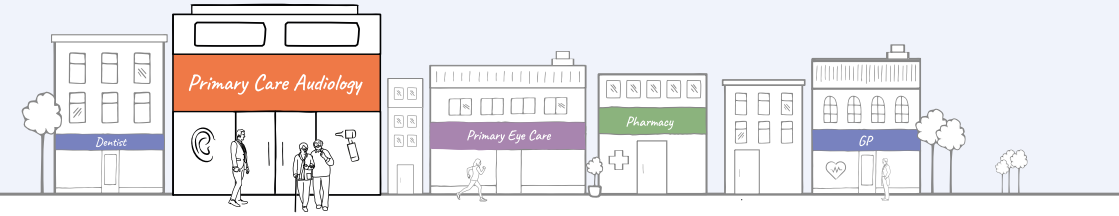


Primary care audiology – the need for change

Primary care is the central pillar of the NHS from which all other healthcare flows. It is the first port of call for prevention, diagnosis and treatment for people concerned about their health and wellbeing. It is also the front door to specialist services for the small proportion of people who do need to travel to hospital for care.

In the UK, people benefit from NHS-funded primary care from GPs, optometrists, dentists and pharmacists. In contrast, historically, only those with the ability to pay have benefited from an accessible primary care audiology service. Most patients needing NHS ear and hearing care are still required to see their GP first for a referral. Many NHS patients must then travel to a hospital to access non-medical ear and hearing care from services which have long struggled to meet needs in a timely and sustainable way.[1]

This two-tier system is inherently unjust. It undermines the fundamental principles of the NHS and exacerbates health inequalities. This helps explain why the Royal National Institute for Deaf People (RNID), health experts and policymakers have repeatedly called for better access to primary ear and hearing care services.[2]

> "At the moment, when we talk about primary care, we mean general practice, pharmacy, optometry and dentistry. I always put in a case for audiology being included within that family. If you have your eyes and your teeth [checked], why would you not include your ears?"
>
> **Professor Claire Fuller, CEO NHS Integrated Care System, now NHS England medical director for primary care[3]**

As the Association for Primary Care Audiology Providers, we have also called on all UK governments to address these inequalities in access[4] and strongly support the national drive for patient self-referral to NHS audiology in England,[5] the Scottish Government's ambition to put audiology services on par with primary eye care services,[6] and the Welsh Government's commitment to improving access to audiology.[7]

Achieving these shared goals will help reduce pressure on GPs and hospitals and result in accessible ear and hearing care for all. That is why we are committed to working with sector partners, governments and health service planners and commissioners throughout the UK to deliver these aims for patients and the NHS:

- Safe, evidence-based and high-quality audiology care in all locations
- Sustainable access to NHS primary care audiology
- Services commissioned around patient and population needs
- Better utilisation of workforce, estate, capacity and investment across primary and hospital care
- Adoption of innovations in technology and care models where this brings patient benefit and improves efficiency
- Integration of primary care audiology within wider primary care alongside ENT departments to meet patients' needs, priorities and choices holistically and cost-effectively.

Urgency of change

> "The [ENT] outpatient waiting list is still enormous and rising [and] referrals outstrip capacity, and this has been gradually worsening over the past 10 years...
>
> We must realise that we cannot offer a comprehensive ear and hearing health care service based in hospitals. We must develop primary or intermediate services that can deal with the simple and recognise the more complex [...] There needs to be a national initiative to tackle this issue now..."
>
> **ENT UK[8]**

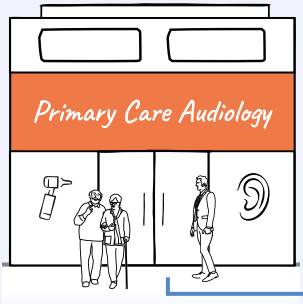
Millions of people across the UK with hearing loss, earwax, tinnitus and other audiological issues cannot get the NHS support they need.[9] This is recognised as a significant and growing public health challenge impacting all aspects of individuals' lives, work and wellbeing.[10] This is especially true for age-related hearing loss, the most common type of hearing loss, which increases the risk of dementia and other health problems.[11]

The need for earlier diagnosis and support for ear and hearing problems is strongly underpinned by clinical and economic evidence.[11] As a matter of urgency, health and care systems across the UK need to reduce the growing risks and the spiralling health and care costs associated with unmet ear and hearing needs.

> "The psychological, financial and health burden of hearing loss can be reduced by prompt and accurate referral, robust assessment and correct management."
>
> **National Institute for Health and Care Excellence (NICE)[12]**

Meeting more of this need cost-effectively through primary care audiology will enable millions more to live and age well, reduce long-term costs to our health and care system, and take pressure off GP and ENT hospital services. This will also free up ENT appointments for the minority of patients whose needs can only be met by specialist hospital services.

Improving access to primary care audiology will mean:



Millions more

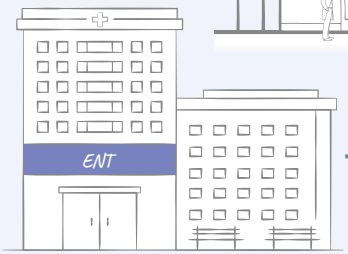
people will have their ear and hearing care needs met closer to home.

More than

2 million

GP appointments saved

per year, enabling GPs to focus on more urgent medical needs.



More than

250,000

ENT appointments saved

per year, freeing up time and capacity for one of the busiest hospital specialities.

Endnote[13]

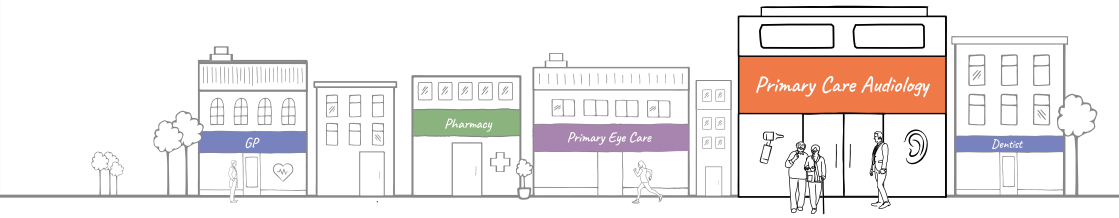
Widespread support for change

Just as with Modernising Hearing Aid Services (MHAS) in the early 2000s, the need for a universally accessible and equitable ear and hearing care service, as the population ages, has long been supported by patients, patient representatives, NGOs, politicians from all parties and successive governments.[14] Yet, progress in reducing reliance on the hospital model of care and delivering better access to primary care audiology has been painfully slow.

Demographic change and unsustainable pressure on the hospital-based model of care now means that the population's ear and hearing care needs are not being met in a timely, sustainable or safe way. This is not the fault of frontline clinical teams but the result of the lack of priority afforded by health systems to the nation's ear and hearing health needs over generations.[15]

After many attempts to patch over historical structural weaknesses in ear and hearing care provision, it is time to meet the challenges head-on and remodel audiology services to focus on patient needs and wishes in the modern world.

