File reference	W18FOI503
Key words	Audiology Questions
Date of release	28/02/2019
Attachments	Yes

Freedom of Information Act Disclosure log - Reply Extract

You asked

Audiology and ENT departments, and finance/coding leads.

1. NHS England Direct Access Audiology (DAA) data show that the trust reported 5,019 completed pathways in 2015-16, 4,993 in 2016-17 and 3,518 in 2017-18. What explains the reduction in completed pathways?

The Trust does not hold a written explanation.

2. When adult hearing aid patients require a reassessment/refit, is a new DAA pathway started:

a) Yes or no?

Yes, if more than 3 years since the previous referral or a significant change in hearing.

b) Has this methodology changed since 2012, yes or no?

No

c) If answer to b is yes, please briefly explain each change and the dates changes were made:
Not applicable

3. Please provide

a) A copy of your DAA criteria?

Please see attachment 1 - referral criteria.

b) a copy of <u>any and each</u> form/process/protocol used to code patients as "AQP" and "non-AQP" contract eligible for hearing assessments and hearing aid fits

Any patient referred via direct access who does not meet these exclusion criteria is coded as AQP (Any Qualified Provider, Age Related Hearing Loss)

Any patient who meets the exclusion criteria is then coded as either complex or not according to the criteria attached.

See attachment 2: Exclusion from AQP Audiologist.doc

See attachment 3: Complex cases – Adults – definitions.doc

c) A copy of the exclusion/inclusion criteria stated in the actual AQP adult hearing service specification at the point the trust was successful at qualifying to provide services under that AQP contract

Contra-indications which should not be referred into or treated by the Direct Access Adult Hearing Service

History:

- Persistent pain affecting either ear (defined as earache lasting more than 7 days in the past 90 days before appointment);
- History of discharge other than wax from either ear within the last 90 days
- Sudden loss or sudden deterioration of hearing (sudden=within 1 week, in which case send to A&E or Urgent Care ENT clinic)
- Rapid loss or rapid deterioration of hearing (rapid=90 days or less)
- Fluctuating hearing loss, other than associated with colds
- Unilateral or asymmetrical, or pulsatile or distressing tinnitus lasting more than 5 minutes at a time
- Troublesome, tinnitus which may lead to sleep disturbance or be associated with symptoms of anxiety or depression
- Abnormal auditory perceptions (dysacuses)
- Vertigo (Vertigo is classically described hallucination of movement, but here includes dizziness, swaying or floating sensations that may indicate otological, neurological or medical conditions)
- Normal peripheral hearing but with abnormal difficulty hearing in noisy backgrounds; possibly having problems with sound localization, or difficulty following complex auditory directions.

Ear examination:

- Complete or partial obstruction of the external auditory canal preventing proper examination of the eardrum and/or proper taking of an aural impression.

- Abnormal appearance of the outer ear and/or the eardrum (e.g., inflammation of the external auditory canal, perforated eardrum, active discharge).

Audiometry:

- Conductive hearing loss, defined as 25 dB or greater air-bone gap present at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.

- Unilateral or asymmetrical sensorineural hearing loss, defined as a difference between the left and right bone conduction thresholds of 20 dB or greater at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.

- Evidence of deterioration of hearing by comparison with an audiogram taken in the last 24 months, defined as a deterioration of 15 dB or more in air conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.

The newer contract with Kernow CCG has the following exclusion criteria:

Contra-indications which should not be referred into or treated by the Adult Hearing Service

- Children and adults under 55 years of age.
- Complex adults 55 years and over who meet the contra-indications set out below:-

History:

If any of the following criteria are evident at the time of the referral, the patient should be referred to the ENT department or other local specialist pathways and not into the routine hearing service:

