

Consultation on draft scope – deadline for comments 5pm on 26 April 2016
email: Hearingloss@nice.org.uk

Please note:		Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly or arrive after the deadline. Developing NICE guidance: how to get involved has a list of possible areas for comment on the draft scope. Question to consider: People whose hearing loss begins in childhood but do not receive care until adulthood will be included within this guideline. Given this, should the title of the guideline be changed from 'Hearing loss (adult onset)' to 'Hearing loss (adult presentation)'?	
Stakeholder organisation (if you are responding as an individual rather than a registered stakeholder please state name here):		The National Community Hearing Association	
Name of commentator (if you are responding as an individual rather than a registered stakeholder please leave blank):		Harjit Sandhu	
Comment No.	Page number or ' general ' for comments on the whole document	Line number or ' general ' for comments on the whole document	Comments Insert each comment in a new row. Do not paste other tables into this table, as your comments could get lost – type directly into this table.
Example	3	55	The draft scope currently excludes people who have already been diagnosed. We feel this group should be included because....

1		General	The National Community Hearing Association (NCHA) represents community hearing care providers in the UK. We welcome this opportunity to comment on <i>Hearing Loss (adult onset): assessment and management</i>. We attended the NICE workshop on 4 March and, in our view, this is an improved draft scope. However we still have some concerns and further recommendations, these are set out in our response below.
2	General	Question to consider	<i>“Question to consider: People whose hearing loss begins in childhood but do not receive care until adulthood will be included within this guideline. Given this, should the title of the guideline be changed from ‘Hearing loss (adult onset)’ to ‘Hearing loss (adult presentation)’?”</i> No, in our view the title should be changed to <i>“Hearing loss: assessment and management in adults”</i> because: - the original title made assumptions about needs without objective justification - for example it assumed that a person aged 25 with the same diagnostic results, symptoms and communication needs as another person aged 25 would require separate NICE guidance on hearing loss based on what age their hearing loss was diagnosed - the suggested change by NICE does not address original assumptions. We do not dispute that the hearing needs of a child – especially during the critical period for language development – are different from somebody with acquired hearing loss in older age. We must however challenge excluding people based on year of diagnosis or presentation despite being an adult with the same condition, and arguably needs, as other adults; especially given that this does not appear to be based on evidence. The number of people with hearing loss aged 0 to 18 is also very small – e.g. likely prevalence 0.1 to 0.3%, i.e. up to 35,000 people in England. It is unlikely NICE will produce guidance for adults that fall outside of the current scope, yet many of these adults will use hearing aids and many of the same research questions will apply to them. We think NICE should consider whether there is credible evidence that an experienced hearing aid user at age 25 (having used hearing aids all their life) should be “tagged” as more complicated or otherwise excluded from this guidance. We know of no evidence that an adult with hearing loss since childhood, other things being equal, should have fewer rights than any other adult when it comes to choice, control and available interventions on the NHS. By excluding adults who experienced a hearing loss before the age of 18 this is what is likely to be the ultimate commissioning outcome in many regions.

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			We are also concerned that this approach could result in marginalising a group of society that is already often excluded. For example if the output of NICE guidance influences commissioning decisions in England, it is probable those commissioning community services will state that only adults aged 18 and over who did not have their hearing loss diagnosed before their 18 th birthday are eligible for care out of hospital, limiting choice and the same opportunities given to other people of the same age.
3	General	20	Equality considerations The prevalence and severity of hearing loss increases exponentially with age. The average person that requires domiciliary care will therefore – on average – be more likely to have a hearing loss, and a more severe hearing loss, than the general population. Individuals in this group are also more likely to have more than one protected characteristic as defined in the Equality Act 2010. We feel that people in care and/or living at home that cannot access hearing care warrant special consideration.
4	1	14	Primary care is often used to refer to the four contractor professions (GPs, dentists, optometrists and pharmacists). Secondary care is usually taken to mean care in hospitals. Today, over 60% of Clinical Commissioning Groups (CCGs) offer people access their hearing care in the community – i.e. but not at a location that those working in the NHS recognise as primary or secondary care ¹ . It is important to reflect the current provision of services and be consistent throughout the guideline scope. We therefore recommend the following change: Current: “Healthcare professionals in primary, secondary and tertiary care”, To: “Healthcare professions in primary, community, secondary and tertiary care”.
5	2	32	We would question whether there is any objective justification for giving special consideration to people aged 18 to 25 – especially given the confusion over what to name this guidance (see comment 2)? We understand that people in transition are often missed/failed because of poor handover and a dearth of leadership on this issue. We therefore support NICE giving special consideration to this group. However if NICE excludes people diagnosed with hearing loss before the age of 18, this is likely to be a very small group. We would recommend that the guideline includes all adults – regardless of when they were diagnosed or presented with hearing loss – and that then people aged 18 to 25 are given special consideration so that transition services can be improved across England.

