Funding Considerations for Adult Hearing Care

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A joint document from BAA and BSHAA

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1. CONTENTS

2. DECLARATIONS OF INTEREST AND DISCLAIMER

The British Academy of Audiology (BAA) and BSHAA are membership organisations. Their members provide audiology services and work in a range of settings across the NHS and private sector.

This guidance has been written to help commissioners of NHS services consider funding requirements for all adult hearing services provided by audiologists.

This guidance is **not** clinical evidence, and as such should not be cited as evidence-based guidance.

This guidance should **not** be used to exclude any provider from providing NHS services. This document does not set out the scope of practice for any individual audiologist or provider. It cannot be used to suggest that an audiology service may not offer appointments to certain groups, without objective justification.

This guidance should be read in a local context and commissioners are strongly encouraged to work with a wide range of providers and stakeholders to ensure they commission effective and sustainable local services.

The BAA and BHSAA disclaim any liability to any party for the accuracy, completeness, or availability of this document, or for any damages arising from the use of the document and the information it contains.

Important note to audiologists:

This document avoids the use of the terms 'routine/non-complex' and 'non-routine/complex', since these may be misleading. Instead, services which may be eligible for additional funding for audiology-led care are referred to as 'specialist' or 'enhanced' services.

Adults with a particular condition will not automatically require care beyond the standard adult hearing pathway and will therefore not automatically warrant additional funding. It is important to work constructively with commissioners to develop high quality and sustainable services, including helping to mitigate the risk of up-coding (e.g. claiming a higher fee per patient more often than necessary) because this ultimately deprives other patients of much needed NHS care.

This document gives named conditions only as examples and is not intended to provide an exhaustive list of conditions which result in the need for enhanced or specialist services. The hope is that it will facilitate constructive discussions and help all providers work with local NHS systems to tackle unmet hearing and audiological needs in a sustainable way.

It is the responsibility of each Audiologist to work within their own scope of practice and to ensure that they are aware of all referral routes available to the adults they see. Audiology professionals should continually review their practice to meet the needs of a variety of patient groups[1].

3. INTRODUCTION

3.1 Context of document

In April 2015 the BAA Service Quality Committee (SQC) published "Guidance on Identifying Non-routine Cases of Hearing Loss in Adults", with a goal to help providers of adult hearing services secure sufficient funding to deliver quality care. That guidance has now been decommissioned and replaced by this joint

guidance by the BAA and BSHAA. This update clarifies terminology and focuses on key interventions that might warrant additional funding to secure sustainable high-quality services.

The main sub-groups addressed within this document broadly include adults who need additional support (not necessarily relating to hearing threshold levels) because of

- non-audiological co-morbidities that prevent the standard age-appropriate procedures from being effective, or
- audiological conditions that prevent the standard age-appropriate procedures from being effective (wording adapted from Audiology Australia et al. 2016[2].)

3.2 Scope of document

It is important to note that the vast majority (an estimated >90-95%) of adults with hearing problems will have their audiology care funded within standard adult hearing pathways.

This estimate takes into account that:

- NHS England commissioning guidance and the NICE guideline on adult hearing loss note that the vast majority of people with hearing loss in the UK will have age-related hearing loss[3, 4]. This patient group will typically be eligible for standard adult hearing services when they access audiology, even if they may require specialist audiology services at a later date.
- Adults with hearing loss might need to see a medical specialist (GP, ENT or audiovestibular medicine) to exclude or treat an underlying pathology[5]. There is no reason to assume that they will also require specialist audiology-led services. The funding for the audiological portion of their care does not always fundamentally differ from patients without medical ear conditions.
- NHS audiology services will usually provide specialist diagnostic clinics which support, and are funded by ENT services. For this reason, a significant proportion of specialist/enhanced appointments undertaken by audiology services are not included within this estimate.