- **Sudden loss or sudden deterioration of hearing** (sudden = within 72 hours), unilateral or bilateral, should be sent to A&E or Urgent Care ENT clinic within 24 hours. Due to the variety of causes of sudden hearing loss, the treatment timescale should be decided locally by the medical team. Prompt treatment may increase the likelihood of recovery
- **Altered sensation or numbness in the face** or observed facial droop. Urgent medical advice should be sought if these symptoms have not previously been investigated
- **Persistent pain affecting either ear,** which is intrusive and which has not resolved as a result of prescribed treatment. (As a general guideline, this includes pain in or around the ear, lasting a week or more in recent months)**.**
- **History of discharge** (other than wax) from either ear within the last 90 days, which has not resolved or responded to prescribed treatment, or which is recurrent

- Rapid loss or rapid deterioration of hearing (rapid=90 days or less);
- Fluctuating hearing loss, other than associated with colds
- **Hyperacusis** (An intolerance to everyday sounds that causes significant distress and impairment in social, occupational recreational and other day to day activities).
- **Tinnitus**, which is persistent and which:
- is unilateral
- is pulsatile
- has significantly changed in nature
- is leading to sleep disturbance or is associated with symptoms of anxiety or depression **Vertigo** which has not fully resolved, or which is recurrent. (Vertigo is classically described as a hallucination of movement, but here includes any dizziness or imbalance that may indicate otological, neurological or medical conditions. Examples include headaches with associated dizziness, spinning, swaying or floating sensations and veering to the side when walking. For further guidance on vertigo, see www.vestibular.org)
- **Normal peripheral hearing, but with altered auditory perceptions** or abnormal difficulty hearing in noisy backgrounds. This may include having problems with sound localisation, the perception of pitch and loudness or difficulty following complex auditory directions.

Ear examination:
Complete or partial obstruction of the external auditory canal preventing full examination of the eardrum and/or proper taking of an aural impression. If wax is obscuring the eardrum or there is a current infection, local wax care or treatment procedures should be followed.
Abnormal appearance of the outer ear and/or the eardrum (Examples include: inflammation of the external auditory canal, perforated eardrum, active discharge, eardrum retraction, abnormal bony or skin growths, swelling of the outer ear or blood in the ear canal)**.**
Tympanometry (performed if there is any indication of middle ear effusion) Unilateral flat tympanogram, regardless of the associated level of hearing loss

Audiometry:
Conductive hearing loss, defined as 20 dB or greater average air-bone gap over three of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz24,25. A lesser conductive hearing loss in the presence of bilateral middle ear effusion may be referred at the discretion of the Audiologist.
Unilateral or asymmetrical sensorineural hearing loss, defined as a difference between the left and right bone conduction thresholds (masked as appropriate) of 20 dB or greater at two or more adjacent frequencies: 500, 1000, 2000, 4000 or 8000Hz. (Other frequencies may be included at the discretion of the Audiologist). In the absence of recordable bone conduction thresholds, air conduction thresholds should be considered instead.

Evidence of deterioration of hearing by comparison with an audiogram taken in the last 24 months, defined as a deterioration of 15 dB or more in bone conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz. In the absence of recordable bone conduction thresholds, air conduction thresholds should be considered instead.

Other findings:
Any other unusual presenting features at the discretion of the Audiologist or according to the requirements of the service to which the adult is being referred. Audiologists are expected to use their professional judgement and relevant guidance to make appropriate onward referrals for adults requiring Audiology services beyond their own scope of practice (for example, due to hearing loss complexity or co-existing conditions). Such referrals may be made in addition to a referral for a medical opinion. Adults with sensorineural hearing loss which does not appear to be age related should, where appropriate, be offered a referral for aetiological investigation.

d) please list <u>any and all</u> material changes made to the AQP adult hearing service contract since it was awarded
As per question C

4. The trust appears to have modified which patients are actually eligible for the AQP adult hearing service. For example the following text appears on its website here
"Any Qualified Provider Referral/Exclusions Criteria

For routine patients on the Any Qualified Provider (AQP) pathway, we will accept referrals that meet the criteria specified in the service specification as follows:

- **Patient is aged 55 or above**
- **Patient has not had a previous hearing aid**
- **Patient's ears are clear of wax**
- **Both ear drums are seen and healthy looking**
- **Hearing loss is equal in both ears**
- **No tinnitus or balance problems**
- **No sudden deafness**
- **No conductive element."**

As noted in the email previously sent, we thank you for identifying some errors on our website, which will be corrected at the next update. However, as all referrals go via the Devon Referral Management Centre (RMC) this will have no material impact on how they are triaged by the RMC, who have responsibility for offering patient choice.

a) When was the criteria above put in place?