These growing needs can best be met through an integrated primary care audiology service, making optimal use of all workforce capacity and resources to drive better outcomes for more people and, by so doing, significantly increase quality-adjusted life years (QALYs) and reduce years lived with disability (YLD).



Policymakers must strengthen primary care audiology as the first-line service from which all other ear and hearing care services flow – moving to a service that will allow people to access essential NHS-funded ear and hearing care close to home, without the need for a GP referral, in the same way as their NHS optometrists, pharmacist, dentist and GP.

In **primary care audiology**, we set out the need and evidence for change so that governments and health systems in all four nations can finally fix the structural issues in NHS ear and hearing care and meet the population's audiological needs in a sustainable way.

Ear and hearing care

Developments in antibiotics, the operating microscope and anaesthetics fundamentally changed ENT services in the 1950s, making catastrophic diseases of the ear, such as serious infection, very rare.[16] Immunisation programmes and improved public and population health have also helped reduce cases of measles, mumps and rubella, protecting against preventable hearing loss in childhood.[17]

As a result, the ear and hearing problems people are most likely to seek help for in the UK are age-related hearing loss, earwax and tinnitus.[18]

Most of these presentations are not acute and need the support of audiology professionals in the community rather than doctors in hospitals. Despite this, the NHS still operates a medical model of ear and hearing care, often requiring people to see their GP and an ENT doctor when the most appropriate care for most adults could be provided by a primary care audiologist close to home.

The medicalised model of care is essentially a legacy issue without an evidence base, as those with the ability to pay have always been able to access safe and effective primary care audiology.

This historical and structural anomaly exacerbates inequalities between people with different sensory needs, for example, between people with ear and eye problems. In the UK, the risk of a person in the general population having a sight-threatening eye disease is greater than having a disease that risks permanent hearing loss.[19] To meet this demand, the NHS has normalised seeing an optometrist for most care, sending only those who require a medical opinion (<5%) for a hospital appointment. This means most eye health needs are met very quickly, delivered closer to home and cost less than hospital-based services.

In contrast, patients with ear and hearing issues are often required to see GPs before accessing NHS care and then wait again to be referred to a hospital-based service. This is not only wasteful of NHS resources and an unnecessary barrier to care but also unsustainable, given the current pressures on GP and hospital capacity.

Invisible disability

> "Hearing loss has often been referred to as an 'invisible disability', not just because of the lack of visible symptoms, but because it has long been stigmatised in communities and ignored by policymakers."
>
> **Dr Tedros Adhanom Ghebreyesus,**
> **Director-General, World Health Organization**[20]

Policymakers have historically underestimated the individual and societal impact of ignoring untreated hearing loss in an ageing population.

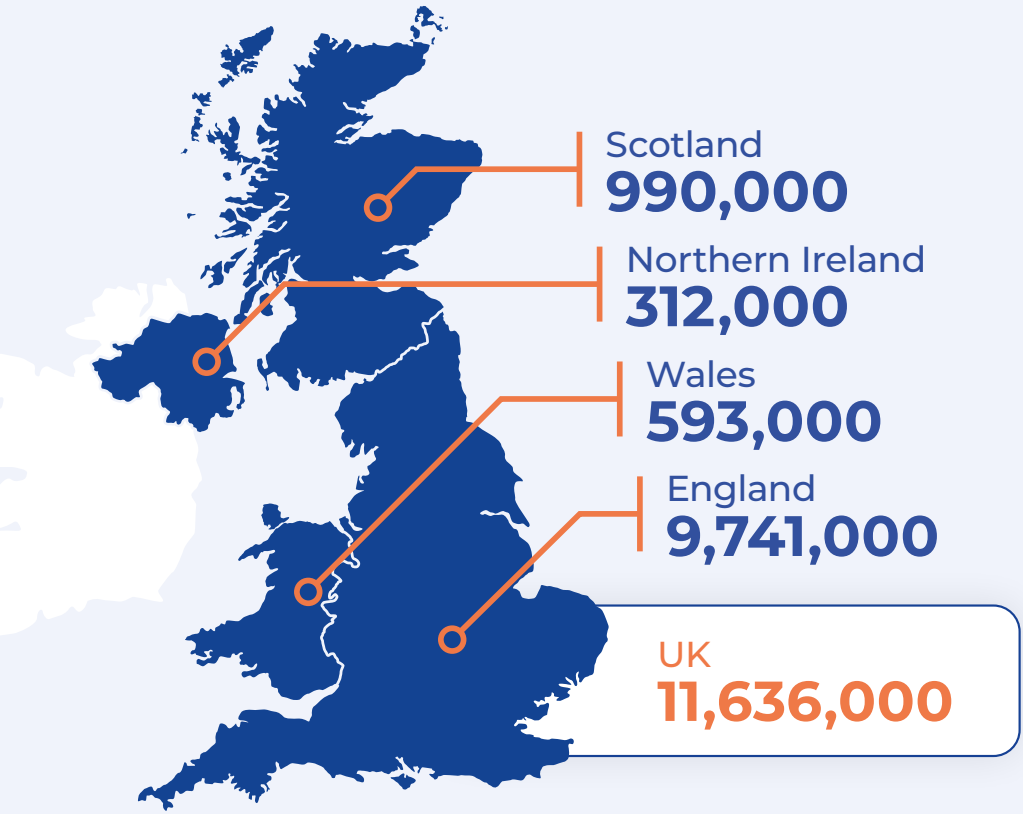
Despite being an 'invisible disability', adult hearing loss already affects 11.6 million people in the UK,[21] and this is set to grow to 14.2 million by 2035.[22] This has made hearing loss the third leading cause of years lived with disability (YLD) in the UK.[23]

We know addressing this is affordable because NICE clinical and economic research has shown that early diagnosis and support for hearing loss with hearing aids is one of the most cost-effective interventions in the NHS.[24]

The challenge is that the increasing demand from adult patients has made the hospital-based model of audiology unsustainable. As a result, it has become more difficult for hospital-based audiologists to provide safe, effective and timely care to children and adults due to system and capacity strains.[25] This is why a coordinated approach to structural remodelling of services is needed.

Without action, the risks and costs associated with hearing loss will increase rapidly as our population ages.

Hearing loss



It makes sense to act on hearing loss

NICE found that providing hearing aids to people with hearing loss at the earliest opportunity is highly cost-effective.[26]

Source[21]

Adult hearing loss

Unsupported adult hearing loss is a serious and growing public health challenge. Left unaddressed, it increases the risk of:

- Dementia and cognitive decline
- Depression and other mental health issues
- Unemployment
- Exiting employment early
- Social isolation and loneliness.[27]

Hearing aids are the primary evidence-based intervention for permanent adult hearing loss. They have been shown to improve quality of life and reduce risks associated with hearing loss.[28] NICE guidelines also show that early diagnosis and management of adult hearing loss with hearing aids is one of the most cost-effective interventions in the NHS.[24]

In fact, if a hearing aid were a drug, it would be a blockbuster which the NHS would prescribe proactively at scale, like statins and other life-preserving interventions.

Yet, the barriers to accessing NHS-funded primary care audiology contribute to a lack of familiarisation and public awareness about the risks of hearing loss and the benefits of early diagnosis and support.