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6	2	33	We are pleased to see that NICE will – rightly – focus on non-medical hearing loss (although the review questions will result in the literature driving this, rather than being explicitly stated in the draft scope). The vast majority of people with hearing loss have age-related hearing loss (a non-medical condition)². Age-related hearing loss is a bilateral and slowly progressive hearing loss. We would also challenge why NICE believes people with unilateral hearing loss warrant special consideration – i.e. they have hearing in the other ear, whereas those with bilateral hearing loss do not and are arguably, other things being equal, more disadvantaged by hearing loss. The guideline committee might also consider that prevalence of hearing loss is often based on better ear averages and that NICE will be reviewing the cost-effectiveness of one vs. two hearing aids etc. – i.e. it does not appear to be logical to single out people with unilateral hearing loss. Instead NICE might want to give special consideration to people who do not have age-related hearing loss – i.e. give special consideration to medical rather than non-medical causes of hearing loss. If the evidence justifies giving unilateral hearing loss special consideration, then it would be helpful for NICE to make this clear.
7	2	29-30 and 36	If the title is not changed (see comment 2), in our view the following text should be changed to help clarify the scope. <u>Line 29-30</u> Current: “Adults (aged 18 years and older) with hearing loss, including those with onset before the age of 18 but presenting in adulthood.” To: “Adults (aged 18 years and older) with hearing loss, including those with onset before the age of 18 but diagnosed in adulthood.” <u>Line 36</u> Current: “Adults who presented with hearing loss before the age of 18” To: “Adults with hearing loss diagnosed before the age of 18” We think this group should be included however - see comments 2 and 5.
8	3	59-66	We welcome the proposal that NICE will review economic aspects when making recommendations and that it will develop an economic plan for each review question.