Detailed guidance on funding this main group of patients is available elsewhere, for example, see NHS England commissioning framework[Error! Bookmark not defined.] and information provided by the British Medical Association[6]. It is important that this main group of patients is funded appropriately to ensure services remain sustainable and the burden of disease associated with unsupported hearing loss can be addressed (see section 4.2). Readers might also find the tools and resources helpful when planning local services, including a resource impact template, published by NICE to support the implementation of its guideline on the management of adult hearing loss[7]

This current document, however, focusses more on a relatively small but important subgroup of patients (an estimated <10% of adults with hearing problems that visit an audiologist about hearing and communication difficulties) who might warrant significantly more resource in order to secure quality outcomes. We refer to the patients as those needing enhanced or specialist audiology-led services.

Unlike 'red flag' medical criteria (as defined by NICE[5]) which warrant a referral to a multi-disciplinary team, often including Ear, Nose and Throat (ENT) or audio-vestibular medical specialists, there is no requirement to make onward referrals based solely on the conditions named in this document.

Audiologists are expected however to always act in the best interest of patients. For example, patients might be seen and funded against a standard adult hearing pathway and, if appropriate, fitted with

hearing aids, while at the same time being referred on to a specialist for additional investigations, which might be funded as audiology-led enhanced services or an ENT service.

This document does not provide any guidance on the training or career level required to carry out the different appointment types. At the time of writing, this may vary between different regions.

This document does not advise clinicians on the management of patients.

4. FUNDING ADULT HEARING CARE

How audiological care is funded can vary from one region to another. For example, services around the UK might be funded with a tariff for a pathway which includes a hearing assessment, hearing aid fitting, devices (e.g. hearing aids), follow-up care and aftercare or with a block contract. There are also local prices for audiology-led aural care (managing earwax) and other extended services such as tinnitus pathways and balance assessment.

Although some funding models are established (for example a tariff for the standard adult hearing care pathway[8]) the NHS often lacks sustainable funding models for enhanced and specialist audiology-led services, and this can slow innovation and act as a barrier to providing quality and sustainable models of care. In turn, this can result in unnecessary burdens, both on patients (reduced access) and on medical colleagues (e.g. excessive use of ENT and GP time). Health policy initiatives across the UK are increasingly encouraging audiology services to set up pathways in co-production with ENT and GPs with the goal of reducing pressure on medical services and NHS budgets as well as improving access to timely care for patients[3 9 10 11].

4.1 Standard Adult Hearing Pathway

We estimate that for an average adult population, over 90-95% of adults with hearing or communication difficulties can be managed by an audiologist and coded against a locally agreed standard hearing care pathway. It is hoped that the publication of this document will promote more detailed research into the proportion of adults who would benefit from a standard hearing pathway and enhanced/specialist audiology support and this will help to inform sustainable workforce plans and services for future generations.

Commissioners should ensure they follow best practice when agreeing to a funding model for standard adult hearing pathways. This includes ensuring that the chosen funding model allows audiologists to offer quality care for all adults who are eligible for the standard pathway (and allowing for a varied caseload within this pathway) and mitigates the risk of up-coding or other perverse incentives.

- If commissioners underfund the standard pathway and pay a premium for enhanced services, they might create incentives for providers to claim (code) enhanced care for more patients than need it.
- If commissioners overfund standard pathways, they might not have the funds necessary to meet the needs of people that require access to enhanced or specialist audiology-led services.
- If commissioners engage with a wide range of providers and stakeholders about local needs and best practice funding models, they are more likely to establish appropriate and sustainable funding models that ensure scarce NHS resources achieve optimal outcomes for patients and the NHS as a whole.

Funding for the standard adult hearing care pathway is based on an average cost per patient. Infrequently, a patient may have requirements that incur additional expense (for example, CROS or in-the-ear aids). These occasional additional expenses do not always warrant additional funding since they simply represent the higher end of the normative range of costs. The average pricing tariff for the standard pathway should allow for this, so these types of interventions are not included as requiring consideration for additional funding. The exception to this rule is when the standard pathway prices are designed to cover a narrower range of patients – i.e. where tariffs are so low that the provider cannot absorb such cost variation.