Please refer to the statement above.

b) If and how was this communicated to referrers?

It is the role of the commissioners to communicate the criteria for their contracts with GPs.

c) Has the criteria above been used to determine which patients have been coded as "routine/AQP" etc. and "complex/non-AQP" etc. hearing losses; yes or no?

Not applicable

d) Is the above criteria still in place, yes or no?

Not applicable

e) If the answer to d is no, when was it removed/changed?

Not applicable

f) If the answer to d is no, what criteria has replaced it (please provide a copy)?

Not applicable

g) Who wrote the text above?

The text was taken from the original AQP documentation provided by the Commissioners.

h) Who approved the text above?

There is no written record of this.

i) Did any NHS commissioner approve the text above, and if so which Clinical Commissioning Group(s)?

There is no written record of this.

5. The trust website states
"Because of our highly qualified staff team, we are able to see most cases which are audiologically complex via direct referral"

[…]

"Where it is clear from the referral that the patient does not meet the AQP criteria, we will appoint the individual into our complex cases assessment service. This change will be coded onto the hospital system on the same day to facilitate the financial management".

And

"Due to the highly qualified staff we employ, this change rarely requires a physical change of appointment time or location, as our staff are able to see routine and complex cases. The GP will be informed in writing of the pathway the patient is on following the assessment."

a) How many audiologists work at the Trust?

19

b) How is highly qualified defined? <u>And</u> how many of the audiologists working at the trust (answer to a) meet this definition?

All of our audiologists have a minimum of a BSc in audiology or equivalent. Highly qualified is defined as having at least masters level qualification or equivalent in at least one area of audiology. 14 of the staff have at least a master's level qualification or equivalent in at least one area of audiology.

c) Is it the view of the trust or audiologist(s) that all the hearing aid fits they have coded as audiologically complex are beyond the scope of practice of HCPC registered hearing aid dispensers?

This question falls outside the scope of the Act. This is because you are requesting an opinion rather than recorded information.

d) Is it the view of the trust or audiologist(s) that all the hearing aid fits they have coded as audiologically complex are not eligible for the commissioned AQP adult hearing loss pathway?

This question falls outside the scope of the Act. This is because you are requesting an opinion rather than recorded information.

e) **Where it states *"due to the highly qualified staff we employ, this change rarely requires a physical change of appointment time or location, as our staff are able to see routine and complex cases",* please explain**

i. **Given the appointment time etc. is the same, what are the variable inputs for the vast majority of adult hearing aid activity the trust is coding as complex hearing loss fits?**

The Trust does not code the majority of work as complex, simply as non-AQP.

ii. **What is main cause of hearing loss in the adults the trust fits with hearing aids in its complex clinic?**

It is beyond the scope of practice of audiologists to diagnose. Patient who are seen without the AQP contract include: under 55 years, conductive hearing losses, abnormal outer/middle ears (e.g. mastoid cavities), asymmetric hearing loss, problem tinnitus, sudden or rapidly changing hearing or fluctuating hearing loss.

iii. **What band of staff see complex cases and what band of staff see routine cases in these clinics?**

Senior staff - see complex cases, or other staff with supervision.

iv. **Are the same highly qualified staff involved in both the complex and routine adult hearing aid clinics?** Yes **If not how does the trust avoid the need for a separate/new appointment? NA**

v. **Are existing patients who need hearing aids coded as complex/non-AQP fits?**

All coding is based on audiological criteria

6. **Submitted NHS reference cost data show that between 2015 and 2018 the trust has consistently coded most adult hearing aids as not being fitted against the AQP contract. The AQP contract is for age-related hearing loss, and experts we have discussed the trust data with have explained given the service specification the CCG commissioned this must be an error. For example they suggest less than 10 percent of adult hearing aid fits would be coded off the AQP contract.**

   a) **Is the data submitted to the NHS accurate?**

      Reference cost returns are audited on a regular basis. The Trust's last audit report gave assurance on our processes.

