

NCHA response

1- What do you think of the general approach taken in this document? Please enter your views below.

We thank the Service Quality Committee for undertaking this important work. We welcome the opportunity to comment on this consultation – guidelines for the onward referral of adults with hearing difficulty directly referred to audiology services.

In terms of the general approach, in our view, it would be helpful if the BAA could work with the BSHAA to produce a single document. Given that there are no significant changes to the referral criteria when compared to past criteria¹, we hope that the BAA Service Quality Committee will consider this approach. The BSHAA also produced guidance on this topic in 2014² and comparing that guidance to these BAA guidelines³ we feel there is significant overlap, and hope that this will help facilitate co-production of a single document for hearing care professionals working in the NHS.

In our response, we have assumed that the BAA has worked with ENT-UK and BAAP on material changes to NHS referral criteria – e.g. interpretation of “tinnitus which has significantly changed in nature” (p 5 and 10).

The current document, we assume, offers UK wide guidance. The way in which NHS hearing care is now commissioned, and will be commissioned in the future, varies across the UK. This is important because legislation and other NHS guidance also varies in each country – and sometimes within England depending on whether choice has been extended locally. We feel this referral guideline should focus on referable conditions, and sections that might be better suited to commissioning guidance are removed from the final version of this referral guideline.

We would welcome joined-up guidance – by the BAA, BSHAA, NCHA, Action on Hearing Loss and other sector partners – to minimise the risk of providers/commissioners acting in a way that is not consistent with existing regulations/legislation in parts of the UK. For example this might be through guidance that focusses on how to manage existing patients/hearing aid users in a way that is consistent with the NHS Standard Contract and licence conditions in England, but also consistent with general UK-wide NHS and Hearing Loss and Deafness Alliance principles.

¹ Hearing Aid Council (2008) Regulations governing the dispensing of hearing aids in the UK, paragraph 5; BAA (2009) British Academy of Audiology Guidelines for Referral to Audiology of Adults with Hearing Difficulty, cited in Department of Health (2012), Adult Hearing Implementation Pack. pp. 27-28; BSHAA (2011) Protocol and Criteria for Referral for Medical or other Specialist Opinion, cited in Department of Health (2012), Adult Hearing Implementation Pack. pp.27-28; BSHAA (2014) Guidance on professional practice for Hearing Aid Audiologists, pp.8-12; Service Quality Committee of the BAA (2016) Guidelines for Direct Referral of Adults with Hearing Difficulty to Audiology Services (2016) ; Service Quality Committee of the BAA (2016) Guidelines for Onward Referral of Adults with Hearing Difficulty Directly Referred to Audiology Services (2016),

² BSHAA (2014) Guidance on professional practice for Hearing Aid Audiologists, pp.8-12

³ Service Quality Committee of the BAA (2016) Guidelines for Onward Referral of Adults with Hearing Difficulty Directly Referred to Audiology Services (2016)

2- Please enter your detailed comments on the document in the table provided in Section 2 of this feedback form.

Page of Document	Document Section	Text from Document	Your Comment
2	Introduction	The criteria have been written for all adults (age 16+), but local specifications regarding age range for direct referral should be adhered to.	This text – in yellow - aligns well with BSHAA referral guidance for HCPC registrants ⁴ . HCPC registrants are legally required to have appropriate levels of professional liability insurance. Given the diversity of the workforce and models of care emerging in the UK, we think it would be helpful to remind readers of the importance of having appropriate professional indemnity cover at all times, and especially if the local referral criteria is changed. Providers might seek advice on this from their insurance provider and/or from the NHS Litigation Authority.
2	Introduction	This document is intended to be used in conjunction with “Guidelines for the Direct Referral of Adults with Hearing Difficulty to Audiology Services (2016) 1 ” and Audiology services are expected to make reasonable efforts to make local GPs aware of these guidelines.	GPs are under significant pressure and hearing care remains a small part of what they do. Therefore current variation in referral criteria for hearing services across the UK can add to GPs’ workload. Multiple providers approaching GPs about local referral criteria risks further confusing them. We therefore suggest the following text - <i>“all local audiology services (regardless of organisational form) should work with neighbouring providers who are also linked to local GPs, to support GPs understanding of local direct access audiology referral criteria”</i>
2	Background	There is a lack of research evidence to support some of the criteria, but they are well accepted both in the UK and internationally ^{5,6} . We recommend that these criteria are investigated further to provide an evidence base to support future guidance.	NICE is currently developing guidance on adult onset hearing loss and is likely to consider referral criteria. This should therefore address the BAA’s recommendation. NICE guidance is likely to supersede any sector specific NHS guidance in England and Wales, and possibly also in Scotland and Northern Ireland. This BAA guidance is therefore important and wider sector collaboration at this stage might help reduce