Commissioners of NHS audiology care should note that most adults accessing adult hearing care have a long-term condition – e.g. age-related hearing loss – and will need audiological support on an ongoing basis for life. When designing funding models, commissioners and providers are encouraged to work together with a focus on patient outcomes and agree on a funding model that ensures ongoing care so that the impact of any hearing disability can be minimised. Put simply, funding models should allow quality care to be offered to both new and existing patients.

4.2 Enhanced Audiology-led Services

When the needs of adult patients fall outside of the standard pathway, then NHS funding mechanisms are not always clear. As a result, it is often difficult to assess whether the best value services are being commissioned, and sometimes what is and is not funded. The goal of the rest of this document is to ensure that commissioners are supported in funding services so that they can deliver quality care in a sustainable and consistent way.

5. HOW ADULTS ACCESS AUDIOLOGY SERVICES

Adult audiology pathways typically begin with self-referral, a referral from the GP or referral from ENT[i].

When adults are referred (or self-refer) into audiology services, they will almost always receive a standard hearing assessment. This may lead to:

- no further action
- the fitting of hearing aids and ongoing audiology management
- the fitting of hearing aids and referral to medical services
- referral to enhanced/specialist audiology-led care pathways with or without a hearing aid fitting
- referral to medical services.

The enhanced/specialist interventions addressed within this document are provided by the audiology service, although the point of access might vary based on local referral pathways. It is important that local pathways do not allow for patients to be referred to specialist services before the relevant clinical

[i] One exception to the usual route into audiology is the proactive offer of hearing assessment to certain patients within care settings whose learning disabilities or dementia may mean that they are not able to self-report as having hearing loss[5].

information is available; for example, a referral cannot be made for cochlear implant assessment before audiometry has established that there is severe-profound hearing loss.

People with a disability – as defined in the Equality Act 2010 – should be able to access the standard hearing care pathway unless there is a valid clinical reason, or it is otherwise in their best interests, to be referred to a specialist pathway. It is important that providers or commissioners do not inadvertently design pathways that assume that adults with a given disability automatically need a specialist audiology service[12].

6. ADDITIONAL FUNDING CONSIDERATIONS FOR ADULT AUDIOLOGY SERVICES

The table below summarises sub-groups that might be considered for additional funding when designing local audiology-led enhanced/specialist services.

These services require at least one of the following:

- Specialist staff training
- Additional equipment
- Additional appointment time
- Agreement with local managers to run Audiology-led services in order to reduce ENT visits

BOX 1: Important notes

The sub-groups addressed within this section broadly include adults who need additional support (not necessarily relating to hearing threshold levels) because of

- non-audiological co-morbidities that prevent the standard age-appropriate procedures from being effective, or

- audiological conditions that prevent the standard age-appropriate procedures from being effective

(wording adapted from Audiology Australia, 2016[13].)

It is important to note that only a small minority of patients will require these services. The standard hearing care pathway should always be the default option, with specialist pathways only being used for valid clinical reasons. Not all adults with the conditions named in the table will require specialist services. Patients receiving specialist audiology care in addition to hearing aids will usually continue on the standard pathway for their hearing aids. Appointments funded as part of an adult's medical care are not included (see section 6.2).

Table 6.1: Enhanced/specialist audiology led services for adult (people aged 18 and older) which may be considered for additional funding