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			We would ask that NICE consider seeking advice from a health economist specialising in evaluating medical devices – a complicated area of economic evaluation due to different market access and licence conditions compared to medicines. Having studied the literature and sector in detail we would ask the health economist to note: - studies make different assumptions about continued hearing aid use and this can have a significant impact on the incremental cost-effectiveness ratio (ICER). In England there are different models of hearing care, that incentivise different behaviours, and these are likely to have an impact on continued use of hearing aids and the ICER – i.e. several of the questions posed by NICE will require detailed methodological examination to manage the risk of inappropriate generalisation and/or transferability - England has a unique purchasing model for hearing technology and hearing care, and this is likely to limit what can be generalised/transferred from the international literature. NICE recommendations might also have a fundamental impact on the ICER – for example the supply chain in England is dependent on a high volume, high spec, low marginal cost model and any treatment threshold that impacts volume is likely to have an impact on marginal cost of hearing aids and therefore the ICER. This is a complex market as the health economics literature will show - age-related hearing loss accounts for the vast majority of hearing aids fitted in the NHS. Age-related hearing loss is a long-term and slowly progressive condition. Economic analysis – unless funded independently – might extrapolate benefit without any sensitivity analysis for drop off in effect over a reasonable horizon, e.g. the cost of re-examination at year x might not be included but the benefit might extend into the future beyond year x - there are multiple funding models in England for NHS hearing care, some more transparent than others – e.g. packages of care with a fixed three or five year price and clear service specification, non-mandated tariff with variable marginal costs per patient over the three year care pathway with/without a service specification, and opaque cost-per case and block contracts. There is extensive market failure due to asymmetric information between purchasers and providers on prices, and many stakeholders – wrongly – believe that the non-mandated tariff price is the baseline price for analysis. In fact the package of care pathway/price is likely to dominate the non-mandated pathway/price in any economic analysis – and given the non-mandated price is derived by yardstick competition from reference cost data from hospital providers, a robust economic analysis is likely to show that community hearing care cost less per case and, other things being equal, is more cost-effective than care provided in hospital settings. For an example of variation in transparency, cost, access and standards see Monitor's (now NHS Improvement) review of adult hearing service³ - there is significant uncertainty in any ICER analysis due to generic instruments – most notably EQ5D – lacking sensitivity to hearing loss - that economic literature in this field might relate to old technologies (e.g. analogue hearing aids or early generation digital aids) and this is not always taken into account when analysing the literature. This is important because over time treatment thresholds have changed from c. 45dB HL in the 1980s to c. 25dB HL post 2000.
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			This has largely been driven by changing need – e.g. more demanding and listening environments – and improved technology. This will therefore have a significant impact on the economic questions NICE has proposed. In terms of scale – based on NCHA analysis, controlling for age and gender – in 2014 8.8 million adults had a hearing loss of 25dB HL in the better ear, c.3 million had a hearing loss of 45dB HL in the better ear⁴. Some subject matter experts, including some Global Burden of Disease collaborators, are now arguing for treatment thresholds to be lowered to 20dB HL which we estimate would equate to 11.5 million people in England. NICE will, from its review questions, come across this politically sensitive issue. We have confidence that NICE will apply the highest standards of research and analysis to help the NHS effectively utilise its resources.
9	3	81-82	In developing this guideline we think it is important for NICE to give special consideration to workforce and physical capacity in the NHS. Given the structure of the committee we would ask that throughout the guideline development – whenever economically feasible – NICE relies on positive analysis, rather than normative analysis, when answering questions that are influenced by the workforce and/or physical capacity. For example: <i>“Who should be referred to audiovestibular medicine or ear, nose and throat (ENT) for medical treatment?”</i> could be rephrased in our view to <i>“Who should be referred for medical treatment – e.g. from ear, nose and throat (ENT), audiovestibular medicine or other specialist?”</i> This is because the number of audiovestibular physicians in England has been in decline for some time and despite attempts by the Royal College of Physicians (RCP) in 2007 to increase the number of consultants by 326% by 2016, the number actually fell by 32% to 32 in 2015⁵. Also, in our view, it is the indication for medical care that should determine referral, if necessary, following triage in primary/community care (which will account for the vast majority of presentations) rather than vice versa.
10		87	Most people with hearing loss are likely to report hearing difficulty in noise as their primary symptom. We therefore welcome that the guideline will cover measuring speech and hearing in noise.

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			The NHS however does not fund speech and hearing in noise assessments. The additional time per test and the knock on effects on capacity (i.e. opportunity costs) are likely to require NICE to consider the economic and practical impact of this form of assessment on the NHS.
11		89-90	<i>"Which tests and investigations should be used in medical services to assess the underlying cause of hearing loss?"</i> This is a crucial question. At the present time the sector has three main professions, audiologists (diverse range of skills), ENT and audiovestibular physicians. Each has a subgroup with a history of erecting barriers to change based on judgement rather than reviewing evidence⁶. We appreciate that NICE will not be recommending how services are commissioned, but we do feel NICE has an important role to play in providing trusted and reliable evidence on the relative and absolute risk and the marginal cost per additional diagnosis when reviewing this particular question. This should also help minimise the risk of supplier-induced demand at a local level – e.g. over utilisation of diagnostic tests that have an associated tariff. There is also often a significant opportunity cost associated with over utilisation that extends beyond direct expenditure – e.g. ordering MRI scans for a low risk of differential diagnosis here could result in delays for an MRI for groups at higher risk of morbidity/mortality.
12	4	91-92 and 102-103	Idiopathic sudden-onset sensorineural hearing loss is featured in this scope, but age related and noise induced hearing loss are not mentioned. Given over 95% of people that present with hearing loss are likely to have age-related hearing loss, noise-induced hearing loss or earwax, whereas only 0.005% to 0.02% of the population might have idiopathic sudden-onset hearing loss⁷ and there is already guidance on this topic by the American Academy of Otolaryngology head and neck surgery⁸, we are concerned that there is a disproportionate emphasis on this condition. We have the following questions: Is the focus on this condition consistent with lines 57 and 58 of the draft scope? Is this a condition being prioritised by an interest group or a committee member with a special interest? Is this a case of falling into the old 'sub-specialty' magnification trap? We would ask the committee to consider whether they might instead consider medical and non-medical causes of hearing loss as useful typologies when carrying out their research. This should, to a large extent, determine whether a person is referred to an audiologist (non-medical) or ENT/audiovestibular doctor (medical) and thus help address other questions raised.