There is now an urgent need for the NHS to support more adults, especially those over 50 at higher risk of hearing loss, to have their ear and hearing health checked regularly as part of an active ageing strategy.[29] We must also ensure that everyone can access audiology services based on clinical need, not ability to pay.

This can only be achieved through the rollout of an NHS primary care audiology service, as the hospital-based model of audiology cannot meet all adult hearing needs in isolation, and the population cannot afford a repeat of historical NHS systems failures based on the same underlying causes.[30]

Given the growing but avoidable burden of disease associated with adult hearing loss and the ethical duty to provide interventions of proven efficacy, the NHS must now stop accepting temporary patches which are not working and address the need for deep-rooted and system-wide service remodelling.

As in other clinical areas, a powerful means of driving change, will be by embedding patient empowerment in the NHS pathway and maximising the use of the infrastructure, workforce and diagnostic equipment that is already available in primary care audiology to meet patient needs and choices.

Improving access to NHS-funded primary care audiology services should include ensuring that people with an ear or hearing concern who cannot leave home through physical or mental illness or disability have the right to access NHS ear and hearing care based on their clinical needs on a domiciliary basis.

Primary care audiology already offers

More than
2,500
primary care audiology locations

Universally
accessible care
at home for those who need it

More than
4,000
audiologists and assistant audiologists

Short waits
and ongoing support on demand

Endnote[31]

Benefits of care closer to home

Evidence shows that improving access to adult hearing care will deliver benefits that far exceed the health investment.[32]

Costs

More people treated but at less cost per patient

Benefits

Reduce risks of social isolation, depression and dementia. Keep people in work and help people age well

NHS evidence

NHS evidence has already shown that offering patients a choice of a local provider for audiology saves the NHS money, drives higher standards, improves access and means more people can be treated for the same spend.[33]

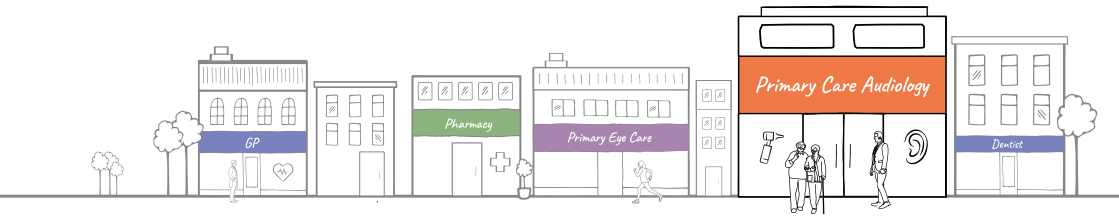
Supporting evidence from NHS commissioning

NHS evidence shows that expanding patient choice for adult hearing services:

- Establishes more robust or higher standards
- Makes services more accessible for patients
- Improves access, which can lead to savings for the wider system by reducing pressures on health and social services as consequences of untreated hearing loss
- Reduces the cost per pathway by 20% to 25%

"This can allow commissioners to treat more patients for the same spend and/or release additional funds that commissioners can spend on meeting other patients' needs"

NHS Research[35]



York model

To support UK governments and NHS and HSC decision-makers, we commissioned the York Health Economics Consortium (YHEC) to develop an open-source tool that allows users to compare different models of adult hearing care.

Users can employ the model to test different care scenarios for economic efficiency, such as varying whether a GP is involved in a pathway or whether prices are based on reference costs or actual prices for a package of care. The model demonstrates that the NHS can see more patients for less money by implementing self-referral to a primary care audiology service.

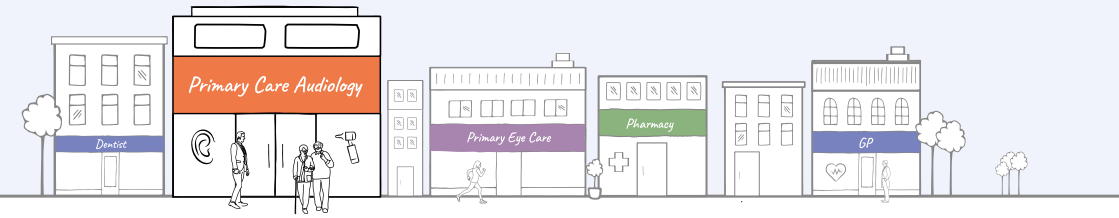
Access

Cost calculator to assess the appropriate treatment of hearing loss

Access

Economic evaluation to assess the appropriate treatment of hearing loss within the NHS

The YHEC cost calculator is designed to be used alongside planning and other guidance to help the NHS make the most of limited resources.



The calculator enables comparison between different adult hearing care pathways and assesses whether more patients can be treated within the same budget through service innovation.

Worked example:

- NHS England's planning guidance states that adults with hearing loss should be able to self-refer to audiology because GP involvement is not clinically necessary. It therefore advises all ICBs to implement self-referral for NHS adult hearing care.[34]
- Evidence shows that the NHS can buy three years of care at a fixed price by risk-sharing with providers at a lower cost than traditional models of care.[35]
- Adult hearing loss is a long-term condition and people need ongoing care. The calculator, therefore, follows one cohort from year one for six years and provides more realistic cost estimates for caring for a long-term condition like adult hearing loss.
- The calculator can be used to estimate the costs of seeing 550,000 adults using different care pathways. It shows that:
  - It would cost the NHS £622m if these patients had to see a GP and had hearing care funded using the traditional model of care
  - It would cost the NHS £463m if these patients accessed primary care audiology without a GP referral, and NHS commissioners paid a fixed price for three years of care
  - That saves £159m or 25% per cohort of patients
  - The money saved could treat an additional 188,712 people with the same NHS budget.

These findings are in line with other NHS evidence, which shows savings of between 20% and 25% before adjusting for Market Forces Factor (MFF).[36]

Positive feedback from service users

Service users also report positive feedback about primary care audiology closer to home.

Improved patient outcomes and inequalities in access tackled

Primary care audiology improves outcomes and has positive feedback from patients:

98%

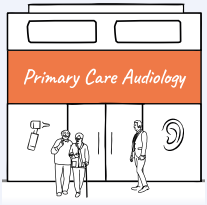
of patients are **extremely satisfied** with the service

93%

of patients **continue** to use their hearing aids after 12 months

98%

of patients are **very likely** to recommend the service to friends and family.[37]



At present, anybody with the ability to pay can access a primary care audiology service throughout the UK.

Access to NHS-funded primary care audiology however is dependent on where people live and is a postcode lottery.

This inequality in access can be tackled by allowing more NHS patients to access existing primary care audiology services without waiting times and with open access to clinical follow-up and hearing aid maintenance on demand.

Delivering sustainable change

There is widespread agreement across all UK governments and health experts that it is imperative to reduce the dependency on hospital models of care and switch to more preventive primary care models.[38]

However, concerns that moving care, albeit to benefit patients, will destabilise hospital services can delay much-needed change. Similar concerns are raised about primary care services being overwhelmed and budgets exceeded by patients self-referring.