Enhanced service[ii]	**Who this service is for**	**Potential benefits**	**Points to consider when developing a local funding model to provide quality care**[iii]
Referral refinement for implantable devices (Please note this is not an implantable service. See section 6.2 regarding funding for implantable devices).	Adults who need to undergo an additional assessment to determine eligibility for Cochlear Implants or Bone Anchored Hearing Devices and Middle Ear Implants based on NICE[14], other NHS[15] or evidence-based eligibility criteria.	Improving referrals to implant centres and reducing associated costs for both the NHS and patients. There are currently 23 cochlear implant centres in the UK so patients might have to travel long distances to seek an assessment. If they are not eligible or ready for a cochlear implant this can be a significant cost for patients and the NHS. Eligible adults who are not referred for implantable devices require more health and social care support, suffer the loss of earnings and reduced quality of life[16].	Cost of tools/equipment required: Aided sound-field testing using the AB word test as recommended by NICE[14]. Staff costs: Time and expertise required to discuss implant assessment, surgery, rehabilitation, potential outcomes with implant versus conventional hearing aids; and to assess motivation and commitment i.e. 'readiness' for a referral to an implant centre. Ongoing costs: Follow-up services that allow annual patient reviews for eligible but undecided candidates, so a timely referral can be made once/if adults are ready to proceed to an implant assessment.

[ii] The requirement for each service should be determined based on local service availability, local protocols and need.
[iii] Overhead costs allocated to each test should also be calculated for each example – e.g. the cost of a clinic room and associated costs. Your organisation will often be able to provide an estimate of the share of overhead costs.

Enhanced service[ii]	Who this service is for	Potential benefits	Points to consider when developing a local funding model to provide quality care[iii]
		Tackling health inequalities by ensuring eligible adults have access to appropriate evidence-based and cost-effective implantable device technology Helping commissioners meet their Public Sector Equality Duty.	Audit costs: Regular audits to ensure all eligible adults are given adequate and timely information on implant referral.
Enhanced rehabilitation support	The standard adult pathway should include rehabilitation support. In addition to this, however, some adults will need enhanced rehabilitation support. Adults requiring this service could have any severity or type of hearing loss. Examples include (but are not limited to) adults: ▪ with severe vision loss who cannot lip-read ▪ with sudden or progressive permanent hearing loss ▪ recovering from a stroke which limits understanding of written and verbal information.	Improving access to extensive rehabilitation support for individuals who need this in order to minimise the adverse impact hearing loss has on their quality of life and mental wellbeing [17, 18]. Reducing the risk of mental ill-health and social isolation in a vulnerable group of adults.	Cost of tools/equipment required: Auditory training packages can be costly e.g. Listening and communication enhancement (LACE). However, few Audiology services offer patients access to these paid training options. In these instances, there is no cost associated with equipment. Staff costs: Additional training is required along with ongoing continued professional development (CPD), longer appointment times, the estimated number of sessions per patient (typically 6 to 10) and the cost per session.

Enhanced service[ii]	Who this service is for	Potential benefits	Points to consider when developing a local funding model to provide quality care[iii]
	▪ who have psychological distress relating to their hearing loss		Costs of special classes/clinics which incorporate multiple interventions which are layered (based on need), with patient-centred counselling at the core: individual or group sessions on lip-reading, communication training for patient, families and carers, listening practice/ training (often called Auditory training), group counselling and/or individual advanced counselling (e.g. personal adjustment or psychosocial). Other costs: Home visits may be required, with an associated cost per session. Ongoing costs: Dependent on whether follow-up support is required once enhanced rehabilitation sessions are complete or whether adults will be discharged back to the standard hearing pathway.

Enhanced service[ii]	Who this service is for	Potential benefits	Points to consider when developing a local funding model to provide quality care[iii]
			Audit costs: To ensure that only people that need enhanced rehabilitation are accessing this service.
Tinnitus support - with and without hearing loss	The standard adult pathway should support the majority of adults with hearing loss and tinnitus. In addition to this, a minority of adults with tinnitus will need to be referred for a medical assessment (ref NICE) and those with distressing tinnitus will need additional audiology-led support.	Audiology-led tinnitus services will include structured assessment and support reducing the need for more costly mental health interventions.	Cost of tools/equipment required: Tinnitus-masking devices might be required (note hearing aids are not provided for tinnitus but hearing loss and this would be funded as part of the adult standard pathway), completing questionnaire assessment (e.g. Tinnitus Functional Index TFI). Staff costs: Additional appointments for initial assessment and follow-up support. Other costs: Whether homecare is required. Ongoing costs: Whether follow-up support is required and if so for how long before discharged or referred on for example to audiologist-led or psychologist-led Cognitive Behavioural Therapy (CBT). There