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13		100-101 106-107	• “<i>What is the effectiveness and cost effectiveness of 1 hearing aid compared with 2?</i>” • In our view this is a key question which should help reduce some uncertainty for commissioners. NICE is probably aware that this is a question that many CCGs in England have asked. We would however urge NICE to use a health economist with special interests in medical devices – see comment 8. “<i>What is the clinical and cost-effectiveness of different types of hearing aid microphones and digital noise reduction technologies?</i>” We feel that whilst this an interesting question, it ignores the way in which the NHS purchases and delivers hearing care. For example, modern technology is likely already to include these additional benefits included without any additional marginal cost to the NHS – i.e. the question on line 100-101 should suffice and any review of the international literature on this specific question (line 106-107) is unlikely to be transferable to the English NHS (especially not cost-effectiveness analysis). See comment 8. If NICE can ask one rather than two questions here, it will have scope to address a different – and arguably more important – question. For example the main cause of temporary hearing loss is occlusive earwax and it’s estimated that over 2 million people seek professional support for earwax each year⁹. This represents a significant burden on both patients and the NHS – particularly GPs, nurses and ENT. Yet there are no robust guidelines on how to manage earwax in people with age-related hearing loss for example, but there is a HTA on the topic¹⁰. If this could be addressed then it is very likely that millions of NHS appointments could be managed more effectively each year – possibly making better use of pharmacists and audiologists, and freeing up GP and ENT resources. We would therefore propose that the question: “<i>What is the clinical and cost-effectiveness of different types of hearing aid microphones and digital noise reduction technologies?</i>” be replaced with: “What is the clinical and cost-effectiveness of different types of earwax management in adults with hearing loss?”
14		110-111	It would, in our view, be a missed opportunity for the current review questions to guide a systematic review of the literature. We hope NICE will review the questions and take a proportionate, objective and needs based approach and consider changing some of the questions asked.
15	5	117	Considering the guideline scope and review questions, we agree it is important to include the positive predictive value of signs and symptoms as an outcome. NICE might find that the UK Screening Committee’s review helpful on this particular point ¹¹ .

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16	5	120	We do not think a main outcome can be as ambiguous as <i>“Appropriate use of hearing aids”</i> . In our view this should be changed to “Continued use and benefit from hearing aids”
17	5	121	Glasgow hearing aid benefit profile is one of a number of tools that are used. We do not know of any literature that suggests this is better than any other validated tool. We think it is therefore important to seek expert input on this before proceeding with any literature review.
18	6-7	154-157	In our view, this diagram is a significant improvement on the original diagram and we are pleased to see that the 4 March workshop feedback has been taken on board. However we think the diagram needs to be changed to reflect current practice in England. The diagram should, in our view: • second box <i>“initial assessment and treatment in primary care”</i> should be changed to “initial assessment and treatment in primary or community care settings”. This is because commissioners in England are now starting to commission open access audiology where people with hearing problems can access NHS hearing care in the community without a GP visit. GPs and CCGs are supportive of this because in the vast majority of cases people have earwax and/or age-related hearing loss, thus it is likely to free up GP and practice nurse time. By the time NICE publishes its guidance we expect most hearing loss will be managed in primary and community care settings – i.e. no longer by non-medical staff in acute hospital settings. This has also been Department of Health Policy since 2007¹² and something the RNID (now Action on Hearing Loss) is documented as supporting many times between 1988 and 2011¹³, Action on Hearing Loss also now delivers hearing care closer to home with a range of providers • the fourth box should become the third box, and the text <i>“management in community or secondary care:...”</i> changed to “audiology management of non-medical hearing loss and other non-medical ear problems”. It should also include an additional bullet point <i>“monitoring and follow-up”</i> • the third box should be the fourth box, and changed from <i>“when to refer to specialist”</i> to <i>“when to refer for medical opinion”</i> • then the last box should be changed to <i>“medical management and follow-up or referral to audiology to support hearing loss”</i>
19	General	158-224	The lack of references in this section and the similarity with policy/campaign documents is slightly disconcerting. We appreciate however that this is only a working draft. We therefore offer feedback on lines 158 to 224 below.
20	7	160-164	<i>“Hearing loss is a major health issue that affects over 11 million people in the UK. It is estimated that, by 2035, there will be more than 15.6 million people with hearing loss in the UK – a fifth of the population. According to the World Health Organization (WHO), by 2030 hearing loss will be in the top 10 disease burdens in the UK, above diabetes and cataracts.”</i>