Nevertheless, evidence shows that demand in primary care is predictable, and hospital services do not have the capacity to meet growing need.[39] Also, hospitals are costly and complex places and far from ideal settings to deliver non-medical care like adult hearing aid services – e.g. hospitals in England alone have historically reported providing more than 1 million routine hearing aid aftercare interactions each year when there is already insufficient capacity to meet higher medical needs. Primary care audiology reduces pressure on GPs and hospitals and saves the NHS money, which can then be reinvested in frontline care.

Following the evidence and making change happen in the best interests of patients is essential if health systems are to meet ear and hearing needs as cost-efficiently as possible and without massive backlogs and clinically unsafe waiting times.

We know that this is achievable. A growing number of NHS trusts have chosen to focus on higher-risk priorities and have safely withdrawn from providing NHS adult hearing aid services, which primary care audiology now delivers. This has freed up hospital capacity to focus on specialist services.

Service transformation in Preston is a case in point, allowing specialist hospital audiology and ENT services to deliver significant efficiency improvements, benefiting all patients, the NHS and taxpayers and better matching supply to demand.

Transforming hospital services

In 2018, the Royal Preston Hospital decided it was not the right site to fit hearing aids for age-related hearing loss. At the time, this hearing aid service generated an income of £1.6m for the hospital. This NHS care was transferred to audiology providers in primary care settings.

The hospital audiology department focused its resources on making sure patients in need of hospital care were seen by the right person at the right time and in a cost-effective way.

The head of audiology focused on ensuring people with sudden hearing loss were fast-tracked to ENT. New pathways empowered the hospital audiology team to safely manage more people with balance and other needs, freeing up ENT capacity for more medically complex patients.

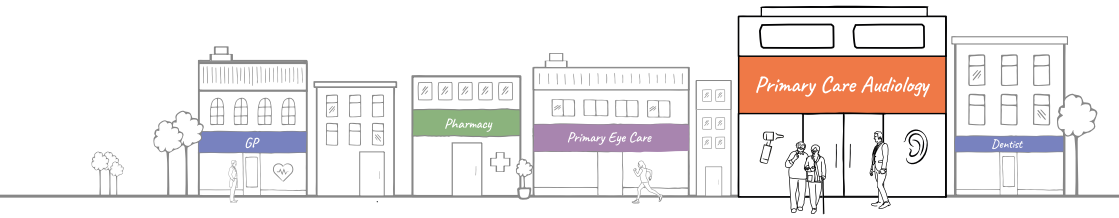
As a result, people with age-related hearing loss can now access hearing care out of hospital and closer to home, hospital audiology has upskilled, and the local NHS has freed up 2,000 ENT appointments a year.

Source[40]

This model can easily be replicated across the UK.

Accordingly, as the Association for Primary Care Audiology Providers, we will:

- Continue to call for a universally accessible adult hearing assessment and hearing aid service based on the NHS principles of clinical need, not the ability to pay
- Continue to advocate for NHS patients to have the same rights to self-refer to audiology as patients with the ability to pay – just as they do across the rest of primary care
- Continue to raise awareness of adult hearing loss, its impacts and the evidenced benefits of early diagnosis and support
- Support governments, regulators and commissioners with evidence to support service change in the public interest.



Hearing loss in children

Permanent childhood hearing impairment (PCHI) is relatively rare, affecting between 0.08% and 0.3% of children.[41]

Although only a relatively small proportion of children will have a permanent hearing loss, each child will require early diagnosis and ongoing support to maximise their quality of life and life chances. So, the UK National Screening Committee recommends high-quality screening for PCHI in all newborns and appropriate follow-up care if a hearing loss is suspected.[42]

The newborn hearing screening programme has led to overall improvements in the detection of PCHI.[43] However, a history of unacceptable variation in the quality of children's hearing care across the UK has resulted in repeated system challenges, letting down many children.[44]

A strong consensus exists across the sector and the wider NHS that the quality of childhood services must improve.[45] To achieve this goal, we must learn from the past and use the evidence to find the best solutions for the future.

The relatively low incidence of PCHI means services need some concentration of expertise to maintain quality and safety, with previous national guidelines recommending that audiologists caring for children assess at least 20-30 new childhood cases a year.[46]

We also know that, as many children with hearing loss will need additional support, they will often benefit from accessing a centre with a multi-disciplinary team and specialist ongoing support and management.[47]

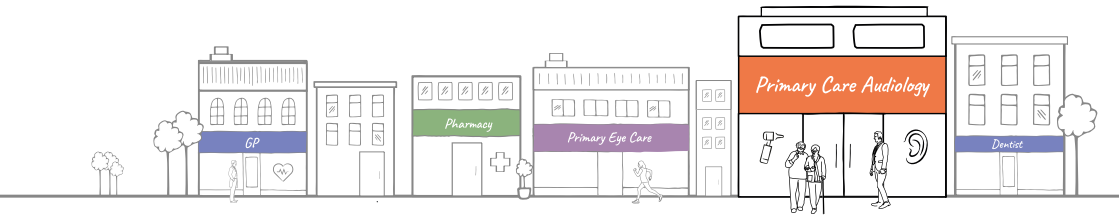
Given the need for specialist equipment and concentration of specialist skills, paediatric audiology (unlike most paediatric eye care services, for example) is not well-suited to a universal primary care service across many sites. Paediatric hearing services, therefore, need to remain concentrated in specialist hubs led by appropriately trained and experienced audiologists working with paediatricians, ENT specialists, speech and language therapists and other experts.

The good news is that, as the RNID acknowledged over 35 years ago, delivering adult hearing care in primary care settings will release significant capacity in hospital specialist services to meet the needs of children.[48]

In addition to PCHI, children might experience a temporary conductive hearing loss. For example, otitis media with effusion (OME), also known as glue ear, is the most common cause of hearing impairment in childhood. In most cases, OME resolves without intervention, but in some cases, it can be more persistent and increase the risk of development problems.[49] OME is typically managed by GPs in collaboration with secondary care. In the future, as more specialist audiologists opt to work in primary care audiology, much of this ongoing care will also be met closer to home with primary care audiologists working to support the child, carers and educators together with GP and ENT colleagues.

To support improved access to quality children's services, we will:

- Work collaboratively with sector partners, especially the third sector, to share our expertise in NHS commissioning, health policy, health regulation and health economics to secure sustainable and safe care for children within the overall remodelling of audiology services
- Continue to reduce pressure on adult hospital services so that departments have the capacity to provide safe paediatric audiology for all children who need it.