Enhanced service[ii]	Who this service is for	Potential benefits	Points to consider when developing a local funding model to provide quality care[iii]
			are options for internet-based CBT available too, that can be offered by primary audiology service but involves additional costs. Audit costs: Collating and reporting on TFI and other validated tools to demonstrate the benefits of service
Objective hearing tests	Adults that cannot perform conventional hearing tests such as pure tone audiometry (PTA)[19] Adults whose pure tone audiogram is inconsistent with their functional hearing abilities.	In these groups, objective tests can be used to ensure that only appropriate amplification is prescribed, and to reduce false unnecessary referrals to ENT and other services [20 21 22].	Cost of tools/equipment required: Otoacoustic-emission equipment suitable for diagnostic OAE testing, Evoked-response equipment suitable for ABR, ASSR and/or CERA will be required. This is usually a stand-alone computer-based system (see BSA guidance for specifications). Staff costs: Training costs (BSA recommends that all staff performing evoked-response hearing assessments (CERA/ABR) have training in addition to undergraduate Audiology training or equivalent[23]. This is typically offered as a short course lasting up to 1

Enhanced service[ii]	Who this service is for	Potential benefits	Points to consider when developing a local funding model to provide quality care[iii]
			week); sessions per week and staff costs. Audit costs: An audit by peers (also known as peer-review) is recommended for electrophysiological investigations (BSA Guidance[24]).
Audiology-led imaging referral	Adults with hearing loss and/or tinnitus who meet the NICE recommended criteria for MRI investigation (NG98 and tinnitus guidance – in draft form at the time of writing).	NICE compliant referral pathways can help ensure people who are most likely to benefit from additional medical imaging are referred in a timely manner by audiologists. This reduces the number of visits for patients and associated costs for the NHS, at the same time as reducing pressure on ENT and other medical specialities.	Cost of tools/equipment required: None to Audiology; Radiology departments will be responsible for any additional equipment costs. Staff costs: Additional local CPD is required to make staff aware of the local policy on this to enable the staff to follow NICE referral criteria (NICE NG98) to refer for the scans. Radiology team will perform and interpret the scans. Allowance should be made for senior Audiology and ENT staff to have sufficient time to supervise referrals, contact patients with

Enhanced service[ii]	Who this service is for	Potential benefits	Points to consider when developing a local funding model to provide quality care[iii]
			results and conduct follow up appointments as needed. Audit costs: collating and reporting on imaging results to demonstrate the benefits of service and ongoing effectiveness analysis
Monitoring service	Adults at high risk of fluctuating or rapidly deteriorating hearing (e.g. Meniere's, Neurofibromatosis, autoimmune factors, ototoxicity)	Regular monitoring can help detect any changes sooner and intervene earlier to reduce risks and impacts of hearing loss. Audiology-led monitoring can save repeated referrals from medical services.	Cost of tools/equipment required: High-frequency audiometry (12 kHz) is required. Equipment with this feature is likely to require more costly headphones and additional calibration compared to standard audiometry equipment. Equipment for otoacoustic emissions is beneficial for monitoring services as it may show deterioration sooner than audiometry. Ongoing costs: follow-up services that allow regular patient reviews for eligible candidates.

