	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the short version and any comments you may have on the evidence presented in the full version. We would also welcome views on the Equality Impact Assessment. We would like to hear your views on these questions: 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) See section 3.9 of Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	Action on Hearing Loss
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	Action on Hearing Loss has never received any material funding from the tobacco industry and has no direct or indirect links with the tobacco industry.
Name of commentator person completing form:	Tahrima Choudhury
Type	[office use only]

Comment number	**Document** (**full** version, **short** version or the **appendices**	**Page number** Or **'general'** for comments on the whole	**Line number** Or **'general'** for comments on the whole	**Comments** Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.

Consultation on draft guideline – deadline for comments 5pm on 12/01/18 **email: hearingloss@nice.org.uk**

		document	document	
Example 1	Full	16	45	We are concerned that this recommendation may imply that ……..
Example 2	Full	16	45	Question 1: This recommendation will be a challenging change in practice because ……
Example 3	Full	16	45	Question 3: Our trust has had experience of implementing this approach and would be willing to submit its experiences to the NICE shared learning database. Contact…….
1.	Full & Short	General	General	Action on Hearing Loss (formerly the RNID) is the largest charity in the UK representing people with hearing loss. We help people confronting deafness, tinnitus and hearing loss to live the life they choose, enabling them to take control of their lives and removing the barriers in their way. We provide information, advice and support for people with hearing loss, we campaign for equality and better services, and we support research efforts to find new treatments and improve the management of hearing loss. We welcome the opportunity to respond to the consultation on NICE's draft guideline on '*Hearing loss in adults: assessment and management'*. Hearing loss is a growing public health challenge and is increasingly seen as a national priority. This is demonstrated by the Department of Health and NHS England's Action Plan on Hearing Loss[1] published in March 2015, and NHS England's Commissioning Framework for Adult Hearing Loss Services[2] published in April 2016. The NICE guideline on '*Hearing loss in adults: assessment and management'* is vitally important. It will further strengthen the case for the prevention and management of hearing loss, and enable providers and commissioners to recognise the impact of hearing loss on individuals, and the economic burden that unaddressed hearing loss places on the health and social care system. When put into practice, these guidelines have the potential to effectively target health and care resources to significantly improve patient outcomes, in line with the best available evidence of clinical and cost-effectiveness. In our response to the consultation, we have given feedback on the recommendations we strongly welcome and have provided evidence to support why these recommendations are critical in tackling the growing challenge of hearing loss. We have also included further recommendations which should be included within the guideline and suggested ways to strengthen those that should be extended. The key points within our response are outlined below: • Users should refer to the Action Plan on Hearing Loss[1] and the Commissioning Framework for Adult Hearing

[1] NHS England and Department of Health (2015) Action Plan on Hearing Loss. London: NHS England and Department of Health. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/03/act-plan-hearing-loss-upd.pdf

[2] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

				Loss Services[2] to improve patient outcomes. (Please refer to comment 6) • The importance of early diagnosis and management of hearing loss and its association with dementia, which is identified as the largest modifiable risk factor for dementia in the recent Lancet Commission (2017).[3] (Please refer to comment 2 and 4). • The significance of the recommendation to offer hearing aids to all adults whose hearing loss affects their ability to communicate. (Please refer to comment 6). • The significance of the recommendation not to use pure tone audiometry classifications such as 'mild' and 'moderate' as the sole determinant for hearing support provision. (Please refer to comment 6 and 21). • The importance of the recommendation to offer two hearing aids to adults with hearing loss in both ears. (Please refer to comment 7). • The urgent need for health and social care systems to develop a coordinated approach to tackle the growing public health challenge of hearing loss. Users should ensure that hearing needs are accurately captured within local Joint Strategic Needs Assessments (JSNA). Guidance for this is detailed in comment 6. • Users should recognise the communication needs of people with hearing loss, and offer appropriate support in accessing health and social care services and equipment such as assistive listening devices. (Please refer to comment 8 and 12). • The significance of GP awareness and training on the diagnosis and management of hearing loss. (Please refer to comment 3 and 28) • It is imperative that NICE support the implementation of the guidelines, in order to reduce health inequalities and local variation in access and quality of hearing services across the UK. • The guideline must take into consideration the rapidly changing landscape of technology and the inevitable significant changes that will occur in the delivery of audiology and social care services as a consequence. As the largest UK charity representing people with hearing loss we asked people to submit their own views regarding

[3] Livingston G, Sommerlad A, Orgeta V, et al (2017) Dementia prevention, intervention, and care. The Lancet.16;390(10113):2673-2734. doi: 10.1016/S0140-6736(17)31363-6

				the guideline, and have incorporated the feedback we received in our response.
2.	Full & Short	General	General	**We welcome that the guideline recognises the importance of early management of hearing loss.** The importance of early diagnosis and management has also been recognised within the Government's Action Plan on Hearing Loss which sets out an objective to ensure that all people with hearing loss are diagnosed early and managed effectively once diagnosed.[1] Without hearing aids and support, research shows that hearing loss leads to people not reaching their full potential at work, and too often leads to early retirement and loss of income (see comment 52 on employment).[4] Hearing loss also doubles the risk of developing depression and dementia.[5] There is good evidence that hearing aids improve employment prospects, quality of life, social activity and mental health.[6] However, approximately only two fifths of people who need hearing aids have them,[7] and wait on average 10 years before seeking help.[8] A universal screening programme for hearing loss would identify and help those who would benefit from hearing aids and other rehabilitation sooner. It would also offer reassurance to those with unimpaired hearing, and would help inform the public at large about the disabling effects of hearing loss and the effectiveness of interventions. Moreover, its long term benefits to social well-being and health make it cost effective: a recent independent analysis found that screening at the age of 65 would be most cost-effective, with an estimated benefit-cost ratio of 8:1 over 10 years.[9]

[4] Action on Hearing Loss. (2014). Hidden Disadvantage. London: Action on Hearing Loss. Available at: www.actiononhearingloss.org.uk/hiddendisadvantage ; Kochkin S. (2007). The Impact of Untreated Hearing Loss on Household Income. Alexandria VA: Better Hearing Institute.

[5] Saito et al. (2010). Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. Journal of the American Geriatrics Society 58(1): 93-7; Lin et al. (2011). Hearing loss and incident dementia. Archives of Neurology 68(2):214-220.

[6] Kochkin S. (2007). The Impact of Untreated Hearing Loss on Household Income. Alexandria VA: Better Hearing Institute; Mulrow et al (1990) Quality-of-life changes and hearing impairment, a randomized trial". Annals of Internal Medicine 113(3): 188-94; National Council on the Aging. 2000. "The consequences of untreated hearing loss in older persons. Head & Neck Nursing 18(1):12-6

[7] Health Survey England (2014): VOL 1 | CHAPTER 4: HEARING. The Health and Social Care Information Centre. Available at: http://www.hscic.gov.uk/catalogue/PUB19295/HSE2014-ch4-hear.pdf; Perez E and Edmonds BA (2012) A Systematic Review of Studies Measuring and Reporting Hearing Aid Usage in Older Adults since 1999: A Descriptive Summary of Measurement Tools. PLoS ONE 7(3), e31831; European Hearing Instrument Manufacturers Association (2015) Eurotrak Survey 2015; Davis and Smith (2013) Adult hearing screening: health policy issues--what happens next? Am J Audiol. 22(1):167-70.

[8] Davis A, Smith P, Ferguson M, Stephens D, Gianopoulos I. (2007) Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. Health Technology Assessment, 11(42):1-294

[9] Action on Hearing Loss. (2010). Cost benefit analysis of hearing screening for older people. London: Action on Hearing Loss. Available at http://www.hearingscreening.org.uk/#!publications/cee5

				In 2015, Action on Hearing Loss, in partnership with a number of charities, submitted a consultation response to the National Screening Committee (NSC) for the introduction of a hearing screening programme for adults. However, in 2016 the NSC, announced its decision on not to support a hearing screening programme, on the basis that there was a lack of evidence, particularly from a randomised controlled trial (RCT). The NSC has stated: *"Further research in the UK is required before screening can be recommended in the UK. It has been suggested that a large scale Randomised Controlled Trial (RCT) of screening for hearing impairment 35+ dB hearing impairment or poorer should be undertaken within the 55 – 74 age group".*[10] A RCT investigating screening for hearing loss among adults will provide the evidence required to meet the criteria set by the NSC. And could potentially lead to the introduction of adult hearing screening, improving health and wellbeing, reducing social isolation, keeping people in work longer, increasing awareness of hearing loss, reducing the stigma around hearing loss and normalising help seeking. The Action Plan on Hearing Loss also commits to Public Health England (PHE) to continue to periodically review the evidence for screening hearing loss in older adults against the NSC criteria.[11] **We therefore urge the NICE guideline committee to include a RCT on screening adults for hearing loss as a research recommendation.** Furthermore, recent evidence from the Lancet Commission (2017) identifies hearing loss as the largest modifiable risk factor for dementia.[12] Cohort studies investigating hearing have shown that even mild levels of hearing loss can increase the long-term risk of cognitive decline and dementia in individuals who are cognitively intact but hearing impaired at baseline.[13] In light of this evidence, it is important that all adults with diagnosed or suspected dementia or mild cognitive impairment are referred to an audiology service for a hearing assessment.

[10] UK National Screening Committee (2015) Screening for Hearing Loss in Older Adults: External review against programme appraisal criteria for the UK National Screening Committee (UK NSC). London: UK National Screening Committee.