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			Changed to <i>“Adult hearing loss is a major public health issue that affects 8.8 million adults in England – 1 in 5 adults¹⁴. It is estimated that by 2037 there will be 12.9 million adults with hearing loss in England¹⁵. Adult hearing loss is now the 6th leading cause of years lived with disability in England¹⁶”.</i> This is based on number of adults with hearing loss/number of adults. The statistic NICE uses is based on adults with hearing loss/total population. Given scope of the guidance, we suspect focussing on adults is best. The projections for 2035 are for the UK and are unlikely to control for gender. Our suggested changes control for gender and age (see referenced endnotes for more details).
21	7-8	165-171	<i>“It is estimated that, in 2013, the UK economy lost more than £24.8 billion in potential output because people with hearing loss were unable to work. Research shows that hearing loss doubles the risk of developing depression and increases the risk of anxiety and other mental health issues, and it is thought that hearing aids may reduce these risks. There is also evidence that people with hearing loss have a higher risk of dementia: this risk is 3 times higher in moderate hearing loss and 5 times higher in severe hearing loss.”</i> We would ask the committee to review this evidence especially carefully as it is important for NICE to be thoroughly evidence based and credible.
22	8	172-174	<i>“On average there is a 10-year delay in people seeking help for their hearing loss, and 45% of people who do report hearing loss to their GP are not referred to NHS hearing services.”</i> This statistic is based on Davis et al. 2007. The primary research was actually carried on in the 1990s – before digital hearing aids were introduced in the NHS. For example audiology activity increased 142% between 2003 and 20013¹⁷ – i.e. after the introduction of digital aids, it is unlikely GP referral was not influenced. The rate of onward referral by GPs also requires further examination. We include an extract from the history of hearing care© here. But please note Benova’s 2014 paper is based on data from the Wave 2 study conducted some years earlier, i.e. this section of the history is simplified for the general reader: <i>“In 1988 the RNID challenged the need to see an ENT doctor before being fitted with an NHS hearing aid because it caused unnecessary delays¹. In response “Provision of hearing aids: Does specialist assessment cause delay?” was published in the BMJ in 1989². The article argued that the “main cause for delay in treating impaired hearing is the failure by patients to seek help promptly”¹. This resulted in several letters to the editor of the BMA in 1989 with ENT doctors and others agreeing that whilst people might delay coming forward, once they did, having to wait to see an</i>

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			ENT doctor still unnecessarily extended the time it took them to receive treatment³. In 1998 the RNID commissioned a MORI poll that showed that 22% of people over 50 had had a hearing test in the last 10 years compared to 87% that had a sight test⁴ – suggesting a lack of public awareness about hearing assessments. In 1999 the RNID reported that only 60% of people with hearing difficulty actually tried to get help and of those that did c.67% were referred⁵. In 2000 the Audit Commission would add that a reason for unmet hearing need was that people did not seek help in the first place⁶. It was not until 2014, however, that a peer-reviewed article with a large sample size (N=8,680) finally confirmed that the main reason for delay was that people did not report their hearing loss to a health care professional. The paper noted ▪ “Among the older population in England, nearly half of self-perceived hearing difficulty is unreported to health professionals, and therefore remains untreated”⁷ ▪ 45% of people aged 65 and over reported hearing difficulties but just 46% of this group told a health professional⁷ ▪ of those that told a health professional 73% were referred to a hearing specialist⁷ System leaders have long stated their objective is to improve early diagnosis and treatment of hearing loss⁸⁻¹⁶. This research suggests that in order to achieve these goals public awareness campaigns, local services and demedicalisation will be required to normalise hearing care in the same way that seeing an optician or dentist has been.”¹⁸
23	8	180-185	“... The main referral pathway for an adult with hearing loss who meets the national ‘direct referral’ criteria set out by the British Academy of Audiology is direct from GP to audiology services. ...” It is important to note that the British Society of Hearing Aid Audiologists (BSHAA) have the same referral criteria as the British Academy of Audiology¹⁹, we would therefore recommend changing this to include the BSHAA “... The main referral pathway for an adult with hearing loss who meets the national ‘direct referral’ criteria set out by the British Academy of Audiology and British Society of Hearing Aid Audiologists is direct from GP to audiology services. ...”
24	8	186-192	Earwax is mentioned on line 187. Occlusive earwax should be considered in the review questions, see comment 13.
25	8	197	“In some parts of England this is through ‘the any qualified provider’ (AQP) scheme.” This is not an accurate statement. Based on Monitor’s – the NHS regulator’s - review of adult hearing care, we recommend this is changed to “In 60% of England this is through ‘the any qualified provider’ (AQP) commissioning”²⁰