Enhanced service[ii]	Who this service is for	Potential benefits	Points to consider when developing a local funding model to provide quality care[iii]
			Audit costs: regular audits to ensure all eligible adults are given adequate and timely service Note: Ototoxicity monitoring might be done as part of oncology or other services under the direction of the prescribing doctor and funded by that clinic, in which case audiology might charge for a regular hearing assessment at each visit.
Earwax management	Adults with impacted wax which can be managed by an audiologist as per NICE guideline on adult hearing loss (NG98)	Improving access for patients. Reducing costs associated with ENT visits. Reducing pressure on GPs and ENT doctors who would otherwise have to manage impacted earwax.	NICE guideline on adult hearing loss[5] states that the wax removing practitioner, 'has training and expertise in using the method to remove earwax' and 'the correct equipment is available'. Cost of tools/equipment required: Additional ear care equipment and consumables are required to perform earwax management (BSA guidance) Staff costs: Most audiology courses currently do not include earwax removal training as part of the

Enhanced service[ii]	Who this service is for	Potential benefits	Points to consider when developing a local funding model to provide quality care[iii]
			course. Therefore, an additional training course is required to be able to perform earwax removal Ongoing costs: Most of the consumables used in earwax removal are single-use. Therefore, consumable cost is incurred per patient. Audit costs: Ongoing audit of effectiveness and complications of the earwax removal procedures is required.
Assistive listening devices (ALDs)	Hearing difficulties which are not fully addressed by hearing aids and rehabilitation delivered as part of the standard pathway. Suitable groups could include (but are not limited to): Adults with specific hearing needs relating to their education and /or employment, for example, professional musicians.	To improve the access to sound and speech when the standard hearing aids are not enough e.g. when listening over or distance or in background noise. To improve access to technology when the users have multiple health conditions e.g. when they have dexterity issues, learning disability or dementia etc, in addition to hearing loss.	Cost of tools/equipment required: Personal loops, personal communicators, TV amplifiers, telephone devices, smoke alarms, doorbell sensors, and technologies such as streamers and apps. Adults should also be told about organisations that can provide the devices. Staff costs: As technology improves rapidly in this area, new devices come in the market. So, the staff

Enhanced service[ii]	Who this service is for	Potential benefits	Points to consider when developing a local funding model to provide quality care[iii]
	Commissioners should refer to the NICE guideline on adult hearing loss[5]. Dual sensory loss/visual impairment which prohibits lip-reading and using text/subtitles. Every effort should be made to attempt to fit adults with dexterity problems with a conventional hearing aid on the standard hearing pathway before onward referral to specialist services. In some rare cases, however, e.g. with severe manual dexterity impairment or other physical conditions, might prevent an adult from inserting and operating a conventional hearing aid		requires ongoing CPD updates. Additional appointment time may be needed to discuss and set up new equipment (even if it has been purchased by the adult) because the hearing aid may require additional settings in order to be compatible. Other notes: The costs of the assistive and augmentative devices (non-hearing aid devices) are primarily funded by Social Services but additional devices may be funded by other bodies including charitable groups (Veterans Hearing Fund) and Government schemes (Disabled Students Allowance and Access to work).
Pathways for adults with learning disabilities	Adults who have been assessed as not able to participate in standard hearing care pathway due to the nature or severity of their learning disabilities.	Appointments modified to cater to the specific needs of the individual patient presenting to the service Access and equality considerations applied to the specific needs of the service user to comply with NICE Guidance 2018 Learning Disabilities	Cost of tools/equipment required: Additional audiometric equipment may be required e.g. visual reinforcement audiometry (VRA) Staff costs: If the assessment is performed with non-standard tests,

Enhanced service[ii]	Who this service is for	Potential benefits	Points to consider when developing a local funding model to provide quality care[iii]
		and behaviour that challenges: service design and delivery [25]	e.g. VRA- CPD course will be required for the staff to perform it. Other costs: Extra contact time may be required to perform the tests at a slower pace and also to include additional tests, beyond the standard pathway. More frequent assessments may be required to ensure a hearing loss is detected and managed in a timely manner. Audit costs: to ensure services meet set service-level and individual outcomes
Pathways for adults with dementia	Dementia or memory problems where the nature or severity of the condition prevents participation in the standard adult hearing care pathway, despite the input of a carer.	Appointments modified to cater to the specific needs of the individual patient presenting to the service Access and equality considerations applied to the specific needs of the service user to comply with Nice Guidance NG98	Cost of tools/equipment required: Additional audiometric equipment may be required e.g. visual reinforcement audiometry (VRA). See the above sections on objective testing and assistive listening devices. Staff costs: If the assessment is performed with non-standard tests, e.g. the VRA course will be required