[11] NHS England and Department of Health (2015) Action Plan on Hearing Loss. London: NHS England and Department of Health. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/03/act-plan-hearing-loss-upd.pdf

[12] Livingston G, Sommerlad A, Orgeta V, et al (2017) Dementia prevention, intervention, and care. The Lancet.16;390(10113):2673-2734. doi: 10.1016/S0140-6736(17)31363-6

[13] Deal JA, et al (2017) Hearing impairment and incident dementia and cognitive decline in older adults: the Health ABC Study. J Gerontol A Biol Sci Med Sci. 72(5): 703–709; Lin FR, et al (2011) Hearing loss and incident dementia. Arch Neurol, 68: 214–20; Gallacher J, Ilubaera V, Ben-Shlomo Y, et al (2012) Auditory threshold, phonologic demand, and incident dementia. Neurology, 79: 1583–90; Lin FR, Ferrucci L, Metter EJ, et al (2011) Hearing loss and cognition in the Baltimore Longitudinal Study of Aging. Neuropsychology, 25: 763–70; Lin FR (2011) Hearing loss and cognition among older adults in the United States. J Gerontol A Biol Sci Med Sci, 66:1131–36; Deal JA, Sharrett AR, Albert MS, et al (2015) Hearing impairment and cognitive decline: a pilot study conducted within the atherosclerosis risk in communities neurocognitive study. Am J Epidemiology, 181: 680–90; Kiely KM, Gopinath B, Mitchell P, et al (2012) Cognitive, health, and sociodemographic predictors of longitudinal decline in hearing acuity among older adults. J Gerontol A Biol Sci Med Sci, 67: 997–1003; Fritze T, Teipel S, Óvári A, et al (2016) Hearing impairment affects dementia incidence. An analysis based on longitudinal health claims data in Germany. PLoS One, 11: e0156876; Gurgel RK, Ward PD, Schwartz S, et al

				Hearing loss is identified as a mid-life modifiable risk factor for dementia, with 55 years being the youngest mean age in which the presence of hearing loss is shown to increase dementia risk.[12] Evidence also shows that the ability to maintain and adapt to hearing aids becomes increasingly difficult the older people are when they present for assessment and intervention.[14] Considering, hearing loss and dementia often co-occur and are particularly difficult to manage when they are experienced together, this suggests that there is significant benefit in ensuring that hearing loss is identified early, so that people can adapt before the onset or progression of dementia. **The diagnosis of dementia must therefore include hearing screening.** Currently the NICE guidelines on Dementia (2006) diagnosis and assessment state that diagnosis of dementia should be made only after a comprehensive assessment, including a physical examination, however it is unclear what a physical examination should consist of.[15] The BMJ best practice, a Clinical Decision Support Tool for healthcare professionals' states that for the assessment of dementia, a physical examination should be undertaken and this should include a hearing test.[16] Although the NICE guidelines on Dementia (2006) states in section 1.4.1.3 that those interpreting test scores should take full account of other factors known to affect performance including any sensory impairments, **section 1.4.1.1 should also explicitly state that hearing screening should be included as part of the assessment process for the diagnosis of dementia.**[9]
3.	Short	3	5 - 7	**The recommendation to refer all adults regardless of age is welcomed.** **Question 1:** This recommendation may be a challenging change in practice for GPs, since evidence suggests that often GPs can act as a barrier to people accessing audiology services. On average, adults with hearing loss wait 10 years before seeking medical advice, and when they do visit their GP, 30 to 45 percent are not referred on for a hearing assessment.[17] This indicates that there is a significant unmet need. Approximately only two fifths of people who need hearing aids have them.[18]

(2014) Relationship of hearing loss and dementia: a prospective, population-based study. Otol Neurotol, 35: 775–81; Amieva H, Ouvrard C, Giulioli C, et al (2015) Self-reported hearing loss, hearing aids, and cognitive decline in elderly adults: a 25-Year Study. J Am Geriatr Soc, 63: 2099–104.

[14] Davis A, Smith P, Ferguson M, Stephens D, and Gianopoulos I (2007) Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models". Health Technology Assessment.11(42). doi:10.3310/hta11420.

[15] NICE (2006). Dementia: supporting people with dementia and their carers in health and social care. Clinical guideline [CG42]. Available at: https://www.nice.org.uk/guidance/cg42

[16] Tampi R, et al. (2017) Assessment of dementia. BMJ Best Practice. Available at: http://bestpractice.bmj.com/topics/en-gb/242

[17] Davis et al (2007) Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. Health Technology Assessment 11:1–294; 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

[18] Health Survey England (2014): VOL 1 | CHAPTER 4: HEARING. The Health and Social Care Information Centre. Available at: http://www.hscic.gov.uk/catalogue/PUB19295/HSE2014-ch4-hear.pdf; Perez E and Edmonds BA (2012) A Systematic Review of Studies Measuring and Reporting Hearing Aid Usage in Older Adults since 1999: A Descriptive Summary of Measurement

				In addition, there is also considerable variation across England in access to audiology services. The NHS England Atlas of Variation shows an 11-fold variation in the rate of audiology assessments,[19] suggesting that there is significant variation in referrals made by GPs for people with hearing loss.[20] In recognition of this, early diagnosis and management of hearing loss has been identified as a key objective in the Action Plan for Hearing Loss.[21] Furthermore, evidence shows that hearing loss is the largest modifiable risk factor for dementia in mid-life. Please refer to comment 2. **Question 3:** To help overcome challenges users should refer to the Commissioning Framework for Adult Hearing Loss Services,[22] which states that *"GPs and other health and social care professionals should regularly check people's hearing as they get older (10, 23) to encourage people to seek help, and to ensure they get a prompt referral on to audiology services".* The Framework also recommends that *"CCGs should plan to ensure services tackle unmet need and ensure that GPs are aware of the evidence and national guidance, as well as local referral pathways".* Further guidance on referral is available from the British Academy of Audiology at http://www.baaudiology.org/index.php/download_file/view/302/178/ , and professional practice guidance from the British Society of Hearing Aid Audiologists can be found at http://www.bshaa.com/Publications/BSHAA, which **should be included within 'tools and resources' under the section 'Putting the guideline into practice' on page 11 of the short version of the guideline.** Furthermore, users should also refer to the Action Plan on Hearing Loss[21] which urges health professionals to recognise communication needs and offer appropriate support in accessing other health and public services to people with hearing loss.
4.	Short	5	16 - 18	**The word *'consider'* should be removed from the recommendation to refer adults with diagnosed or suspected dementia or mild cognitive impairment for hearing assessment.**

Tools. PLoS ONE 7(3), e31831; European Hearing Instrument Manufacturers Association (2015) Eurotrak Survey 2015; Davis and Smith (2013) Adult hearing screening: health policy issues--what happens next? Am J Audiol. 22(1):167-70.

[19] Public Health England (2013). NHS Atlas of Variation in Diagnostic Services: Reducing unwarranted variation to increase value and improve quality.

[20] Davis et al (2012). Diagnosing patients with age-related hearing loss and tinnitus: Supporting GP clinical engagement through innovation and pathway redesign in audiology services. International Journal of Otolaryngology, available at: http://www.hindawi.com/journals/ijoto/2012/290291/

[21] NHS England and Department of Health (2015) Action Plan on Hearing Loss. London: NHS England and Department of Health. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/03/act-plan-hearing-loss-upd.pdf

[22] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

				Question 1: The symptoms of dementia can make both the diagnosis and management of hearing loss challenging. This is because firstly, when testing for hearing loss the individual relies on their memory to recognise how their hearing compares with their hearing in the past.[23] They also rely on their memory to tell them how long they have been experiencing hearing loss for.[23] Secondly, diagnosing hearing loss relies on the individual's ability to understand the instructions from the audiologist. This becomes difficult when the individual has symptoms of dementia, and as a result may feel confused.[23] Additionally, there is a risk that hearing loss may be misdiagnosed as dementia,[24] since dementia itself can cause communication problems, such as difficulty in finding the right words. Furthermore, hearing impairment can adversely affect performance on cognitive testing and can cause a diagnostic challenge. The most commonly used test to determine cognitive status, the Mini-Mental State Examination (MMSE), relies on the individual's ability to fully hear the instructions.[25] The Jorgensen et al (2016) study found that reduced audibility significantly reduces scores on the MMSE, resulting in greater apparent cognitive deficits as audibility decreased.[26] **Question 3: The diagnosis of dementia must therefore include hearing screening, and should be included within the NICE guidelines on Dementia (2006).[27] Please refer to comment 2.**
5.	Short	5	22-24	**We welcome the recommendation to "consider referring people with a diagnosed learning (intellectual) disability to an audiology service" every two years**. People with learning disabilities may require specialist support to ensure they can access and benefit from hearing aids. The prevalence of hearing loss is higher in people with learning disabilities compared to the general population,

[23] Echalier M. (2012). A World of Silence. The case for tackling hearing loss in care homes. London: Action on Hearing Loss. Available from: http://www.actiononhearingloss.org.uk/-/media/ahl/documents/research-and-policy/reports/care-home-report.pdf

[24] Boxtel van M, Beijsterveldt van C, Houx P, et al. (2000). Mild Hearing Impairment Can Reduce Verbal Memory Performance in a Healthy Adult Population. Journal of Clinical and Experimental Neuropsychology 22(1):147-154.

[25] Alzheimer's Society. (2017). The MMSE test. Available at: https://www.alzheimers.org.uk/info/20071/diagnosis/97/the_mmse_test.

[26] Jorgensen L, Palmer C, Pratt S, et al. (2016). The Effect of Decreased Audibility on MMSE Performance: A Measure Commonly Used for Diagnosing Dementia. Journal of the American Academy of Audiology. 27(4):311-323.

[27] NICE (2006). Dementia: supporting people with dementia and their carers in health and social care. Clinical guideline [CG42]. Available at: https://www.nice.org.uk/guidance/cg42

				and people with learning disabilities are more likely to develop hearing loss and its associated health problems earlier.[28] Around 40% of people with learning disabilities have hearing loss[29] but this often goes undiagnosed or is misdiagnosed as behavioral difficulties.[30] Diagnosing and managing hearing loss is crucial for improving the health and wellbeing of people with learning disabilities. As stated in full guideline, hearing loss that is *"not addressed will significantly affect understanding and will exacerbate underlying cognitive difficulties. It will contribute to increasing confusion and withdrawal."* **An additional recommendation should also be added to this section to acknowledge the communication difficulties that some people with learning disabilities may face during primary care hearing assessments, and the adjustments that may be needed to ensure they can access treatment.** One study found that the format of hearing checks carried out in GP surgeries are often inappropriate for people with learning disabilities.[31] Some GPs who were interviewed as part of this study were also reluctant to refer people with learning disabilities for a hearing test, due to misconceptions that diagnosis and treatment would be ineffective. **The following paragraph should be added to recommendation 1.1.11:** ***"Adjustments should also be made to ensure the format of primary care hearing assessments are suitable for people with learning disabilities. People with learning disabilities should be provided with appropriate support to communicate well and understand information, in line with NHS England's Accessible Information Standard."*** NHS England's Accessible Information Standard[32] provides guidance for providers of NHS Care and publicly funded adult social care on making their services accessible to people with disabilities and sensory loss. The Standard became a legal requirement in August 2016, and sets out a clear process to make sure people with disabilities and sensory loss can contact services when they need to, communicate well during appointments and understand health information or correspondence they are given. This also includes the communication and/or information needs of parents, guardians or carers.
6.	Short	8	11	**The recommendation to offer hearing aids to all adults whose hearing loss affects their ability to communicate**