   b) **Are there any concerns about the accuracy of how many adult hearing aid fits have been coded off the local AQP hearing loss pathway?**

      No concerns have been raised by CCG Commissioners regarding the coding of audiology activity.

   c) **The AQP contract has quality reporting requirements and robust standards in place, what data is collected for patients fitted off the AQP contract?**

      Please see embedded below the schedule 6 information requirements for the healthcare contract held with the CCG's that lists all data required by the contract.

      See attachments 4 and 5

      Due to technical constraints, the Trust is unable to upload attachments 4 and 5 relating to this request. To obtain these please email plh-tr.FOI-requests@nhs.net, quoting the file reference.

   d) **Is there any financial incentive, at all, for coding adults with age-related hearing loss off the AQP pathway, yes or no?**

      We have not examined this question as activity is coded without regard to income.

   e) **If the answer to d is yes, please explain here:**

      Not applicable

7. The Trust website states that
"The Head of Audiology sits within the local Clinical Pathway Group, and works actively with commissioners, local GP representatives and ear, nose and throat (ENT) specialists to ensure that commissioned pathways are current and cost-effective. This group also enable feedback and changes to guidance to be fed to GPs in the area both by direct communication via Sentinel and through the Map of Medicine."

a) Please provide a list of all the CCGs the head of audiology has engaged with since January 2017 regardless of their geographical location?

The Trust holds audiology contracts with NEW Devon, South Devon & Torbay and Kernow Clinical Commissioning Group.

b) Please provide any education material or referral advice or templates provided to GPs and other referrers since the AQP contract went live?

The Directory of Service used by the referral management centre is attached – a sample for one site which is replicated across other sites.

See attachment 6.

c) Please can the head of audiology define how cost-effectiveness is determined?

The Clinical Pathway Group was led by Commissioners, therefore, please refer to them.

d) Given the national commissioning framework for hearing loss services sets out the vital importance of working to a service specification, and in the context of the statement above, what is the reason that the trust has not introduced a service specification for its complex hearing loss pathways and complex hearing aid fits?

Service Specifications are drawn up by the Commissioners; therefore please contact relevant Clinical Commissioning Groups regarding this question.

Attachments included: Yes (Minus 2 out of 6)

AUDIOLOGY DEPARTMENT

Title	Referral Criteria – Direct Referrals and Reassessments - Adults
Written by	Adam Beckman ……Signature Clinical Scientist in Audiology, Head of Audiology & James Rainsbury, Consultant ENT Surgeon
Approved by	Leanne Smith ……..……Signature Advanced Audiologist
For use in	Audiology Department, Plymouth Hospital NHS Trust
By	Audiology Staff
Guideline issued	*December 2017*
To be reviewed	*December 2022* Reviewed
Protocol number: (version) Adult referral criteria 2.1	Supersedes August 2015 (unnumbered)

Introduction

The guidelines for onward referral of adults expired in August 2017. These have been reviewed to take into account the updated guidelines issued by the British Academy of Audiology in the interim, and to take into account local pathways.

Criteria and Actions are on the following 2 pages

References

Guidance for Audiologists: Onward Referral of Adults with Hearing Difficulty Directly Referred to Audiology Services; *Service Quality Committee of the British Academy of Audiology*; November 2016