Enhanced service[ii]	Who this service is for	Potential benefits	Points to consider when developing a local funding model to provide quality care[iii]
			for the staff to perform it. Staff will need some specialist knowledge of dementia to ensure effective communication during appointments. Other costs: Extra contact time may be required to perform the tests at a slower pace and also to include additional tests, beyond the standard pathway. Joint working may be required with other services for adults with dementia, such as Dementia nurses and Social Services, requiring more time. Audit costs: To ensure services meet set service-level and individual outcomes
Auditory processing pathways, including appropriate diagnostic tests and rehabilitation	A service user who shows no apparent hearing loss on pure tone audiometry but complains of listening difficulties.	The individuals suffering from APD type listening difficulties will typically have a normal hearing on the puretone audiogram but will still present with listening issues. Pathways currently vary and there is ongoing research in this area of	Cost of tools/equipment required: Cost of objective test equipment (see the section on objective testing above) such as otoacoustic emissions, ipsi and contra reflex measurement. Also, the cost of a variety of computer-based tests of

Enhanced service[ii]	Who this service is for	Potential benefits	Points to consider when developing a local funding model to provide quality care[iii]
	Suspected auditory processing disorder and other sensory processing disorders which result in listening difficulties beyond those expected of their level of hearing, as discussed within BSA guidance.[26,27,28]	work. These services should, therefore, be kept under close review as evidence on APD improves. The BSA documents on APD (2011 and 2018) summarise current evidence and reference international position statements on the diagnosis and management of APD. Much of the evidence currently is about APD in children, and most cases are expected to present in paediatric audiology clinics. The numbers recognised in adulthood are, therefore, likely to be rather low.	auditory perception (in addition to pure tone audiometry) Any equipment issued will be according to the assistive listening devices section, see above. Ongoing costs: Follow-up services that allow regular patient reviews for eligible candidates. Audit costs: regular audits to ensure all eligible adults are given adequate and timely service.

6.1 Exclusions

Cochlear implant fitting and follow up care
This service is commissioned and funded centrally within each part of the UK. This includes electro-acoustic stimulation.

Fitting and follow up care for other implanted devices
Funding for these devices is linked to ENT and national funding.

The cost of non-standard hearing aid devices

For example, CROS aids, sound generators, frequency compression aids and specialist earmoulds. The standard hearing care pathway should be designed to cover these expenses.

Hearing assessments requested by ENT and which are funded as part of the ENT service

The tests requested by ENT may be funded from other NHS funding streams. This includes pre- and post-operative hearing assessments and other diagnostic testing. If commissioners choose to fund these as standalone services, then they should work with a wide range of providers and stakeholders to ensure these are funded so that quality care can be delivered.

7. DEFINITIONS

7.1 Abbreviations

APD – Auditory Processing Disorder

AVM – Audiovestibular Medicine

BAA – British Academy of Audiology

BSA – British Society of Audiology

CI – Cochlear Implant

CBT – Cognitive behavioural therapy

CPD – Continuing professional development

CROS – Contralateral routing of sound

ENT – Ear, Nose and Throat

GP – General Practitioner

MRI –Magnetic Resonance Imaging

NICE – National Institute for Health and Care Excellence

NHS – National Health Service

SQC – Service Quality Committee

TFI – Tinnitus Functional Index

TRT – Tinnitus retraining therapy

WHO – World Health Organisation

7.2 The relevance of definitions within this document

The table in Sections 6 contains terms which are typically used within current guidance and literature. Having one of the named conditions does not automatically mean that an adult will require specialist audiology services. Equally, adults with apparently uncomplicated hearing conditions may require specialist audiology services because of the way their hearing impacts on their daily life.

8. ACKNOWLEDGEMENTS

Section to be completed following the consultation period.

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