[28] Kiani R and Miller H. (2010). Sensory impairment and intellectual disability. Advances in psychiatric treatment. 16:228–235.
[29]Carvill S. (2001). Sensory impairment, intellectual disability and psychiatry. Journal of Intellectual Disability Research. 45:467–83; Kiani R and Miller H. (2010) Sensory impairment and intellectual disability Advances in psychiatric treatment. 16:228–235; McShea et al. (2015) Paid support workers for adults with intellectual disabilities; their current knowledge of hearing loss and their future training needs. Journal of Intellectual Disabilities. 28 (5), 422-432.
[30] Kiani R and Miller H. (2010). Sensory impairment and intellectual disability. Advances in psychiatric treatment. 16, 228–235.
[31] McShea L. (2015). Managing hearing loss in Primary care. Learning Disability Practice.18(10):18-23. doi:10.7748/ldp.18.10.18.s19
[32] NHS England (2017). Accessible Information Standard. DCB 1605. To find out more, please visit www.england.nhs.uk/accessibleinfo

				is welcomed. There is a significant body of evidence to show the improvements to health and wellbeing from using hearing aids. Most recently, a Cochrane review on the effectiveness of hearing aids in mild to moderate hearing loss showed that hearing aids are effective at improving hearing specific and general health related quality of life and listening ability in adults with mild to moderate hearing loss.[33] Furthermore, a systematic review by Ciorba et al (2012) found that people benefited from hearing aids on a variety of different quality of life measures.[34] Health improvement benefits were also found by Swan et al (2012) and Barton et al (2004) using quality of life outcome measures.[35] Hearing aid users were also found to have better social engagement, mental and physical health than non-users.[36] Using hearing aids also reduces the risk of dependence on social care and risk of premature death. Furthermore, findings from recent studies show that the rate of cognitive decline decreases with the use of hearing aids which may reduce the risk of developing dementia.[37] **Question 1.** Recent proposals by Clinical Commissioning Groups (CCGs) to decommission hearing aids for people with mild and moderate hearing loss, indicate that this recommendation may be perceived as a challenge to implement due to financial pressures. Despite the extensive clinical evidence, professional opinion and national policy prioritising hearing loss, 16 CCGs across the country have proposed to decommission hearing aid provision for people with mild and moderate hearing loss. In 2015, North Staffordshire CCG went ahead with these proposals and became the first CCG to no longer provide NHS hearing aids to people with mild hearing loss, and require people with moderate hearing loss to undergo an eligibility test before gaining access. North Staffordshire CCG is expected to review their policy on hearing aids once the NICE guidelines on hearing loss are published. Hence the importance of this recommendation in the guideline.

[33] Ferguson MA, Kitterick PT, Chong L, Edmondson-Jones M, Barker F, Hoare DJ. (2017). Hearing aids for mild to moderate hearing loss in adults. Cochrane Database of Systematic Reviews.
[34] Ciorba A, Bianchini C, Pelucchi S and Pastore A. (2012). The impact of hearing loss on the quality of life of elderly adults. Clinical Interventions in Aging. 7:159–163.
[35] Swan IR, Guy FH, Akeroyd MA. (2012). Health-related quality of life before and after management in adults referred to otolaryngology: a prospective national study. Clinical Otolaryngology. 37(1):35-43; Barton GR, Bankart J, Davis AC, Summerfield QA. (2004). Comparing utility scores before and after hearing aid provision: results according to the EQ-5D, HUI3 and SF-6D. Applied Health Economics and Health Policy 3(2):103-5.
[36] Kochkin S and Rogin CM. (2000). Quantifying the obvious: The impact of hearing instruments on quality of life. The Hearing Review. 7(1).
[37] Amieva H, Ouvrard C, Giulioli C, et al. (2015). Self-Reported Hearing Loss, Hearing Aids, and Cognitive Decline in Elderly Adults: A 25-Year Study. J Am Geriatr Soc. 63(10):2099-104. doi: 10.1111/jgs.13649.

				The proposals made to decommission hearing aids are extremely concerning, since hearing aids are the "only viable treatment option"[38] for people with mild and moderate hearing loss. In addition, hearing aids are cost effective. A hearing aid costs the NHS £90, and on average £390 for all of a person's appointments, two hearing aids and repairs for three years.[39] This small cost per person enables the NHS to deliver huge benefits in terms of quality of life and reduces the need for more costly interventions in the future. As summarised by Access Economics (2006), "the literature shows that hearing aids yield significant benefits for relatively low investments".[40] NHS England state that the benefits of providing hearing aids outweigh the costs, and that hearing aids provided through the NHS are cost effective.[41] In contrast, purchasing a set of hearing aids privately costs £3,000 on average,[42] which is beyond the savings of 55% of UK households.[43] **Question 2.** Although CCGs are facing financial pressures, this should not impact patient care. There are a number of effective alternative ways that CCGs can respond to financial challenges without decommissioning hearing aid services for people with mild and moderate hearing loss. The Commissioning Framework for Adult Hearing Loss Services is guidance published by NHS England to support CCGs to commission high quality, cost effective audiology services, which enables CCGs to reduce costs of hearing services without restricting provision. There are several case studies of good practice cited within the Commissioning Framework for Adult Hearing Loss Services, this includes West Hampshire CCG, which redesigned the hearing care pathway for adults in the local area resulting in significant cost savings. The pathway was co-produced with Ear, Nose and Throat (ENT) doctors and audiologists, and designed around patient needs allowing all audiology providers to refer directly into ENT, and provides ENT an efficient method of offering users a choice of community audiology services. These changes have resulted in a more integrated model of care which is tailored to patient needs. **Question 3.** To help CCGs to overcome challenges they should refer to the following national strategy and guidance documents: • **The Action Plan on Hearing Loss**:

[38] Chisholm et al. (2007). A systematic review of health-related quality of life and hearing aids: Final report of the American Academy of Audiology task force on the health-related quality of life benefits of amplification in adults. Journal of American Academy of Audiology, 18:151-183
[39] Monitor and NHS England. (2013). National tariff information workbook 2014/15. Available at: https://www.gov.uk/government/publications/national-tariff-information-workbook-201415
[40] Access Economics. (2006) Listen Hear: The economic impact and cost of hearing loss in Australia. Canberra: Access Economics
[41] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf
[42] Which? (2018). Hearing aid prices - Which? Available at: https://www.which.co.uk/reviews/hearing-aid-providers/article/how-to-get-the-best-hearing-aid/hearing-aid-prices
[43] Department for Work and Pensions (2014): Family Resources Survey: financial year 2013/14. Available at: https://www.gov.uk/government/statistics/family-resources-survey-financial-year-201314

				To tackle the growing public health challenge of hearing loss, the Department of Health and NHS England published the Action Plan on Hearing Loss in 2015. The Action Plan is a national Government strategy, which demonstrates a commitment to tackling hearing loss at a national level, and clearly lays out the evidence base around the impacts of hearing loss and the need for improved awareness, technology and services. The Action Plan proposes to address hearing loss through promoting prevention of hearing loss, improving both the commissioning and integration of services, providing innovative models of care and ensuring that people of all ages with hearing loss are actively supported and empowered.[44] • **The Commissioning Framework:** The Commissioning Framework for Adult Hearing Loss Services[45] was published by NHS England in 2016, and is one of the main outputs from the Action Plan on Hearing Loss. It is a crucial document for promoting good practice amongst commissioners, providing tools and practical guidance to support CCGs to make informed decisions to achieve good value for local populations, provide services which are of high quality, consistent and integrated. The Framework suggests improving services by basing services on local needs, monitoring outcomes, considering flexible and innovative commissioning models, streamlining pathways, signposting well to support services and improving accessibility, convenience and choice. • **Joint Strategic Needs Assessment (JSNA) Guidance:** This guide[46] has been co-produced by NHS England, the Local Government Association, the Association of Directors of Public Health and other stakeholders, and will be published in 2018. The guide provides the data, evidence and insight local authorities and NHS commissioners need to develop robust hearing needs assessments to meet local needs. It will allow decision makers define the future health, care and wellbeing needs of their local populations with regards to hearing loss and to signpost to guidance on how audiology services can help them to meet these needs.

[44] NHS England and Department of Health (2015) Action Plan on Hearing Loss. London: NHS England and Department of Health. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/03/act-plan-hearing-loss-upd.pdf

[45] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

				People with hearing loss can often find it difficult to communicate without the right support, and are at a greater risk of unemployment, social isolation, depression and other mental health issues.[46] This worsens health inequalities and increases avoidable costs for individuals, the health and care system and the economy.[46] The correct local support can ensure that those with hearing loss are not disadvantaged, and the costs and impact associated with hearing loss are significantly diminished. Tackling the growing challenge of hearing loss requires a coordinated response across the health and social care system. Central to this, is ensuring that hearing needs are accurately captured in every local JSNA. This local approach is key to ensuring that by working together the national and growing public health challenge of hearing loss can be tackled in a sustainable way.
7.	Short	8	13	**The recommendation to offer two hearing aids to adults with hearing loss in both ears is welcomed.** Research shows that bilateral fittings improve speech clarity, reduces listening strain in dynamic and demanding situations (such as noisy environments or group conversations),[47] and enables better localisation of sound.[48] Bilateral hearing aid provision impacts on a person's safety, social competence, and emotional wellbeing.[49] It also plays a significant role in suppressing tinnitus,[50] and in reducing the risk of auditory deprivation, which affects the brain's ability to process sounds.[51] Fitting two hearing aids for people with hearing loss in both ears is needed to ensure the person can hear well, communicate, maintain their hearing, stay safe and not become socially isolated. Worryingly, in recent years several CCGs across the country, including Milton Keynes and Kernow CCGs have proposed to restrict the provision of bilateral fittings. After consultation with Action on Hearing Loss and other stakeholders they decided not to go ahead with these proposals. We therefore believe that this recommendation is particularly important in light of these proposals, and strongly welcome the clear recommendation made for bilateral

[46] NHS England et al. (*Forthcoming* 2018). Guidance for Local Authorities and NHS commissioners on assessing the hearing needs of local populations. London: NHS England

[47] Köbler S and Rosenhall U. (2002). Horizontal localization and speech intelligibility with bilateral and unilateral hearing aid amplification. International Journal of Audiology, 41(7):395-400; Leeuw A and Dreschler W. (1991). Advantages of Directional Hearing Aid Microphones Related to Room Acoustics. International Journal of Audiology, 30(6):330-344.