Condition/Finding	Action
Unilateral or asymmetrical tinnitus	Referral to acoustic neuroma screening pathway
Unilateral or asymmetrical sensorineural hearing loss, defined as a difference between the left and right bone conduction thresholds of 20dBHL or greater at two or more adjacent frequencies: 500, 1000, 2000, 3000 or 4000 Hz	Referral to acoustic neuroma screening pathway
Over 50 years of age, deterioration of hearing by comparison with previous audiometry that introduces previously uninvestigated asymmetry of the levels above	Referral to acoustic neuroma screening pathway
Persistent pain affecting either ear (defined as earache lasting more than 7 days in the past 90 days before appointment) with normal otoscopic examination and no conductive hearing loss	Refer to GP with advice to check oral cavity and oropharynx for possible sources of referred pain
History of discharge other than wax from either ear within the last 90 days with normal otoscopic examination and no conductive hearing loss	Inform GP; no other action
Complete or partial obstruction of the external auditory canal preventing proper examination of the eardrum and/or proper taking of an aural impression	If possible, ENT to remove on the day; if not possible, refer back to GP for wax management
Sudden loss or sudden deterioration of hearing (sudden = within 1 week)	Refer to the on call ENT SHO – bleep 0470
Altered sensation or numbness in the face, or observed facial droop – that has not been previously investigated	Refer to the on call ENT SHO – bleep 0470
Fluctuation hearing loss, other than associated with colds	Patient to attend for audiometry when their hearing is different – attend during the ENT clinic for audiometry. If fluctuation of >10dBHL refer to ENT with both audiograms. If fluctuation ≤10dBHL reassure[1]
Troublesome or distressing tinnitus	Provide audiological management; refer to Hearing Therapy or senior staff as required; may require GP referral to additional services if associated with anxiety or depression
Rapid loss or rapid deterioration of hearing (rapid = 90 days or less)	Refer to ENT
Pulsatile tinnitus	Refer to ENT

[1] A separate Standard Operating procedure will give guidance on this process

Abnormal auditory perceptions (dysacusis)[2]	Refer to ENT
Normal peripheral hearing but with abnormal difficulty hearing in noise, with a perception of a significant asymmetry or unilateral problem.	Refer to ENT If bilateral provide advice & reassurance
Condition/Finding	**Action**
Vertigo, light-headedness or imbalance	Report back to GP - with a letter asking if this as already managed or new. And if new and unrecognised the GP should refer to ENT or other specialist[3]
Abnormal appearance of the outer ear and/or eardrum (e.g. inflammation of the external auditory canal, perforated eardrum, active discharge)	Refer to ENT For active infection also refer back to GP for management
Conductive hearing loss, defined as 20dBHL or greater air-bone gap present over three or more of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz	Refer to ENT, with PTA + tympanogram
If under 50 years of age, deterioration of hearing by comparison with an audiogram taken in the last 24 months, defined as a deterioration of 15dBHL or more in air conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz	Refer to ENT
If under 50 years of age, sensorineural hearing loss of an atypical pattern (low frequency, mid-frequency, severe for age) that has not been previously investigated	Refer to ENT
If under 50 years of age, a deterioration in hearing where one ear changes more than the other (by more than 15dBHL at two or more of the following frequencies: 500, 1000, 2000, 4000Hz)	Refer to ENT
At any age, deterioration of hearing to levels where cochlear implant referral may be considered	Offer referral to the CI programme
Any other unusual presenting feature at the discretion of the audiologist – must be specified	Refer to ENT
Glue ear but with conductive hearing loss of <25dBHL (either alone or on top of a SNHL) and no previous known long-term middle ear problems.	Refer to ENT with tympanogram (If it is unsure if this is long-standing, check hospital records first)

[2] Either: a hearing impairment in which the loss is not measurable in decibels, as in disturbances in discrimination of speech or tone quality, pitch, or loudness. OR: a condition in which certain sounds produce discomfort.

[3] For true rotatory vertigo that is a new symptom, also consider direct referral to ENT

Exclusion from the AQP pathway:

The following patients should be referred for a reassess to admin staff and not back to the GP for a re-referral in to the AQP system at present:

- **All Children and Adults under 55 years of age**
- **Complex adult patients who meet the contra-indication as set out below:**

History:

- Persistent paint affecting either ear (earache lasting more than 7 days in the past 90 days)
- Discharge from either ear within the last 90 days
- Sudden/ rapid loss/ rapid deterioration of hearing (sudden = <1 week – go to A&E)
- Fluctuating hearing loss (not cold related)
- Unilateral/ asymmetrical/ pulsatile/ distressing tinnitus - > 5 mins duration
- Troublesome tinnitus – may lead to sleep disturbance or anxiety/ depression
- Vertigo