Technology and innovation

> "Loss of hearing, which is often under-appreciated, can have a substantial effect on quality of life including social interaction [...] Hearing loss is generally slowly progressive. [....]. There is strong evidence that hearing technology, including hearing aids and (more rarely) cochlear implants, enables most people with hearing loss to stay socially active, reduce the risk of depression, and may reduce the risk of dementia."
>
> **Professor Chris Whitty, Chief Medical Officer's Annual Report 2023: Health in an Ageing Society.[50]**

Life-changing tech

Hearing aids are the primary intervention for most permanent hearing loss. Their clinical effectiveness has been demonstrated by both a Cochrane systematic review and independent analysis by NICE.[51]

NICE has also shown that early diagnosis of hearing loss, timely provision of hearing aids and ongoing support helps improve quality of life and is very cost-effective for the NHS.[52]

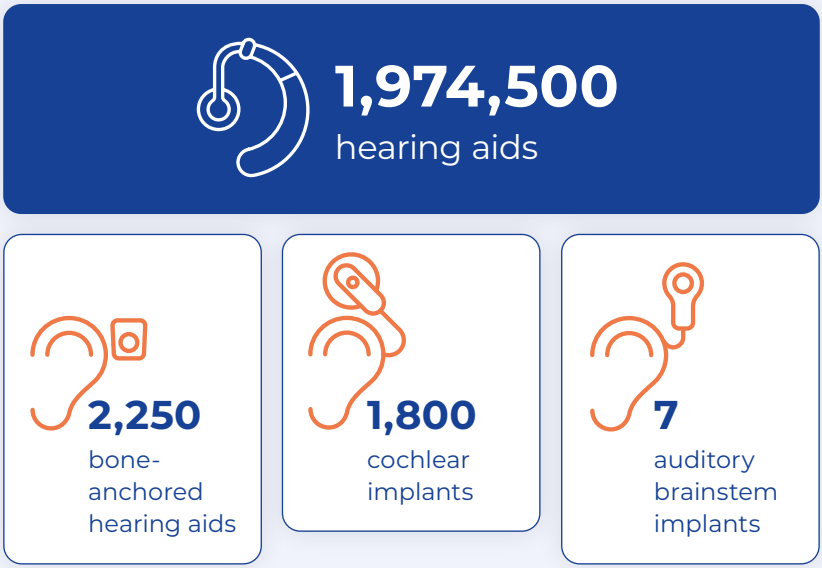
Emerging evidence also shows that hearing aids might protect against the risk of developing dementia.[53]

In addition, hearing aid technology continues to advance rapidly, with modern digital hearing aids providing high-tech noise management and the ability to seamlessly adapt to different environments, helping further reduce the impact that hearing loss has on daily life.

Yet, despite more than 1.97 million hearing aids being fitted annually in the UK (76% by the NHS and 24% through self-funded care)[54] and the significant health benefits this brings, fewer than half the people who could benefit from hearing aids access them. Almost all these people could have their needs met more conveniently, and more cost-effectively for the NHS, in primary care audiology.[55]

A smaller number of people with more severe hearing loss or a specific cause of hearing loss will not benefit from conventional hearing aids. Some will choose to explore alternative hearing technologies such as NHS-funded cochlear implants, bone-anchored hearing aids, middle ear implants or, in rare cases, auditory brainstem implants. These specialist devices need to be fitted and supported by multi-disciplinary teams in hospitals.

Ensuring people have the choice of access to evidence-based life-changing tech or alternatives, which reflect their individual needs and wishes, will be at the heart of tackling the risk and cost associated with unsupported hearing loss.



Endnote[56]

Innovation

In addition to ensuring timely access to existing technologies, as champions of hearing care and patients' rights, we will support all clinical and service innovations which advance safety, effectiveness, and patient and public benefit. This includes better self-management and choice in ear and hearing technologies, which improve patient outcomes and advance the possibilities of audiology as a therapeutic science.

In time, innovation may include evidence-based hearables, over-the-counter devices, hearing aids with general health monitoring capabilities, new cochlear implant eligibility criteria, and techniques such as video otoscopy, remote monitoring and applying artificial intelligence (AI) in diagnostic, therapeutic and support services.

In all cases, where the evidence supports it, we will call for the most effective audiology models to be properly funded by the NHS to ensure patients can access the care they need in the most appropriate locations. Planning should also transcend traditional sector boundaries so that high-quality patient-focused services are available to all.

To meet population needs, we are committed to the following:

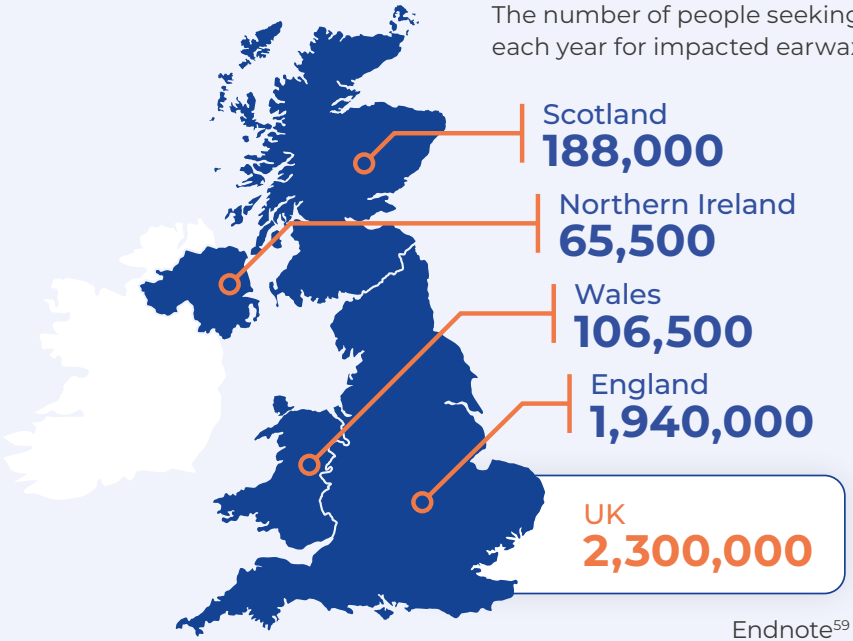
- Promoting evidence-based guidance on adopting hearing technologies
- Improving education and training about referral criteria for specialist implantable devices so that every person can make an informed choice about the intervention that is right for them
- Supporting innovative and evidence-based technologies, provided these are safe and benefit patients
- Tackling barriers to accessing and using hearing technologies, including the stigma associated with using hearing aids
- Ending the unjustifiable levying of standard-rated VAT on hearing aids
- Publicly supporting innovation to improve quality of life, outcomes and access for people with hearing and communication difficulties and challenging obstacles to change in the public interest.

Wax

Earwax is a natural substance that helps protect the ear canal. However, when it builds up – known as impaction – it can cause hearing loss and earache, contribute to infections, and increase the risks of stress, social isolation and depression.[57] It can also prevent adequate clinical examination of the ear, requiring repeat visits to audiologists, GPs and ENT, and delay assessment and management.[58]

People with impacted earwax will often seek help. With an estimated 2.3 million people doing so each year and a reported 4 million ears treated annually, earwax removal is the most common ENT procedure in the UK.[58]

Earwax



Endnote[59]

It is widely accepted that, given other pressures, practice nurses, GPs, and ENT departments no longer have the capacity to meet this need alone. Experts in the field also acknowledge that managing earwax in uncomplicated ears is not the best use of ENT time and that utilising secondary care is too costly for this intervention.