[48] Stephens SD, Callaghan DE, Hogan S, et al. (1991). Acceptability of binaural hearing aids: a cross-over study. Journal if the Royal Society of Medicine, 84(5):267-9; Dreschler WA and Boymans M. (1994). Clinical evaluation on the advantage of binaural hearing aid fittings. Audiologische Akustik, 5:12-23.

[49] Noble W, Gatehouse S. (2006). Effects of bilateral versus unilateral hearing aid fitting on abilities measured by the Speech, Spatial, and Qualities of Hearing Scale (SSQ). International Journal of Audiology. 45(3):172-181; Brooks DN, Bulmer D. (1981). Survey of binaural hearing aid users. Ear Hear, 2(5):220-4.

[50] Brooks DN, Bulmer D. (1981). Survey of binaural hearing aid users. Ear Hear, 2(5):220-4.

[51] Nielsen H. (1974). Effect of monaural versus binaural hearing aid treatment. Scandinavian Audiology, 3(4):183-187; Silman S, Silverman CA, Emmer MB, Gelfand SA. (1992) Adult-onset auditory deprivation. J Am Acad Audiol, 3(6):390-6; Hurley RM. (1993) Monaural hearing aid effect: case presentations. J Am Acad Audiol, 4(5):285-94; discussion 295.

				fittings within the guideline. **Question 3:** To overcome challenges in implementing this recommendation users should refer to the Commissioning Framework for Adult Hearing Loss Services, which outlines the importance of bilateral fittings: *"If hearing aids are recommended as the preferred intervention, people generally benefit from being offered 1 for each ear (bilateral) (46, 62) unless there are reasons that this is inappropriate. Fitting of bilateral hearing aids is beneficial as many modern hearing aids interact with each other to offer greater improvement in speech discrimination in everyday environments".*[52]
8.	Short	9	1-9	**We welcome recommendations 1.5.8 and 1.5.9 on assistive listening devices. However, an additional recommendation should be added to this section to encourage audiology services and local authorities to work together to help people who are deaf or have hearing loss access assistive equipment.** Assistive equipment (usually provided by local authority sensory services) can help people who are deaf or have hearing loss communicate well and live safely and independently in their own home, and manage their condition more effectively. **Question 1:** This recommendation may be challenging to implement. Evidence from our '*Under Pressure'* report[53] shows that people who are deaf or have hearing loss might not know that these services are available and referral routes are often underutilised. These findings are consistent with patient survey results from Monitor's report on NHS adult hearing services in England,[54] which showed that only one in ten respondents surveyed said that they were provided information about additional services and equipment. Provides who were interviewed stated that it is difficult to identify all the other services which are available locally, and that significant investment is needed to build awareness and knowledge of those services. As stated in the full guideline, at present *"liaison between health and social services does not happen routinely and, as a consequence, services are not joined up".* **Question 3:** It is therefore vital that NHS audiology services and local authorities work together to ensure assistive

[52] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

[53] Lowe C. (2015). Under Pressure. London: Action on Hearing Loss. Available from: https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/under-pressure-report/

[54] Monitor. (2015). NHS adult hearing services in England: exploring how choice is working for patients. London: Monitor

				equipment is available to everyone who needs it. NHS England's Commissioning Framework for hearing loss services[55] states that *"commissioners should be open to new ideas about how to meet needs and deliver services wherever they come from, including working closely with other parts of the health and social care system".* **The following sentence should be added to the "Assistive listening devices" section.** ***"Work closely with other parts of the health and social care system and consider innovative solutions (such as joint-commissioning between NHS and local authority services) to help people access assistive equipment and other forms of support, as recommended by NHS England's Commissioning Framework for Adult Hearing Loss Services for Adult Hearing Loss Services".***
9.	Short	9	11-12	**We welcome that the guideline recommends that adults should be offered a face- to face audiology appointment 6 to 12 weeks after their hearing aids are fitted.** **Question 1:** A challenge may arise in ensuring CCGs are aware of the importance of follow ups and that they are routinely offered to all those who are provided with hearing aids, alternative listening devices or other support. Research shows that follow up provision varies considerably across England. Research from our *'Under Pressure'* report found that only 49% of NHS audiology services offer patients face to face follow up appointments[56] and some areas are not contractually required to provide a follow up appointment.[57] Evidence confirms that given good support, follow up and rehabilitation, high levels of hearing aid use and satisfaction can be achieved at low costs[58] and improves people's quality of life, safety and independence.[59] It is apparent from engagement with some CCGs, that there are misconceptions about the use of and benefit of hearing aids. Largely, it is assumed that hearing aids are not beneficial to people who have them, audiologists issue hearing

[55] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

[56] Lowe C. (2015). Under Pressure. London: Action on Hearing Loss. Available from: https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/under-pressure-report/

[57] Monitor. (2015). NHS adult hearing services in England: exploring how choice is working for patients. London: Monitor

[58] Abrams H, Chisolm TH, McArdle R, et al. (2002). A cost utility analysis of adult group audiologic rehabilitation: are the benefits worth the costs? Journal of Rehabilitation Research and Development, 39(5):549-558

[59] Yueh B, Souza PE, McDowell JA, et al. (2001). Randomized trial of amplification strategies. Archives of Otolaryngology Head & Neck Surgery,127(10):1197-204; Cacciatore, et al. (1999). Quality of life determinants and hearing function in an elderly population: Osservatorio Geriatrico Campano Study Group. Gerontology 45:323-323; Mulrow CD, Aguilar C, Endicott JE, et al (1990) Quality-of-life changes and hearing impairment. A randomized trial. Ann Intern Med. 1:113(3):188-94; Chisolm TH, Johnson CE, Danhauer JL, et al. (2007) A systematic review of health-related quality of life and hearing aids: final report of the American Academy of Audiology Task Force on the Health-Related Quality of Life Benefits of Amplification in Adults. Journal of the American Academy of Audiology, 18(2):151-83; Kochkin S. (2005). The impact of untreated hearing loss on household income. Better Hearing Institute

				aids when they are not needed and NHS hearing technology is of poor quality which lead to the devices not being used. A consequence, in some areas of England CCGs have proposed to decommission hearing aids. The fitting of hearing aids, although a key component of managing hearing loss, should not be provided in isolation. As detailed in the full draft guideline, not providing a follow up *"can result in people giving up using their hearing aids and may consequently have a negative impact on their quality of life over time as their ability to communicate and participate in everyday situations declines".* In reality, often people who stop wearing their hearing aids do so because the device has stopped working; they are having issues with managing, using or inserting the hearing aid or they are uncomfortable, which are all issues that can usually be resolved in follow up appointments. Those with hearing loss should be informed that they are entitled to have a follow up and know how to access the service if they have any questions or problems. The Commissioning Framework for Adult Hearing Loss Services states that *"follow-up and other support after the initial hearing aid fitting has been shown to improve satisfaction with hearing aid and increase hearing aid use".* [60] **Question 3:** To ensure that people receive the optimum benefit from the management they are provided, and money is not wasted by misuse of hearing aids and the number of unplanned follow up appointments, audiologists should work with their local CCGs to implement the Commissioning Framework for Adult Hearing Loss Services.[61] In addition to this, as detailed in section 14 'Assistive listening devices' the draft guideline for hearing loss recognises that a follow up appointment is an appropriate time *to "explore continuing communication or listening difficulties following hearing aid provision and ALDs may be a suitable topic to cover then".* As outlined in comment 8, access to such devices varies across the country and often access is underutilised. Anecdotally, we have heard that audiologists are not always clear on how and what information to provide people about assistive listening devices or what other support services such as lip reading classes are available locally for people with hearing loss. As outlined in comment 8 we recommend that audiology services and local authorities work together to improve access to support services for people with hearing loss. The updated service specification for adult audiology services[62] provides more in depth information about what should be included within a follow up appointment and should therefore be referred to within the 'Other considerations' section of the draft guideline for hearing loss within the 'Monitoring and follow up' section.

[60] Perez E and Edmonds BA. (2012). A Systematic Review of Studies Measuring and Reporting Hearing Aid Usage in Older Adults since 1999: A Descriptive Summary of Measurement Tools. PLoS ONE, 7(3):e31831. doi: 10.1371/journal.pone.0031831; European Hearing Instrument Manufacturers Association. (2015). Eurotrak Survey 2015; Abrams H, Chisolm TH, McArdle R. (2002). A cost utility analysis of adult group audiologic rehabilitation: are the benefits worth the costs? Journal of Rehabilitation Research and Development 39(5): 549-558

[61] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

[62] NHS England. (2016). NHS Standard Contract 2016/17 Particulars (Full Length): Adult Hearing Service

10.	Short	9-10	13-1	**We welcome that the guideline states that patient reported outcomes and experience measures are obtained at follow up**. As outlined in comment 6, the Commissioning Framework for Adult Hearing Loss Services makes the recommendation for CCGs to base services on local needs and monitor outcomes.[61]
11.	Short	10	10-28	**The recommendations in section 1.7 on information and support are welcome. The section should also acknowledge the difficulties older people living in care homes may face when seeking help for their hearing loss or when using their hearing aids**. **Question 1:** This recommendation may be particularly challenging to implement in care homes. Our '*A World of Silence*'[63] report shows that older people in care homes are less likely to want address their hearing loss without support – and that care staff found it difficult to encourage them to seek help. The report found that staff had a lack of training in this area and that hearing loss was often seen as less important compared to other issues such as sight loss, pain or safeguarding. Some care staff also lacked the know-how to carry out basic hearing aid maintenance. Our '*Under Pressure*'[64] report also found that less than half (46%) of NHS audiology services in England offer hearing aid support to older people living in care homes. Many older people with hearing loss have other health problems such as frailty and physical impairments so they may need additional support to visit their audiologist or look after their hearing aids. Alternatively, if they are unable to attend appointments due to other conditions, they will need access to hearing aid assessments or aftercare in the care home itself. Please refer to comment 46 & 47. **Question 3.** To help overcome challenges users should refer to NHS England's Healthy Ageing 'What Works' Guide,[65] which recommends training for care staff on the communication and hearing needs of older people. Additional guidance can be found in the Action Plan on Hearing Loss,[66] which states that properly diagnosing and managing hearing loss is essential for improving the health and wellbeing of older people living in care homes. The Action Plan also lists "Improved communication experience in mainstream care homes" as a key outcome measure for service improvement.