Ear examination:

- Abnormal appearance of the outer ear and/ or the eardrum (e.g. Inflammation/ perforation)

Audiometry:

- Conductive hearing loss - **>20 dB** A-B gap @ **>1** of 500, 1000, 2000, 4000 Hz
- Unilateral/ asymmetrical sensorineural hearing loss (difference between L&R B/C **>15 dB** @ **>1** of 500, 1000, 2000 or 4000 Hz
- Deterioration of hearing in the last 24 months with audios of **>10 dB** in A/C @ **>1** of 500, 1000, 2000, 4000 Hz

Adult complex cases (as defined by NHS Improvement Pilot Sites Programme)

- **Severe and profound levels of hearing impairment. (≥ 80dB HL at 2kHz and 4kHz)**
- **Suspected non-organic hearing loss.**
- **Surgical ears such as a Mastoid cavity, acoustic neuroma**
- **Patients with moderate or severe dementia**
- **Patients with learning disabilities**
- **Patients with dual sensory loss**
- **Patients with severe ski slope hearing loss (≥ 50dB per octave between 500 Hz and 4kHz)**
- **Patients with a conductive hearing loss (BC ≤ 20dB HL with air-bone gap ≥ 50dB)**
- **Patients with a mixed hearing loss (AC ≥ 60dB HL with air bone gap ≥ 30dB HL**
- **BAHA and cochlear implant candidates**
- **Fluctuating hearing losses**
- **Frequent (≥ 3) follow up/fine tune attendees**
- **Auditory Neuropathy Spectrum Disorder (ANSD)**

Service: Adult Hearing Aid Reassessment-Audiology-Liskeard-RK9

Section 1 - Service Details

Service ID:	5394229
Service Comments:	
-	
Referrer Alert:	
Existing NHS hearing aid users	
Service Location:	LISKEARD COMMUNITY HOSPITAL
Specialty:	Diagnostic Physiological Measurement
Appointment Type:	First outpatient
Gender Treated:	Male and Female
Directly Bookable:	Yes
Service Transition Date:	-
Service Effective Date Range:	23/06/2011 to -
Age Range Treated:	17 years and over
Request Types Supported	
Appointment Request:	Yes
Advice Request:	No
Diagnostic Request:	No
Publish:	Yes
Available on Secondary Care Menu:	Yes

Section 3 - Clinical Terms

Clinical Findings:

Bilateral deafness
Chronic deafness
Conductive hearing loss
Deafness symptom

Noise-induced hearing loss
Partial deafness
Sensorineural hearing loss

Situations:

Unilateral sensorineural hearing loss with unrestricted hearing on the contralateral side

Procedures:

Audiometric test
Evaluation for hearing aid and testing
Fitting of hearing aid
Hearing aid provision
Provision of auditory appliance
Refer for audiometry
Referral to audiological service
Referral to audiology clinic

Section 7 - Service Personnel

Allocated Clinicians: Beckman, Adam (Named)

Section 9 - Service Specific Booking Guidance

Conditions Treated:

Hearing loss

Procedures Performed:

Hearing aid fitting

Exclusions:

Red Flags requiring urgent ENT:

1. *Sudden loss or sudden deterioration of hearing*
2. *Rapid loss or rapid deterioration of hearing*

Other exclusions
Persistent pain affecting either ear (more than 7 days in the past 90)
Recent history of discharge other than wax

paediatrics
adults with learning disability
people not previously fitted with a NHS hearing aid

Suggested Investigations:

ears checked for wax/obstruction

Service Notes:

This service is run on a Monday with Adam Beckman

Alternative Services:

Paediatric patients
Adults with learning difficulties, paper referral only.
Adult Hearing Loss ¿ Any Age - Adult Hearing Diagnostic-Audiology clinic
NHS hearing aid repair service see website for details:
<a
href="http://www.plymouthhospitals.nhs.uk/ourservices/healthcareprofessionalsguide/Pages/Audiology.aspx"
target="_blank">Audiology Department