⁴ BSHAA (2014) Guidance on professional practice for Hearing Aid Audiologists, pp.8-12

			the risk of significant changes when NICE publishes its guidelines in early 2018.
2-3	Scope of this Document	Please note that these guidelines relate to the direct referral of adults with hearing difficulties to Audiology services and may not be directly interchangeable with guidelines for other pathways, for example, Any Qualified Provider (AQP). For service planning, this document may need to be considered alongside the BAA Guidance on Identifying Non-Routine Cases of Hearing Loss in Adults (2015)⁸	In our view, the use of AQP in this section is not an appropriate example because it suggests there is some confusion about contracting mechanisms and clinical procedures. These guidelines are as likely to be interchangeable with single provider block contracts, competitive tenders, AQP pathways and/or other contract mechanism. Having reviewed the guideline and compared it to other referral guidelines, we found no evidenced-based reason to support this – in yellow – statement. Text highlighted in grey (p3) follows the text highlighted in yellow (p.2). This is UK wide guidance, but the emphasis on contracts and service planning appears to be focussed on England. We would not normally expect to see this text in a referral guideline. Publishing separate commissioning guidelines for members might help ensure that all appropriate services are commissioned, or that when commissioners – in England for example – are planning services they can include a range of services in any tender. The commissioner in England can then – as it is legally required to do – assess which procurement strategy is in the best interests of patients. When reading the BAA Guidance on Identifying Non-Routine Cases of Hearing Loss in Adults (2015) it is not clear if commissioners should modify reimbursement and qualification criteria based on the classification system provided, and if so how, why and the evidence for doing so. We would recommend that the BAA Service Quality Committee work with sector partners – e.g. BSA, BSHAA, NCHA and others that can contribute – to help translate several documents into commissioning tip sheets. These could be designed for each UK country and help account for

			variation in policies and regulations. This referral guideline could then focus on the clinical needs of patients and be generalised/transferable across the UK.
3	Scope of this Document	This document assumes that the adult referred does not already have an NHS hearing aid. Audiology services are encouraged to have regional policies in place regarding the referral of existing hearing aid users to Audiology services. This document is not intended to guide Audiologists in the reassessment of existing hearing aid users.	We think this risks further compounding a complex challenge that often does not have a clear root cause at a local level. We would welcome joined-up guidance – by the BAA, BSHAA, NCHA, Action on Hearing Loss and other sector partners – on how to manage existing patients/hearing aid users in a way that is consistent with the NHS Standard Contract and licence conditions in England, but also consistent with general UK-wide NHS and Hearing Loss and Deafness Alliance principles. The main aim here would be to ensure providers at a local level remain compliant with their legal duties and do not, unknowingly or otherwise, behave anti-competitively and in any way that is not in the best interests of patients. We also feel this wording increases risks for the patient beyond any benefit for the patient – please see response to the GP consultation.
3	Scope of this Document	In some services, Audiologists may undertake extended roles and provide pathways which substitute for medical referral. They must always operate within their defined role, according to their regional and/or professional protocols.	In similar guidance by professional bodies across the health sector the term “ <i>within their scope of practice</i> ” is the norm. The BAA Service Quality Committee might wish to use a similar form of words.
4	Notes on the onward referral of adults	Direct referral assessments must be conducted by a Healthcare Science Practitioner at a minimum of career level 5 (equivalent to NHS Band 5). For further definition, see the BAA Scope of Practice Document 7. This will usually be a qualified Audiologist, registered with the RCCP, a Clinical Scientist (Audiology) or a Hearing Aid Dispenser, registered with the HCPC.	Suggested change to wording: <i>“Direct referral assessments must be conducted by a qualified audiologist. A qualified audiologist for this purpose is defined as a</i> <i>audiologists at a minimum career level 5 (equivalent to NHS Band 5) or</i> <i>hearing aid dispenser registered with the HCPC.</i>

			<i>All audiologists should have appropriate professional liability insurance. It is important to ensure professional liability insurance covers audiologists for any enhanced services they deliver. Whether professional liability insurance is classified as appropriate will also depend on whether care is provided in autonomous clinics or in a consultant-led clinics"</i> We suggest these changes because • in the current text level 5 appears to have a different definition to level 5 in the referenced BAA document • the guideline sets clear – and commendable – aspirations for audiologists to extend their scope of practice. The document however does not advise audiologists that they should ensure they have appropriate indemnity cover. • There is a legal requirement for all regulated health care professions in the EU to have appropriate liability insurance (Article 4(2)(d) of the European Union Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (the Directive)). • The definition of appropriate is likely to vary depending on the functions an audiologist is responsible for.
4	Notes on the onward referral of adults	If any of the following criteria become evident on assessment in Audiology, a specialist opinion should be sought. Depending on local protocol, this referral will usually be to an Ear, Nose and Throat (ENT) department, Audiovestibular Medicine or back to the referring GP. In certain services, this may be to another specialist or private service. Pre-existing and investigated (medical) conditions should be taken into account, if relevant. Referral for a medical opinion should not normally delay impression taking or hearing aid provision. The Audiologist must make a professional decision, based on ear examination, whether it is safe	We have no comment on this advice because we have assumed that the BAA has worked with ENT-UK and BAAP on these and other changes to NHS referral criteria. However, we think that the text in yellow requires greater clarity. We have the following feedback on text highlighted in grey: <i>"for conditions requiring medical or specialist investigation which could lead to treatment, provision of a hearing aid prior to investigation and/or treatment outcomes are known to carry a risk. The official view of ENTUK and BAAP should guide this"</i>.

		to proceed with impression taking ⁹ and hearing aid fitting.	We ask the committee to consider this feedback based on the risks and benefits. As in our response to question 1, we have assumed the BAA has worked with ENT UK and BAAP, but we felt this comment should be shared.
10-11	Appendix	All	Referral checklists can help support busy professionals make accurate and safe referrals, and on this basis we welcome the use of a referral checklist.

3 - If you have any further comments on the document please add them here.

We would ask the BAA to consider working with sector partners to ensure these referral criteria – particularly the guidance for audiologists – are not later challenged on the grounds that they are being used in a way that is not consistent with the provider licence condition in England for example. We would also welcome a joined-up sector guidance on the management of existing NHS hearing aid users – particularly in England – so that legacy patients are also offered their legal right to choose a provider where this has been extended locally.