[63] Echalier M. (2012). A World of Silence. The case for tackling hearing loss in care homes. London: Action on Hearing Loss. Available from: http://www.actiononhearingloss.org.uk/-/media/ahl/documents/research-and-policy/reports/care-home-report.pdf

[64] Lowe C. (2015). Under Pressure. London: Action on Hearing Loss. Available from: https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/under-pressure-report/

[65] NHS England. (2017). What works: hearing loss and healthy ageing. London: NHS England

[66] NHS England and Department of Health (2015) Action Plan on Hearing Loss. London: NHS England and Department of Health. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/03/act-plan-hearing-loss-upd.pdf

				The following recommendations may help users overcome these challenges and should be added to Section 1.7 ***"Provide support to help older people living in care homes access hearing assessments and support to use their hearing aids by:*** • ***Ensuring care home staff are alert to the early signs of hearing loss and the role of the GP in referring people for a hearing test, in line with the NICE quality standard on mental wellbeing in care homes.*** • ***Establish good working relationships between audiology services and care homes to help older people access support. This could include outreach services, such as audiology clinics in care homes.*** • ***Provide training for care home staff to help them recognise the early signs of hearing loss and support older people to get the most out of their hearing aids".*** Section 1.7 should also acknowledge the communication difficulties that some people who are deaf or have hearing loss with multiple needs, such as learning disabilities or dementia, may face during audiology assessments. Research shows that hearing loss can complicate the symptoms of dementia for example by making communication more difficult and in some cases hearing loss can even be misdiagnosed as dementia due to the appearance of similar symptoms.[67] Please refer to comment 4. **The following recommendation should be added to section 1.7:** **"*Ensure the format of audiology assessments are suitable for people with diagnosed or suspected dementia, mild cognitive impairment or learning (intellectual) disabilities and provide specialist support, if needed. For example, this could include onward referral to an Ear, Nose and Throat (ENT) department or a multi-disciplinary assessment."*** The provision of communication support and accessible information is also crucial for ensuring people with disabilities and sensory loss can participate fully in discussions about their treatment and care. Section 1.7 should explicitly reference the requirements of NHS England's Accessible Information Standard,[68] as this provides clear guidance for NHS and adult social care providers on how to improve the accessibility of their services for people with disabilities and sensory loss.

[67] Boxtel van, Beijsterveldt van, Houx PJ, et al. (2000). Mild hearing impairment can reduce verbal memory performance in a healthy adult population, Journal of Clinical and Experimental Neuropsychology, 22(1):147-54; Burkhalter CL, Allen RS, Skaar DC, et al. (2009). Examining the effectiveness of traditional audiological assessments for nursing home residents with dementia-related behaviors, Journal of American Academic Audiology, 20 (9):529-38.

[68] NHS England (2017). Accessible Information Standard. DCB 1605. To find out more, please visit www.england.nhs.uk/accessibleinfo

				The following sentence should be added to Section 1.7: ***"Follow the principles of NHS England's Accessible Information Standard to ensure people with disabilities and sensory loss get the support they need to communicate well and understand information"***
12.	Short	10	11-26	**We welcome the recommendations on the principles on tailoring healthcare services for each person and enabling people to actively participate in their care.** **Question 1:** This recommendation will impact the way some staff currently communicate with patients with hearing loss in GP surgeries. [redacted] In addition, research from Action on Hearing Loss's *'Nursing Practice Project'*[70] identified that issues with hearing loss and communication were also very common in elderly care wards. Of the 33 patients who took part in the research, 71% stated that they did not fully understand what staff were saying and 43% felt that they were not fully involved in decision-making regarding their care. The staff who were questioned also stated that they experienced difficulty communicating with patients, possibly due to hearing loss. **Question 3:** [redacted]

[69] Action on Hearing Loss. (2018). *Forthcoming*

[70] Action on Hearing Loss and Heart of England NHS Foundation Trust. (2014). Caring For Older People with Hearing Loss. A toolkit for change. London: Action on Hearing Loss

				[redacted] [redacted] Users working in secondary care should refer to Action on Hearing Loss's nursing practice toolkit to ensure people with hearing loss receive high quality care in hospitals. The toolkit provides recommendations and resources, based on the findings from our research undertaken in a hospital elderly care assessment unit.[70] ***Text within this comment has been redacted as the research referred to is currently under embargo and is due to be published in February 2018.***
13.	Short	11	General	**We welcome that the draft guideline provides an outline on putting the guideline into practice, which includes tools and resources.** **Question 1**: A key challenge arises from ensuring that commissioners are informed of the benefits to their local population and cost benefits of implementing the NICE guidelines for hearing loss. Anecdotally, following engagement with commissioners, some have highlighted that there may be some reluctance to implement the entire NICE guideline for hearing loss due to the perceived cost implications of doing so. We have also seen such reluctance in the implementation of the national Commissioning Framework for Adult Hearing Services. In the instance of urgent and routine referrals it is imperative that commissioners are informed of the long term benefits and reduced morbidly for people who require urgent referral if recommendations are implemented, as well as cost savings. **Question 3:** Organisations such as The British Society of Audiology (BSA), British Academy of Audiology (BAA) and British society of hearing aid Audiologists (BSHAA) as well as NHS England can play a significant role in overcoming the challenge of putting the guidelines into practice, and ensuring that the NICE guideline for hearing loss are disseminated and used widely. These organisations too can help share good practice and case study examples of services who have undergone or implemented change as a result of the publication of the NICE guideline for hearing loss. In the instance of urgent referrals it is imperative that audiologists are informed of the dangers of not implementing these recommendations and delaying the urgent care that some individuals may require which may lead to increased

[71] NHS England (2017). Accessible Information Standard. DCB 1605. To find out more, please visit www.england.nhs.uk/accessibleinfo

				morbidity and poor long term outcomes. **Tools and resources within this section should also include the Action Plan on Hearing Loss, the Commissioning Framework for Adult Hearing Loss Services and the JSNA guidance. Please refer to comment 6.**
14.	Short	14 - 17	General	**The recommendations for research should also include a randomised controlled trial (RCT) on screening adults for hearing loss. Please refer to comment 2.**
15.	Short	14-17	General	**The recommendations for research should include assessment on the levels of awareness of hearing loss in primary care.** In the UK, information on the causes, diagnosis and management of hearing loss is readily available for GPs, including guidance in the Royal College of GP's (RCGP) curriculum,[72] information and good practice guidance on GP notebook,[73] patient.co.uk,[74] medical journals,[75] as well as online training through e-learning modules run by the British Medical Journal (BMJ)[76] and e-GP.[77] However, there is less information for GPs on the full impacts of hearing loss, for example on communication, social participation, employment, dementia and mental health. Although, some reference is made to these in the RCGP curriculum[78] and a wide variety of information and research is available through charities such as Action on Hearing Loss.[79] It is likely that there is a lack of awareness, specifically about the diagnosis and management of hearing loss, and the latest research.
16.	Short	15	20	**The use of hearing aids and incidence of dementia is an important research recommendation which should be**

[72] RCGP. (2015). RCGP Curriculum: Professional and Clinical Modules. Available at: www.rcgp.org.uk/~/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-3-15-ENT-Oral-and-Facial-Problems.ashx
[73] Gpnotebook.co.uk. (2018). hearing loss - General Practice Notebook.Available at: http://www.gpnotebook.co.uk/simplepage.cfm?ID=1208352773
[74] Patient.info. (2018). Hearing Problems. Common hearing problems; Information.Available at: https://patient.info/health/hearing-problems ; Patient.co.uk. (2018). Presbyacusis (Hearing Loss of Older People) | Health. Available at: http://www.patient.co.uk/health/presbyacusis-hearing-loss-of-older-people
[75] Schwartz SR. (2017). Assessment of hearing loss. BMJ Best Practice. Available at: http://bestpractice.bmj.com/topics/en-gb/434
[76] Hall C, Rolfe C. (2011). Hearing loss and tinnitus in adults: a guide for GPs. BMJ Learning. Available: http://learning.bmj.com/learning/module-intro/hearing-loss-and-tinnitus-in-adults--a-guide-for-gps-.html?moduleId=10029379 ; Edmiston R, Mitchell C. (2013) Hearing Loss in Adults. BMJ. 346 doi: https://doi.org/10.1136/bmj.f2496
[77] e-Learning for Healthcare. (2018). e-Learning for Healthcare. Available at: https://www.e-lfh.org.uk/
[78] RCGP. (2015). RCGP Curriculum: Professional and Clinical Modules. Available at: www.rcgp.org.uk/~/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-3-15-ENT-Oral-and-Facial-Problems.ashx
[79] Actiononhearingloss.org.uk. (2018). Publications. Available at: https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/ ; Actiononhearingloss.org.uk. (2018). Policy research and influencing. Available at: https://www.actiononhearingloss.org.uk/you-can-help/campaigns-and-influencing/policy-research-and-influencing/

				prioritised. The significance of this research area is recognised by the James Lind Alliance, Priority Setting Partnership on Mild and Moderate Hearing Loss, which identifies the effect of early fitting of hearing aids on the rate of cognitive decline as a key research question.[80] Current evidence shows that hearing loss is the largest modifiable risk factor for dementia.[81] Although existing evidence on the association between hearing aids and cognition is limited, it suggests a positive association. For example, a prospective study by Amieva et al (2015) showed no difference in the rate of change in MMSE score over the 25 year follow up period in participants with hearing loss using hearing aids compared to the control group (participants without hearing loss). In contrast, participants with hearing loss who did not use hearing aids declined more rapidly on the MMSE than the control group, the findings suggest that hearing aid use decreases cognitive decline.[82] Findings from Dawes et al (2015) study showed hearing aids to be associated with better cognition, which was independent of social isolation and depression. Suggesting that positive effects of hearing aid use on cognition may be due to improvements in audibility or associated increases in self-efficacy, rather than social isolation or depression.[83] Furthermore, in a cohort study by Deal et al (2015) decline in cognitive function was found to be greatest among participants who did not wear hearing aids then compared to those who did.[84] This research recommendation is particularly important in light of the recent proposals to decommission hearing aid provision across the country by several CCGs (Please refer to comment 6). The need to understand the association between hearing loss and incidence of dementia is imperative for reducing inequalities in health.
17.	Short	16	14	**The prevalence of hearing loss among populations who under-present is a key research recommendation which should be prioritised. This should include those who are particularly disadvantaged due to their health issues which may lead to a lack of awareness of their hearing loss, or failure to seek help.** This includes individuals with learning (intellectual) disabilities, dementia and mild cognitive impairment. Unaddressed hearing loss is a significant problem in the UK. Despite proven and effective interventions being available which can restore quality of life, many people experiencing hearing loss do not seek medical advice and remain undiagnosed. Typically, people who are referred to hearing assessment are aged in their mid-70s and on average wait 10 years from the initial onset of hearing loss until they seek medical advice. It is estimated that only two million people have hearing