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26	9	201-209	This is an important part of this draft scope. However, the variation in services is not limited to one or two hearing aids. In July 2015 the NCHA performed a national project that involved sending a Freedom of Information (Fol) request to every CCG and NHS provider in England. We found unwarranted variation in prices paid, bilateral fitting rates, ENT to audiology referral rates and service specifications. If it would be helpful, we would willingly share our Fol data with the committee.
27		209	<i>“In many cases hearing aids are tried but discontinued because the person has not had the support they need to use them”</i> This is an important point. In our review of the grey and published literature we found gaps in follow-up care and that these could be traced back to 1982; this has had an impact on hearing aid use (as acknowledged by the Audit Commission in 2000 in their review of audiology services) and patient satisfaction with their hearing aids (as acknowledged by Monitor in its review of adult hearing services in 2014/2015); and despite guidance, standards and lobbying to address gaps in follow-up care, people still do not always get the support they need²¹. It is important to assess the root cause of why such a chronic problem might exist and/or be tolerated. For example, this could be due to a lack of capacity and if NICE’s review of the evidence shows ongoing support is important, then it might be acknowledged by commissioners and audiology departments that rationing follow-up care to meet referral to treatment times (i.e. prioritise capacity in this way) is not a cost-effective strategy, and that by focussing instead on increasing efficiency and capacity might be more beneficial for patients and taxpayers.

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Checklist for submitting comments

- Use this form and submit it as a Word document (not a PDF).
- Include page and line number (not section number) of the text each comment is about.
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use

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¹ Monitor, 2015. NHS adult hearing services in England: exploring how choice is working for patients

² NCHA, (May 2016, forthcoming), Causes of Hearing Loss. www.the-ncha.com this section of the website will include a table with a list of causes of hearing loss and prevalence of each condition. We would be happy to forward the committee any section of the website in an accessible format – e.g. word, excel etc.

³ Monitor, 2015. NHS adult hearing services in England: exploring how choice is working for patients

⁴ NCHA, (May 2016, forthcoming), Hearing Map. www.the-ncha.com this section of the website will include prevalence data and a paper explaining in detail how calculations have been made. We would be happy to forward the committee any section of the website in an accessible format – e.g. word, excel etc. We would also be happy to forward the committee master excel sheets so that analysts can review how we calculated prevalence

⁵ Sandhu, HS (2015) analysis for forthcoming *History of Hearing Care*. Primary sources used for analysis: Royal College of Physicians of London. Hearing and balance disorders. Achieving excellence in diagnosis and management. Report of a Working Party and Health and Social Care Information Centre, 2015. NHS Hospital & Community Health Service (HCHS) monthly workforce statistics - Provisional Statistics. NCHA, (May 2016, forthcoming), History of Hearing Care. www.the-ncha.com, We would be happy to forward the committee any section of the website in an accessible format.

⁶ NCHA (May 2016, forthcoming), History of Hearing Care, www.the-ncha.com this section of the website will be based on hand search of archives, review of grey and published literature We would be happy to forward the committee any section of the history of hearing care in an accessible format – e.g. word

⁷ American Academy of Otolaryngology head and neck surgery, 2012. AAO-HNSF Clinical Practice Guideline: Sudden Hearing Loss; NCHA, (May 2016, forthcoming), Causes of Hearing Loss. www.the-ncha.com this section of the website will include a table with a list of causes of hearing loss and prevalence of each condition. We would be happy to forward the committee any section of the website in an accessible format – e.g. word, excel etc.