> "Relying on hospital ENT [for wax management] causes a delay and is an expensive and unnecessary use of specialist resources."
>
> **Professor Kevin Munro, Ewing Professor of Audiology, NIHR Manchester Biomedical Research Centre[60]**

This was especially true during the Covid pandemic when ENT departments and GP colleagues had to prioritise managing high-risk patients. As a result, the Royal College of General Practitioners (RCGP) and the British Medical Association (BMA) recommended that GPs signpost people with impacted earwax to primary care audiology practices on the high street.[61]

Our members responded to this call and today provide more than 300,000 de-waxing appointments each year, helping people access the support they need in safe and effective clinical settings across the UK.[62]

Unfortunately, the NHS has been slow to capitalise on this service shift, leaving huge gaps in NHS-commissioned services. People pay £55 on average to access this care where it is not funded by the NHS, worsening health inequalities for those who cannot pay. As the RNID has reported, many regions in England lack a funded NHS de-waxing service, disadvantaging millions of people.[63]

Worst still, in some regions, NHS commissioners continue to require patients to visit their GP for a referral to ENT to remove earwax. This pathway can cost the NHS three times as much as it costs people to fund their own care in primary care audiology closer to home.[64]

The solution is simple – all health systems should follow the NICE recommendation that most adult earwax should be treated in primary care and community rather than hospital. All savings can then be reinvested in frontline care, helping tackle more cases of earwax or funding other services.

Providers in primary care audiology are committed to improving access to safe and effective de-waxing services closer to home. They are already investing significantly in technology and workforce development to ensure sufficient capacity to meet the growing needs of our ageing population, who are more likely to experience problems with a build-up of earwax.

To meet population needs in a safe, effective and sustainable way, we will:

- Campaign for the NHS to commission de-waxing services from primary care audiology providers so people with earwax get the right support at the right time, in the right place, based on clinical need, not the ability to pay
- Work with higher education institutions, evidence-based organisations, UK governments and regulators to help train and retain the necessary skilled workforce to meet this need in primary care audiology
- Respond to non-evidence-based barriers to people accessing de-waxing services
- Work with sector partners to improve advice and guidance, including on safe options for self-care and how to minimise risk.

Tinnitus

Tinnitus describes hearing a sound where there is no external sound source. This might be ringing, humming, buzzing, or more than one sound at a time.[65]

About 10% of the population is estimated to experience tinnitus at some point, and it will be moderately annoying in 2.8% of the population, severely annoying in 1.6%, and disrupt a person's ability to live a normal life in 0.5%.[66]

Many people with tinnitus will also have other ear and hearing needs, which are best managed in primary care audiology – e.g. 75% of people with hearing loss might experience tinnitus[66] and tinnitus is also often associated with a build-up of earwax.[66]

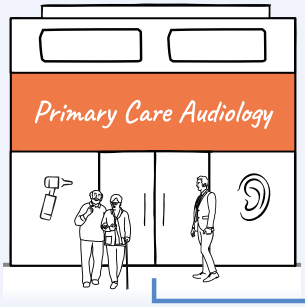
So, while 6.7 million people in the UK will eventually experience tinnitus, many will self-manage their tinnitus without intervention, while others will need routine ear and hearing care support. A smaller group will need access to more specialist tinnitus services, and some will need a medical examination to exclude any underlying pathology.[66]

The challenge is that without a clear clinical pathway to specialist care, it is estimated that more than 1 million people with tinnitus turn up at their GP practice each year for support, guidance and referral.[67] GPs are under pressure and cannot meet this need alone. GPs also often lack access to diagnostic equipment to help reduce the rate of false positive referrals to ENT.[68]

To help patients, GPs and ENT colleagues, and decision-makers across the UK should implement the NICE guidelines for managing adult hearing loss and tinnitus. These guidelines make it clear that people with tinnitus and no red-flag symptoms should be offered an audiology assessment as the first-line intervention.[69]

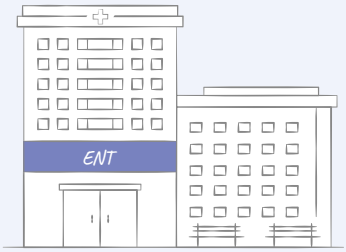
Primary care audiology can then support patients with underlying hearing loss and earwax, provide advice and guidance where appropriate and triage patients to specialist tinnitus or ENT services as clinically necessary. This will help free up GP capacity and reduce false positive referrals to ENT.

Together, these changes will free up capacity in specialist tinnitus clinics so more people can access timely specialist care and support when they need it.



Primary care audiology

- Audiology assessment
- Manage underlying causes – hearing loss and earwax
- Advice and guidance
- Triage as clinically necessary

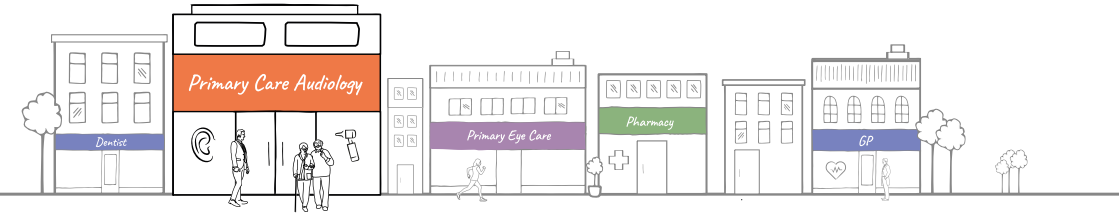


Specialist care and support

- Medical management of any red flags by ENT
- Timely mental health support
- Person-centred management plan

The goal in all cases should be to offer an integrated ear and hearing care service to ensure each person gets the right care at the right time in the right place. That is why we will do the following:

- Raise awareness about tinnitus and the role primary care audiology can play in supporting patients and the wider NHS in meeting patient needs
- Support the dissemination and adoption of NICE guidelines on adult hearing loss and tinnitus
- Call for more patients with tinnitus to have access to the care they need on an individual basis, reflecting how tinnitus affects them personally.



Integration with ENT

> "For conditions beyond the scope of audiology services, referrals can be made directly to ENT departments from the audiology service. The development of these non-surgical pathways will be one of the most significant and effective transformations in ENT outpatient practice."
>
> **NHS, Transforming ENT Outpatient Services**[70]

As with any speciality, not all care can or should be delivered in primary care settings. Examples include complex surgical specialities and medical conditions that require centralised infrastructure and skills, which should remain hospital based.

In these cases, the goal is to help patients access the hospital care they need in the most efficient way. In ear and hearing care, this can be achieved with better integration of primary care audiology and ENT, ensuring people are referred appropriately and do not suffer undue delays in accessing the support and treatment they need.