[80] James Lind Alliance. (2018). Mild to Moderate Hearing Loss Top 10. Available at: http://www.jla.nihr.ac.uk/priority-setting-partnerships/mild-to-moderate-hearing-loss/top-10-priorities.
[81] Livingston G, Sommerlad A, Orgeta V, et al (2017) Dementia prevention, intervention, and care. The Lancet.16;390(10113):2673-2734. doi: 10.1016/S0140-6736(17)31363-6
[82] Amieva H, Ouvrard C, Giulioli C, et al. (2015). Self-Reported Hearing Loss, Hearing Aids, and Cognitive Decline in Elderly Adults: A 25-Year Study. Journal of the American Geriatrics Society, 63(10):2099-2104.
[83] Dawes P, Emsley R, Cruickshanks K, et al. (2015). Hearing Loss and Cognition: The Role of Hearing Aids, Social Isolation and Depression. PLOS ONE, 10(3), p.e0119616.
[84] Deal J, Sharrett A, Albert M, et al. (2015). Hearing Impairment and Cognitive Decline: A Pilot Study Conducted Within the Atherosclerosis Risk in Communities Neurocognitive Study. American Journal of Epidemiology, 181(9):680-690.

				aids out of the six million who have hearing loss which is significant enough to benefit from hearing aids in England, suggesting that there is a significant unmet health need.[85] In addition, the Davis, et al (2007) study shows that the ability to adapt to and manage hearing loss becomes increasingly difficult the older people are when they present for assessment and intervention.[85] Highlighting that earlier identification and intervention would ensure that individuals are supported to manage their hearing loss at an age when they are likely to benefit the most.[85]
18.	Full	General	General	**The evidence presented in the full version of the guideline should include recent evidence on the association between hearing loss and dementia. This should be included within the introduction and throughout the document. Please refer to comment 2.**
19.	Full	18	3-27	**This section should include the wider costs of hearing loss. The economic burden of hearing loss consist of factors wider than solely the costs related to unemployment, it also includes the costs related to the use of health and social care services and the monetary value of the lost quality of life.** Findings from The Ear Foundation (2014) show the financial cost of hearing loss to society to be approximately £136 million per annum in 2013, this includes approximately £76 million per annum associated with additional use of GP services and £60 million associated with additional use of social care services. Furthermore the report estimates the net burden of illness in terms of reduced quality of life associated with hearing impairment to be approximately £26 billion in 2013.[86]
20.	Full	18	34	**The statement that the AQP (any qualified provider) scheme means that people have choice of services is misleading.** Although the AQP scheme was introduced by the Government to extend patient choice, in reality this has not always been the consequence. In some parts of England, such as North Staffordshire, the AQP policy has led to a single provider, resulting in a lack of choice for patients.[87] Furthermore, findings from Monitor's research on NHS adult hearing services in England[88] found lack of awareness of choice among patients, with fewer than one in four respondents surveyed who said that they were aware that they

[85] Davis A, Smith P, Ferguson M, et al. (2007). Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. Health Technology Assessment:11(42).
[86] Archbold S, Lamb B, O'Neill C, Atkins J. (2014). The Real Cost of Adult Hearing Loss: reducing its impact by increasing access to the latest hearing technologies. The Ear Foundation.
[87] North Staffordshire Clinical Commissioning Group. (2017). Request for information under the Freedom of Information Act 2000
[88] Monitor. (2015). NHS adult hearing services in England: exploring how choice is working for patients. London: Monitor

				could choose their provider before visiting their GP. The research also showed that very few patients were offered choice by their GPs at the point of referral. Interviews conducted with GPs suggested that GP knowledge of providers and service quality was extremely limited. Some GPs reported that they were unaware that commissioners have introduced choice, and that patients are entitled to choose their provider. The interviews also suggested that some GPs are often unable to identify most providers in the area.
21.	Full	18	39-42	**The recommendation not to use pure tone audiometry classifications as the sole determinant for hearing support provision is welcomed.** **Question 1:** This recommendation may be perceived as a challenge by CCGs who wish to make cost savings. And is particularly significant in light of the proposals made by several CCGs across the country to decommission hearing aids for people with mild and moderate hearing loss, despite the extensive clinical evidence, professional opinion and national policy prioritising hearing loss, as detailed in comment 6. Under these proposals people with mild hearing loss would not receive hearing aids, and those with moderate hearing loss would need to undergo an eligibility test. The effects of "mild" and "moderate" impairments on someone's hearing can often be underestimated in terms of the impact that this will have on the individual's ability to communicate in real life situations. A high proportion of vowels and consonants are lost with mild and moderate hearing loss, making speech unclear and difficult to understand. Given that a typical conversation is heard around 60dBHL,[89] someone with a mild hearing loss will hear speech at a much reduced volume, which may sound like a whisper, and someone with moderate hearing loss will barely hear what is being said even in a quiet situation. Where there is background noise this will make hearing even more difficult, and often impossible. Hearing aids provide amplification of sounds, making lost speech and environmental sounds audible without making them uncomfortably loud to the wearer. Although audiometry is a vital part of a hearing assessment, it is only a measure of hearing sensitivity and is not the only factor that should be used to determine the management and rehabilitation of someone with a hearing loss; including the provision of hearing aids. As well as the level of a person's hearing loss, there are a range of other factors (auditory and otherwise) involved in the clinical assessment that determine appropriateness of hearing aid provision, requiring case-by-case, patient-centred judgement. **Question 3:** To help CCGs overcome challenges they should follow national strategy and guidance detailed in comment 6.

[89] American Speech Language Hearing Association. (2014). Making effective communication, a human right, accessible and achievable for all. Available at: http://www.asha.org/public/hearing/noise/

22.	Full	19	3-5	This section acknowledges that in some areas of the country some adults are offered one hearing aid rather than two. Although, several factors need to be taken into account when deciding to fit one or two hearing aids, such as degree of hearing loss, lifestyle and individual preference, this section should highlight that issuing only one hearing aid to anyone whose hearing loss affects their communication that could benefit from two, or denying NHS hearing aids for hearing loss described as mild and moderate, is bad practice. Hearing aids are the only viable treatment option for mild and moderate hearing loss,[90] and evidence, including randomised controlled trials and systematic reviews, show the benefits of hearing aids for people with mild and moderate hearing loss, including improved communication, mental health, quality of life, and an increased ability to stay in work.[91] Research also shows that patients whose hearing is deteriorating with age find it easier to adapt to hearing aids and gain greater benefits the earlier they are fitted,[92] so it is important that people are given hearing aids when they have mild hearing loss. Without hearing aids, mild and moderate hearing loss lead to communication difficulties and are shown to lead to social isolation, which poses serious risks to mental health.[93] Research shows that mild and moderate hearing loss significantly increase the risk of developing depression, anxiety and other mental health issues. Despite the extensive clinical evidence, professional opinion and national policy prioritising hearing loss, CCGs across the country still continue to propose restrictions on hearing aid provision for people with mild and moderate hearing loss. Please refer to comment 6. **The section should also highlight that offering two hearing aids to adults with hearing loss in both ears is best practice. Please refer to comment 7**.
23.	Full	22	7	**Section 3.3.3 'Relationships between the guideline and other NICE guidance' should include additional related guidelines such as the following:**

[90] Chisolm TH, Johnson CE, Danhauer JL, et al. (2007). A systematic review of health-related quality of life and hearing aids: Final report of the American Academy of Audiology task force on the health-related quality of life benefits of amplification in adults. Journal of American Academy of Audiology 18:151-83

[91] Yueh B, Souza PE, McDowell JA, et al. (2001). Randomized trial of amplification strategies. Archives of Otolaryngology Head & Neck Surgery,127(10):1197-204; Cacciatore F, Napoli C, Abete P, et al. (1999). Quality of life determinants and hearing function in an elderly population: Osservatorio Geriatrico Campano Study Group. Gerontology 45:323-323; Mulrow CD, Aguilar C, Endicott JE, et al. (1990). Quality-of-life changes and hearing impairment. A randomized trial. Annals of Internal Medicine, 113(3):188-94; Chisolm TH, Johnson CE, Danhauer JL, et al. (2007). A systematic review of health-related quality of life and hearing aids: Final report of the American Academy of Audiology task force on the health-related quality of life benefits of amplification in adults. Journal of American Academy of Audiology 18:151-83; Kochkin S. (2005) The impact of untreated hearing loss on household income. Better Hearing Institute; Matthews. (2011). Unlimited potential: a research report into hearing loss in the workplace. London: Action on Hearing Loss

[92] Davis A, Smith P, Ferguson M, et al. (2007). Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. Health Technology Assessment, 11:1–294

[93] Gopinath B, Hickson L, Schneider J, et al. (2012). Hearing-impaired adults are at increased risk of experiencing emotional distress and social engagement restrictions five years later. Age and Ageing, 41(5):618–623; Pronk M, Deeg DJ, Smits C, et al. (2011). Prospective effects of hearing status on loneliness and depression in older persons: identification of subgroups. International Journal of Audiology, 50(12):887-96

				• Dementia: supporting people with dementia and their carers in health and social care. (2006). NICE guideline [CG42] [94] Hearing impairment can adversely affect performance on cognitive testing. The most commonly used test to determine cognitive status, the Mini-Mental State Examination (MMSE), requires the patient to be able to fully hear what is being asked.[95] Jorgensen et al (2016) study found that reduced audibility significantly reduces scores on the MMSE, resulting in greater apparent cognitive deficits as audibility decreased. Although the NICE guideline CG42 (2006) Section 1.4.1.3 states that those interpreting test scores should take full account of other factors known to affect performance including any sensory impairments, section 1.4.1.1 should also explicitly state that hearing screening should be included as part of the assessment process for the diagnosis of dementia. • Tinnitus. NICE guideline in development (2020)[96] Tinnitus affects 10% of the UK population,[97] it is often not diagnosed, and is more common in people who have hearing loss or other ear problems.[98] Research highlights that 9 out of 10 people with tinnitus will also have some degree of hearing loss.[99] Tinnitus cannot be cured, but hearing aids are an important part of its management, a significant body of evidence suggests that for many people hearing aids reduce the effects of tinnitus.[100] Recent research shows