⁸ American Academy of Otolaryngology head and neck surgery, 2012. AAO-HNSF Clinical Practice Guideline: Sudden Hearing Loss. http://www.entnet.org/sites/default/files/March2012_SuddenHearingLossFactSheet.pdf, accessed 26 April 2016

⁹ * Not all earwax will result in an individual seeking help from a health care professional. The actual prevalence of earwax varies with age: 0 to 16 years: 10% to 43%. 16 to 59 years of age: 2% to 5%. ≥60: 16% to 57% [Ref: Cited in: The safety and effectiveness of different methods of ear wax removal: a systematic review and economic evaluation. Clegg et al. Health Technology Assessment]

¹⁰ The safety and effectiveness of different methods of ear wax removal: a systematic review and economic evaluation. Clegg et al. Health Technology Assessment

¹¹ Spiby, 2015, Screening for Hearing Loss in Older Adults, External review against programme appraisal criteria for the UK National Screening Committee (UK NSC). UK National Screening Committee

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¹² Department of Health, March 2007. Improving Access to Audiology Services in England; Department of Health, 2009. Best Practice Guidance. Hearing Services for Older People; NHS Improvement, 2011. The best of clinical pathway redesign. Practical examples delivering benefits to patients; Department of Health, 2011. Liberating the NHS: Greater choice and control. Government response. Extending patient choice of provider (Any qualified provider); Department of Health, 2011. Liberating the NHS: Greater choice and control. Equality analysis. Extending patient choice of provider (Any qualified provider); Department of Health, 2012. Any Qualified Provider Adult Hearing Services Implementation Packs. London: Department of Health

¹³ RNID, 1988. Hearing Aids the Case for Change; RNID. 1989. Hearing Aids – The Developing Debate. The RNID’s Refined Views; RNID, 1999. Waiting to Hear? A report on waiting times for hearing tests; Action on Hearing Loss, 2011. Hearing Matters; Action on Hearing Loss, 2011. Annual Report and Financial Statements; Action on Hearing Loss, 2012. Annual Report and Financial Statements for the year ended March 2012

¹⁴ Please note this guidance is for adult hearing loss. The 1 in 6 figure is based on [adults with hearing loss/population] whereas [adults with hearing loss/adult population] results in an average prevalence of 20%. The range across CCG areas is 10% to >26%. NICE can cite: NCHA, (May 2016, forthcoming), Hearing Map. www.the-ncha.com this section of the website will include prevalence data and a paper explaining in detail how calculations have been made. We would be happy to forward the committee any section of the website in an accessible format – e.g. word, excel etc. We would also be happy to forward the committee master excel sheets so that analysts can review how we calculated prevalence and for the committee to run its own analysis and cite NICE.

¹⁵ NCHA, (May 2016, forthcoming), Hearing Map. www.the-ncha.com this section of the website will include prevalence data and a paper explaining in detail how calculations have been made. We would be happy to forward the committee any section of the website in an accessible format – e.g. word, excel etc. We would also be happy to forward the committee master excel sheets so that analysts can review how we calculated prevalence and for the committee to run its own analysis and cite NICE.

¹⁶ Vos et al. 2015. Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. [http://dx.doi.org/10.1016/S0140-6736\(15\)60692-4](http://dx.doi.org/10.1016/S0140-6736(15)60692-4)

¹⁷ NCHA (May 2016, forthcoming), Growth in NHS Audiology, www.the-ncha.com this section of the website will share H. Sandhu, NCHA analysis of DH reference cost data. We would be happy to forward the committee any section of the history of hearing care in an accessible format – e.g. word, excel etc.

¹⁸ 1. RNID, 1988. Hearing aids the case for change. 2. Watson, C and Crowther, J. 1989. Provision of hearing aids: Does specialist assessment cause delay? BMJ. Vol. 299. 3. Browning et al. 1989 Provision of hearing aids. BMJ: British Medical Journal, 299(6700), pp. 678-678. 4. RNID, 1998. It's time for a hearing test 5. RNID, 1999. Waiting to hear 6. Audit Commission, 2000. "Fully equipped: the provision of equipment to older or disabled people by the NHS and social services in England and Wales" Audit Commission, London 7. Benova, L. et al 2013. Socioeconomic Position and Health-Seeking Behaviour for Hearing Loss Among Older Adults in England. *Journals of Gerontology, Series B: Psychological Sciences and Social Sciences* 8. Stephens, S. D. G., 1982. Letters to the Editor. What should be done about hearing impairments? *Journal of the Royal Society of Medicine*, 75, pp. 137 9. RNID, 1988. Hearing Aids the Case for Change 10. RNID. 1989. Hearing Aids – The Developing Debate. The RNID’s Refined Views. 11. RNID, 1988. It's time for a hearing test. A

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¹⁹ See pages 27 and 28 of Department of Health, 2012, Adult Hearing AQP Implementation Pack
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²⁰ Monitor, 2015. NHS adult hearing services in England: exploring how choice is working for patients

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