In a related example, primary care optometrists test and correct vision and other issues, referring between only 3% and 5% of patients to hospital when clinically necessary. Likewise, hospital departments can treat and discharge patients back to primary eye care or continue to co-manage patient needs outside hospital.[71]

It makes sense to replicate this model between primary care audiology and ENT, especially as the prevalence and incidence of ear disease in the adult population is typically lower than eye disease. In doing so, we estimate that primary care audiology could manage 95% of adult patients closer to home without referral to secondary care.[72]

> "**About 40% of new referrals [to ENT are for] uncomplicated hearing problems** and simple perennial rhinitis, and **others include wax, presbyacusis, tinnitus** and a runny nose."
>
> **ENT UK**[73]

An integrated primary care audiology service, therefore, has the potential to reduce false positive referrals to ENT, a speciality that already makes up more than 4% of all first outpatient attendances[74] and is seeing new referrals growing on average 3.7% per year.[75]

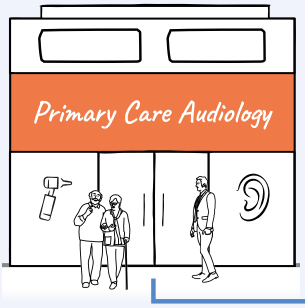
There are also opportunities to go further in the future by supporting better IT connectivity between audiologists working in primary care, GPs, and audiology and ENT departments in hospitals. This will allow the remote transfer of diagnostic data, including video otoscopy and images, and enable more needs to be met in primary care audiology, reducing the need for patients to attend hospitals for face-to-face appointments.

This will free up more capacity and help GPs and ENT departments focus on patients who would benefit most from medical care without the long waits and system pressures they currently experience.

Integrated primary and secondary care – feasibility study

A feasibility study assessed the benefits of using technology to reduce hospital referrals.

Patients attended an NCHA member practice in a primary care setting, where an audiologist conducted an audiological assessment and used a smartphone-based application and otoscope to capture images and video of eardrums.



The member sent diagnostic data to ENT for remote review. 65% of patients avoided a hospital visit. 98% of patients were satisfied with the pathway.

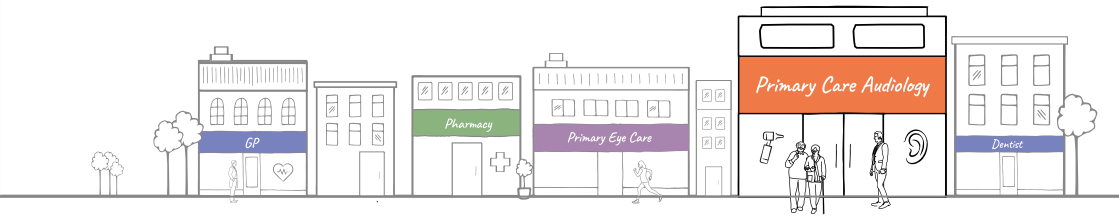
Source: BMJ Open Quality[76]

Current models of care can result in false positive referrals to already stretched ENT clinics. Improved connectivity between primary care audiology and ENT will mean that GPs can send people to primary care audiology for effective triage, helping more patients to be managed close to home and releasing scarce NHS ENT resources.

We also believe audiologists of the future will practise more like their pharmacist and optometrist colleagues of today, working in primary care and at the top of their licence to meet most adult needs outside hospital.

To ensure patients get the care they need and deliver an integrated primary care audiology service for all, we will:

- Collaborate with GPs and hospital ENT and audiology departments to improve all ear and hearing health pathways
- Focus on reducing pressure on GPs and ENT by calling on commissioners to support a more joined-up model of ear and hearing care
- Call for better IT connectivity between primary and secondary ear and hearing care services to reduce unnecessary trips to hospitals, benefiting patients, the NHS and the environment.



Workforce, quality and College of Audiology

To help ensure we deliver on our vision for the future of primary care audiology we will lead on workforce analysis, development and research, and work with sector partners to develop quality in primary care audiology (Qi-PCA). We will also support the sector in establishing an independent, transparent, accountable, evidence-based College of Audiology founded on a robust charter to work for the public benefit and which is accountable to the Charity Commission.

Workforce

Audiology is an essential non-medical speciality that can offer significant health and wellbeing benefits to patients and populations. Audiologists, as skilled clinicians, can assess and manage patients within their registered scope of practice, as well as supervise trainees and junior staff. They should be the first point of contact for accessing ear and hearing care in all localities, whether on the high street, elsewhere in the community or in acute hospitals.

As with any healthcare workforce, planning capacity should be based on population needs. However, owing to audiology being incorrectly classified as a low-priority service, the profession has experienced a lack of strategic planning and poor investment by health services.

To overcome these issues and better align the workforce with population needs, providers, training practices, hospitals and higher education institutions (HEIs) now need to work together to build a workforce that can meet growing patient demand in a safe, effective and sustainable way.

Of course, there are some challenges to overcome in this area. For example, the audiology workforce in secondary care has been in decline for some time and now suffers from chronic shortages,[77] with the British Academy of Audiology stating that "the staffing crisis is significant and without immediate action will worsen until NHS audiology services grind to a halt".[78]

One reason for the more acute workforce crisis in secondary care is that the current training route for most hospital-based audiologists has been designed around non-audiological professions. As a result, it is not sufficiently agile to help scale up the workforce to meet population needs. We are committed to working with sector partners and the NHS to help find solutions to some of these structural challenges in secondary care.

Investing in primary care audiology

Meanwhile, in primary care audiology settings, the HCPC-registered audiologist workforce has doubled to more than 4,300 in less than a decade.[79] As a sector, we are also making record investments in training and development and supporting HCPC registrants with CPD and additional training to expand their scope of practice to meet the population needs of the future.

We will continue to base our workforce planning in primary care audiology on population needs and factor in likely technological innovations in the coming years, including new technologies that make skilled wax removal even safer. This will ensure we are prepared for when subgroups of people with hearing loss obtain self-fitting hearing aids and seek a different kind of support from audiologists than they do today.

As we have seen with pharmacists, optometrists and dispensing opticians, we also expect primary care audiologists to take on more complex caseloads over time and support hospital-based colleagues by delivering higher levels of first-line care in primary care settings.

At the heart of this will be ensuring high education standards and training.

Quality in primary care audiology (Qi-PCA)

As sector partners have done in primary eye care, we will work collaboratively with audiology sector partners to develop a bespoke quality framework for primary care audiology that is proportionate to risk.

We will then continue to review and adapt Qi-PCA to ensure patients continue receiving high-quality and accountable ear and hearing care in primary care settings. We will also support this work with the necessary tools, guidance and CPD.

College of Audiology

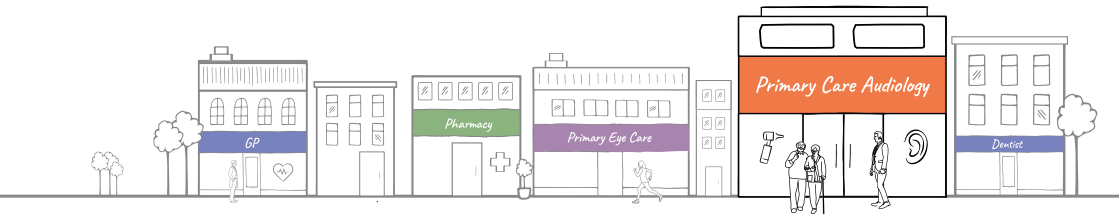
It was our commitment to independent and evidence-based clinical leadership that led to our proposing the establishment of a College of Audiology to sector partners and NHS England. We have also put on record the importance of a College of Audiology being:

- Independent, evidence-based, open and transparent – free from undue influence of any nature
- Accountable to the Charity Commission against a robust charter and operating rules, demonstrating the highest levels of probity
- Focused on public benefit and improving outcomes, care and access for all.