[94] NICE (2006). Dementia: supporting people with dementia and their carers in health and social care. Clinical guideline [CG42]. Available at: https://www.nice.org.uk/guidance/cg42
[95] Alzheimer's Society. (2017). The MMSE. Available at: https://www.alzheimers.org.uk/info/20071/diagnosis/97/the_mmse_test.
[96] NICE. (2020). Tinnitus *Forthcoming*
[97] Davis and El Refaie (2000) The epidemiology of tinnitus. In Tyler (ed.) The Handbook of Tinnitus p1 - 23
[98] Culhane BA. (2014). All About Tinnitus, version 1.5. British Tinnitus association. Available at: https://www.tinnitus.org.uk/Handlers/Download.ashx?IDMF=f293c6c7-a16f-4542-81e2-992c3d6076a6
[99] Davis and El Refaie. (2000). The epidemiology of tinnitus. In Tyler (ed.) The Handbook of Tinnitus p1 - 23
[100] Saltzman M, Ersner MS. (1947). A hearing aid for the relief of tinnitus aurium. Laryngoscope, 57: 358 -366; Vernon J. (1977). Attempts to relieve tinnitus. Journal of the American Audiology Society, 2(4): 124-31; Stacey JS. (1980). Apparent total control of severe bilateral tinnitus by masking, using hearing aids. British Journal of Audiology, 14(2):59-60; Surr RK, Montgomery AA, Mueller HG, et al. (1985). Effect of amplification on tinnitus among new hearing aid users. Ear and Hearing, 6(2):71-5; Melin L, Scott B, Lindberg P, Lyttkens L. (1987). Hearing aids and tinnitus-an experimental group study. British Journal of Audiology, 21(2): 91-7; Trotter and Donaldson (2008) Hearing aids and tinnitus therapy: a 25-year experience. Journal of Laryngology and Otology, 122(10): 1052-6.

				that providing open fit digital hearing aids to those with mild to moderate high frequency loss made a significant clinical improvement to their tinnitus.[101] There is evidence to support that bilateral hearing aids are more effective at reducing the difficulties associated with tinnitus than unilateral aiding.[102] • Falls in older people: assessing risk and prevention. (2013). NICE guideline [CG161] [103] Hearing is important in maintaining balance, recognising spatial orientation and avoiding environmental hazards which may lead to falls.[104] The risk of falling has been identified to increase in those with hearing loss. A systematic review by Jiam et al (2016) found that hearing loss is associated with a significantly increased odds of falling in older adults.[105] A study on older female twins found that poor hearing was significantly associated with a higher risk of falls after controlling for shared genetic and environmental factors.[104] • Stroke rehabilitation in adults. (2013). NICE guideline [CG162][106] Evidence suggests that there may be a high prevalence of hearing loss among stroke patients.[107] Since, hearing plays a crucial role in the effective communication between patients and healthcare professionals,[108] hearing impairment may restrict patients from participating fully in rehabilitation programs, resulting in functional decline.[109] **The following guidelines for older people should also be included:** • Mental wellbeing of older people in care homes. (2013). Quality standard [QS50][110]

[101] Byrom. (*Forthcoming*). Tinnitus, hearing aids and mild hearing loss. MSc Thesis, awaiting publication
[102] Brooks DN, Bulmer D. (1981). Survey of binaural hearing aid users. Ear and hearing, 2(5):220-224
[103] NICE. (2013) Falls in older people: assessing risk and prevention. NICE guideline [CG161]. Available at: https://www.nice.org.uk/guidance/cg161
[104] Viljanen A, Kaprio J, Pyykko I, et al. (2009). Hearing as a Predictor of Falls and Postural Balance in Older Female Twins. The Journals of Gerontology Series A: Biological Sciences and Medical Sciences, 64A(2):312-317.
[105] Jiam NT, Li C, Agrawal Y. (2016). Hearing loss and falls: A systematic review and meta-analysis. Laryngoscope, 126(11):2587-2596.
[106] NICE. (2013). Stroke rehabilitation in adults. Nice guideline [CG162]. Available at: https://www.nice.org.uk/guidance/cg162
[107] Edwards DF, Hahn MG, Baum CM, et al. (2006). Screening patients with stroke for rehabilitation needs: validation of the post-stroke rehabilitation guidelines. Neurorehabilitation and Neural Repair, 20(1):42-48. doi: 10.1177/1545968305283038; Formby C, Phillips DE, & Thomas, RG. (1987). Hearing loss among stroke patients. Ear Hear, 8(6):326-332; O'Halloran R, Worrall LE, & Hickson L. (2009). The number of patients with communication related impairments in acute hospital stroke units. Int J Speech Lang Pathol, 11(6):438-449. doi: 10.3109/17549500902741363
[108] Bensing J. (2000). Bridging the gap. The separate worlds of evidence-based medicine and patient-centered medicine. Patient Education and Counseling, 39(1):17-25.
[109] Landi F, Onder G, Cesari M, et al. (2006). Functional decline in frail community-dwelling stroke patients. Eur J Neurol, 13(1):17-23. doi: 10.1111/j.1468-1331.2006.01116.x
[110] Mental wellbeing of older people in care homes. (2013). Quality standard [QS50]. Available at: https://www.nice.org.uk/guidance/qs50

				• Older people with social care needs and multiple long-term conditions. (2015). NICE guideline [NG22][111] • Older people: independence and mental wellbeing. (2015). NICE guideline [NG32][112] • Home care: delivering personal care and practical support to older people living in their own homes. (2015). NICE guideline [NG21][113] • Social care for older people with multiple long-term conditions. (2016). Quality standard [QS132][114] • Home care for older people. (2016). Quality standard [QS123][115]
24.	Full	50	10-15	**We welcome the questions identified by the committee as high priority questions for original heath modelling.** *"What is the clinical and cost effectiveness of early versus delayed management of hearing loss on patient outcomes?"* - **Please refer to evidence cited in comments 2 and 3.** *"What is the clinical and cost effectiveness of hearing aids for mild to moderate hearing loss in adults who have been prescribed at least 1 hearing aid?* - **Please refer to evidence cited in comment 6**. *"What is the clinical and cost effectiveness of fitting 1 hearing aid compared with fitting 2 hearing aids for people when both ears have an aidable hearing loss?* - **Please refer to evidence cited in comment 7.**

[111] Older people with social care needs and multiple long-term conditions. (2015). NICE guideline [NG22]. https://www.nice.org.uk/guidance/ng22

[112] Older people: independence and mental wellbeing. (2015). NICE guideline [NG32]. Available at: https://www.nice.org.uk/guidance/ng32

[113] Home care: delivering personal care and practical support to older people living in their own homes. (2015). NICE guideline [NG21]. Available at: https://www.nice.org.uk/guidance/ng21

[114] Social care for older people with multiple long-term conditions. (2016). Quality standard [QS132]. Available at: https://www.nice.org.uk/guidance/qs132

[115] Home care for older people. (2016). Quality standard [QS123]. Available at: https://www.nice.org.uk/guidance/qs123

25.	Full	54	12-16	**We welcome that the draft NICE guideline for hearing loss clearly sets out the recommendations for when to refer adults with sudden or rapid onset hearing loss that require urgent or routine referral.** Anecdotally, we have received some reports from individuals delaying treatment for sudden onset hearing loss because it were believed that the underlying cause was a common cold or flu causing congestion. Subsequently, the issue was not treated urgently and the individual was later diagnosed with sensorineural hearing loss. The draft NICE guideline recognises that there are 'several clinical guidelines for GPs and audiologists outlining the circumstances in which they should consider referral for more specialist medical care, for example, the British Academy of Audiologists' Guidance for Audiologists and for Primary Care which reflect a broad clinical consensus. Whilst most of the recommendations made reflect current practice, there remains variation and not all clinicians would currently be aware of all the signs and symptoms, which lead to an urgent referral. The NICE guidelines for hearing loss will help to overcome these variations by setting out clear national guidance.
26.	Full	57	General	**We welcome that definitions for 'immediate' and 'urgent' referral times have been included in the guideline.** **Question 1:** A challenge and significant requirement for the guideline to be implemented and work successfully, is ensuring that adequate training is provided for those working in primary, secondary and tertiary care on the symptoms that should be recognised as needing 'immediate' and 'urgent' care. **Question 3:** Triaging of referral letters into audiology and ENT is important. To help overcome challenges, staff involved in triaging should be trained to recognise 'red flags' that indicate signs and symptoms as detailed in referral letters that require urgent and complex care. This will help to mitigate any delay in treatment by helping to ensure people are referred to the right place at the right time, and avoid inconvenience for the patient; wasted appointment times and cost. In the case of urgent care required, the impacts can be devastating if someone is not referred to the right place in the first instance. We welcome that the BAA guidelines for audiologists have been referred to, however, where there are local variations in practice and where some clinicians may not be aware that all of these signs and symptoms should lead to an urgent referral, the British Society of Audiology (BSA) and British Academy of Audiology (BAA) can also play a role in helping to ensure that audiologists are educated on these guidelines and the signs and symptoms that require urgent care. Please refer to comment 13.
27.	Full	58	General	**We welcome that the draft guideline includes the recommendation within the 'other considerations' section that a checklist or table of signs and symptoms should be produced for health professionals.**

				Question 1: It may be challenging to ensure that primary healthcare staff and audiologists are adequately trained to recognise all of the signs and refer to the appropriate specialist within the correct time frame. Our *'Under Pressure'* report shows that NHS audiology services are under significant pressure, with 41% offering patients a reduced service because of reduced budgets or increased demand.[116] In England, 15% of NHS services said that they have seen a reduction in the overall number of staff; 6% have reduced average qualification level of professional staff and 6% reduced number or qualification level of specialist staff for complex cases.[116] Therefore implementation of the NICE guidelines and in particular, where training is required to ensure staff are aware of what signs and symptoms require urgent referral could be challenging in some local areas.
28.	Full & Short	General	General	**We recommend that the NICE guideline for hearing loss is included within the RCGP curriculum as well as the Action Plan on Hearing Loss and the Commissioning Framework for Adult Hearing Loss Services to provide GPs with more information about the impacts of hearing loss; the benefits of addressing hearing loss early and accessing support and management that is available on the NHS.** The standard of training and education of GPs is monitored by the General Medical Council (GMC), and the curriculum and assessment are developed by RCGP, but the content of GP training is determined locally by individual Deaneries, Local Education, and Training Boards, and so varies across the UK. The RCGP curriculum for the 'Care of People with ENT, Oral and Facial Problems' gives examples of how to apply the competencies a GP needs to have to cases of people with hearing loss. For example, it states that doctors should ensure they can communicate with the patient, that they should "appreciate the impact of hearing loss on quality of life", including its "isolating effect", and that they should find out and gain experience of the services available for people with hearing loss.[117] However, GPs may have little specific training on diagnosing and managing hearing loss, and they may not know the latest research, such as on the link between hearing loss and dementia. The RCGP curriculum provides very little detail in these areas, and apart from a link to ENT UK and a link to a website with one e-learning module, it does not reference any other information or guidance.
29.	Full	61	General	**We welcome that the guideline states *"wax removal may be an urgent requirement in order to exclude this as***