We will support the establishment of a College of Audiology that is consistent with these principles.

To ensure the UK has the necessary workforce to meet population needs and can deliver world-class care, we will:

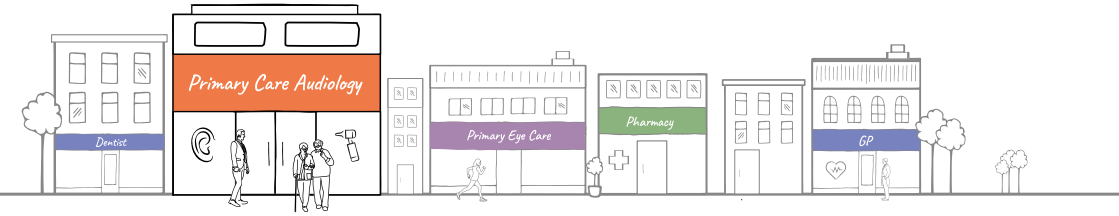
- Lead workforce analysis and development, including calling on the NHS to recommence collecting and recording audiology workforce data separately so we can more effectively model the UK-wide audiology workforce
- Collaborate with patient groups, sector bodies, HEIs, regulators and governments to promote more audiologist training
- Support all audiologists to join the HCPC register and, for those who choose to do so, support them in expanding their scope of practice
- Raise awareness of audiology as a lifelong and rewarding career
- Work with partners to develop a Qi-PCA framework that is open to all providers and audiologists in primary care
- Support an independent, transparent, accountable, evidence-based College of Audiology established on a robust charter to work for the public benefit and which is accountable to the Charity Commission.



Our route map

As always, we will follow the evidence in all we do and focus relentlessly on meeting individual patient and population needs equitably in a safe and sustainable way in line with government and health system goals in all four nations. We will achieve this by working in collaboration with all stakeholders as we follow our route map to accessible ear and hearing care for all:

- Raise awareness about ear and hearing care issues
- Promote the growing body of evidence for better access to NHS-funded primary care audiology
- Support new models of care, including evidence-based tech and innovation, which allows the NHS to treat more people in a cost-effective way
- Ensure we have the workforce to meet growing needs and secure quality care for future generations
- Work with ENT, GP and wider primary care to deliver an integrated service for all



Delivering our vision of an integrated primary care audiology service will mean:

- Everybody with an ear and hearing problem will have timely access to care
- Most needs will be met in primary care audiology, close to home, reducing pressure on GP colleagues and hospital systems
- Improved quality of life for millions of people with hearing loss and a reduction in YLD and the cost and risk associated with unsupported hearing loss
- Modern diagnostic equipment and connectivity between primary care audiology and ENT will deliver frictionless patient care, freeing up scarce ENT and specialist audiologist time
- A clinical workforce developed around population needs and modern models of care
- Use of new technologies, innovation and remodelled services so the NHS can finally address this significant and growing public health challenge
- Freeing significant GP and hospital appointments, which can then be used to meet other needs
- A leap forward in public health and wellbeing outcomes for individuals and the population.

Annexes

Equality and health inequalities statement

For millions of people in the UK, hearing loss is a permanent, progressive and long-term condition which can substantially affect the ability to carry out typical daily activities.

With the right support at the right time in the right place, we can significantly mitigate the impact of hearing loss. Unfortunately, this is often not the case in the UK today, and many are unaware of the benefits of seeking help. Those who try can face avoidable barriers to care.

Many adults with hearing loss that is significant enough to require help will often have at least two protected characteristics – older age and disability. Children with permanent hearing loss can experience barriers to accessing the support, education and care they deserve. Often, Deaf people who use BSL face barriers in accessing many services, including healthcare.

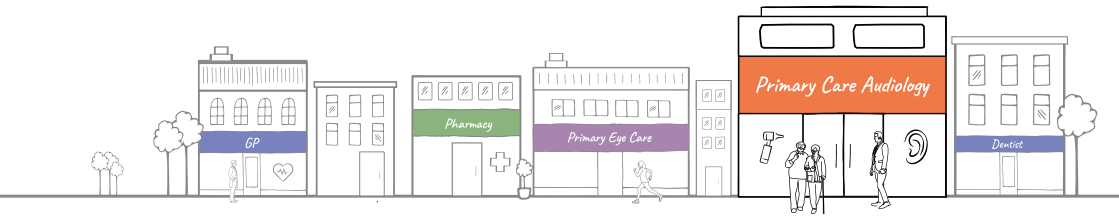
In **primary care audiology**, we set out a road map that will benefit millions across the UK. It is, however, not the only action that needs to be taken. We must also do more to

- Raise awareness about preventing hearing loss and its impacts
- Support Deaf people and the use of BSL
- Protect and promote other specialist services that people depend on.

We will continue contributing to this broader body of work through a partnership with the Hearing Loss and Deafness Alliance and other collaborative networks.

We also know that all UK governments have committed to promoting equality and tackling inequalities in health outcomes independently of legislation. This commitment, in addition to the public sector equality duty (PSED), should empower all to act on unsupported hearing loss and help tackle what is now a leading cause of years lived with disability.

As the evidence has shown, this can be done in a cost-effective and sustainable way, benefiting patients, the health and care system and the wider economy. The time to transform ear and hearing care services is now if we want to meet the PSED and help people live and age well.



NCHA
The Association for Primary Care Audiology Providers

About us

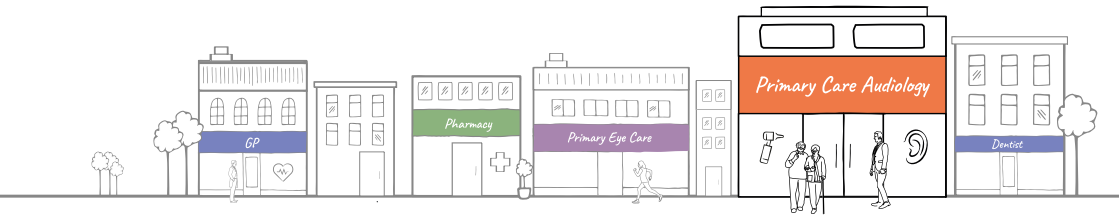
We are the Association for Primary Care Audiology Providers in the UK. We exist to improve ear and hearing care for all and work with the NHS, health and social care bodies and policymakers to make this happen.

Our goals are to work with partners to achieve better ear and hearing care for all by:

- Ensuring everyone has access to primary care audiology in the same way as to GPs, dentists, opticians and pharmacists, based on personal choice
- Making sure ear and hearing care is recognised as a public health priority
- Breaking down barriers between primary, community and secondary care for the benefit of patients
- Supporting effective regulation of ear and hearing care services
- Ensuring we have the workforce, infrastructure and funding models to deliver excellence in hearing care for all.

References and endnotes

Access here



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