[116] Lowe C. (2015). Under Pressure. London: Action on Hearing Loss. Available from: https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/under-pressure-report/

[117] RCGP. (2015). RCGP Curriculum: Professional and Clinical Modules. Available at: www.rcgp.org.uk/~/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-3-15-ENT-Oral-and-Facial-Problems.ashx

				the cause of hearing loss and avoid delay in treatment of underlying pathology". **This should be included in the section 'Management of ear wax' of the guideline to ensure that any urgent causes of hearing loss can be investigated and treated appropriately without delay due to excess wax.**
30.	Full	75-76	General	**We welcome that section 6.2.4 within the guideline states that "*the consequence of missing a patient with vestibular schwannoma could result in increased morbidity*".** The guideline clearly sets out the recommendation for referral of someone who presents with symptoms or audiometry test results that could indicate vestibular schwannoma or CPA lesions. These do not differ from current recommendations as specified within the Department of Health criteria. It is also welcomed that other symptoms or signs are noted as *"a strong recommendation based on the potential harms of not referring in these cases."* **Question 1:** The main concern is the local variations and in particular, where services are under referring, the challenge will be in influencing audiology, ENT and radiology to implement any changes as this will increase cost but will be clinically beneficial.
31.	Full	78	15-18	**This section should also make reference to the recent Lancet Commission (2017) on dementia prevention, intervention, and care.[118]** The commission identifies hearing loss to be the largest modifiable risk factor for dementia in middle age, and calls for better management and prevention strategies of hearing loss and other risk factors to reduce the burden of risk.[118] Please refer to comment 2.
32.	Full	78	19-25	**This section should acknowledge the diagnostic challenge of dementia which may arise from the presence of hearing loss. Please refer to comment 4.**
33.	Full	78	8-12	**We welcome the recommendation from the Down's Syndrome Medical Interest Group drafted guidelines that hearing assessment should be carried out every two years, however it is noted that it is unclear what happens in practice when a child transitions into adult services.** This is concerning as the guideline states that *"individuals with Down's Syndrome are at a risk of developing a high frequency hearing loss from the second or third decade even if hearing has been good when younger".* **Question 1:** Challenges arise here, particularly if a young adult is not already under the care of audiology – some may not be able to communicate that they have hearing difficulties or know how to get a referral for support. We therefore welcome that the guideline later states that it is important to conduct hearing assessment and review on a regular basis for those with mild, cognitive impairment, dementia, and learning disabilities.

[118] Livingston G, Sommerlad A, Orgeta V, et al (2017) Dementia prevention, intervention, and care. The Lancet.16;390(10113):2673-2734. doi: 10.1016/S0140-6736(17)31363-6

34.	Full	79	General	**The research recommendation to investigate whether hearing aids reduce the incidence of dementia in adults with hearing loss is welcomed. Please refer to comment 2 and 4.**
35.	Full	81	General	**We welcome the recommendation that hearing assessments are carried out by trained audiologists in an appropriately sound-treated room when assessing people who have learning disabilities or additional needs, as opposed to relying on results of assessments carried out in GP surgeries alone.** **Question 1:** This recommendation may be challenging to implement since some checks are carried out in primary care and the standard of care is likely to vary. One study found that the format of hearing checks carried out in GP surgeries are often inappropriate for people with learning disabilities.[31] Some GPs who were interviewed as part of this study were also reluctant to refer people with learning disabilities for a hearing test, due to misconceptions that diagnosis and treatment would be ineffective. GPs should be adequately trained to ensure that the format of primary care hearing assessments are suitable for people with learning disabilities (please refer to comment 28). People with learning disabilities should be provided with appropriate support to communicate well and understand information, in line with the Accessible Information Standard.[32] In addition, as detailed in comment 27 audiology services are under pressure with budget cuts to services, which includes a reduction in staff as well as reduced number or qualification level of specialist staff for complex cases. **Question 3:** To overcome challenges in implementing this recommendation users should refer to the Commissioning framework for Adult Hearing Loss Services[119] which states that *"the provider will need to have systems in place to accommodate services users who have sight loss/dual sensory loss; have learning disabilities and or require domiciliary care."* The framework also *states "Commissioners should seek assurance that providers have the necessary qualifications, skills and equipment to accommodate these client groups."*
36.	Full	97	General	**We welcome that the guideline states that an example of what comprises an audiological assessment is provided in the assessment guidance, set out in the NHS Standard Contract for adult hearing aid services.** **Question 1:** However, following engagement with CCGs, Action on Hearing Loss recognise that there are local variations in the use of outcome measures. In particular, the use of 'validated self-report instruments' vary. In some areas, CCGs do not seem to fully understand what is detailed within local audiology contracts, including what 'validated self-report instruments' are listed as requirements of the service; even where these are within local contracts, outcomes are not being reported to the CCG.

[119] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

				Question 3: The Commissioning Framework for Adult Hearing Loss Services[120] sets out recommendations for hearing services. In particular, the Framework states that *"contracts for hearing services that do not include service specifications and outcome measures should be avoided".* The Framework also recommends that commissioning hearing aids services should be outcomes focused, which will *"have a positive impact in terms of access, choice, quality and other related outcomes that benefit the services user and assure CCGs that services are providing good value for money".*[120]
37.	Full	130	General	**We welcome that the guideline states in section 10.3.4 that wax removal services should be encouraged in primary and community care settings as long as there are health professionals trained to carry out the procedure and the right equipment available.** Anecdotally, we have heard reports of there being confusion about what wax removal services are available locally and what is most suitable for an individual needing to get their wax removed. We have received reports of limited or no access within primary care to wax removal services. However, as the guideline states this may be due to confusion about ear syringing, which is no longer recommended as a procedure and individuals not receiving information about other wax removal services available.
38.	Full	130-131	General	**We welcome that the guideline states in section 10.3.4 that *"referring people to ENT services for simple cases of wax removal would not be an appropriate use of ENT resources"* but that clear criteria for accessing microsuction services should be developed.** This is an important recommendation and should be highlighted, since**,** worryingly, we have been informed of several CCGs proposing to stop providing microsuction services. Which could be due to too many people being referred inappropriately for microsuction, when they would benefit from wax removal in primary care as a non-complex wax case. A clear criteria would help overcome this challenge. In January 2017, Wirral and Cheshire CCG proposed to stop providing microsuction services in ENT because too many people were being referred into the service. After consultation with Action on Hearing Loss and other stakeholders, they decided not to go ahead with the proposals and instead introduce a clear criteria for accessing the service for those who have contraindications for wax removal in primary care. This included allowing people to access the service

[120] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

				if other methods of ear wax removal had not been successful. The criteria was agreed by the CCG's governing body. We therefore welcome that the guideline provides a criteria which highlights contraindications that would lead to someone being referred into secondary care for microsuction. The Commissioning Framework for Adult Hearing Loss Services states that wax is a cause of temporary hearing loss and that *"it is very important that a clear local pathway is developed and understood to deal with ear wax before audiological assessment is undertaken, as visits to audiology, prior to wax being checked and removed, are a significant source of inappropriate referrals".* **Question 3:** To help users overcome challenges we recommend that clear local information is provided on what wax removal services are available as well as what may be the most appropriate for an individual wanting to access wax removal services; this should help to mitigate confusion for someone trying to access wax removal services in their area and reduce repeat appointments with the GP, ENT and audiology. A key element is ensuring that GPs and nurses in primary care are well informed about the importance of wax removal for hearing aid users and people attending audiology appointments. In addition, users should refer to the Commissioning Framework for Adult Hearing Loss Services, which clearly demonstrates that individuals should be checked at primary care for wax before someone accesses audiology, and should also be checked by audiologists periodically along the audiology pathway. The Framework includes a case study of Coventry and Rugby CCG where the service was redesigned to introduce direct access hearing care services for people aged 19+. This removed the need to see a GP for referral and also removed the current restrictions as detailed within the AQP implementation pack and ENT acute outpatients' appointments. The service included wax removal, which was previously available in the acute service, and has effective outcomes measures, improves patient experience and enables acute, and community services to operate alongside each other. Many audiology services are training audiologists to carry out wax removal in clinics, which is not only more convenient for individuals receiving care, but also helps mitigate the issues of wax removal services being removed from primary care.
39.	Full	132	20-22	**We welcome that the question *"what is the most clinically and cost effective treatment for idiopathic sudden sensorineural hearing loss (SSNHL)?"* has been reviewed within the guideline.** Whilst it is recommended that sudden onset hearing loss requires urgent assessment, the committee highlights the fact that hearing aid use, audiological rehabilitation and overall management strategies were not considered within this review, which are all very important factors that need to be considered when treating someone with SSNHL.

				Question 3: The Commissioning Framework for Adult Hearing Loss Services[121] lists sudden deterioration and onset (sudden = 72 hours) as one of the contraindications for routine adult hearing aid services. The Framework recommends that 'the definition and service pathway should be made available to service users and referrers to support service users to access the most appropriate service. Complex services should include a clear basis on which service users are returned into the non-specialist care pathway and can benefit fully from the choices available. On a local level, CCGs should work with their audiology, ENT and social care services to develop clear pathways for both routine and non-routine (complex) cases. There are likely to be some cases that require special management and support for their hearing loss and CCGs should encourage services to use evidence and good practice guidance, including case study examples to help ensure that services are delivering the best care they can for all that access the service.
40.	Full	170 -177	General	**Information, support and advice given to adults with hearing loss, and their families and carers should also include information about social care. Please refer to comment 8.**
41.	Full	185	General	**We welcome that the committee *"discussed the importance of having validated tool to support the decision-making process"* within audiology appointments.** The guideline states that some *"decision tools were being marketed for use in the field of hearing loss but noted that these tools have not been validated for this particular use and this specific patient group and therefore may not be fit for purpose."* The Hearing Handicap Inventory for the Elderly (HHIE-S), is a 10-item questionnaire that examines the socio-emotional needs of a person, and has been used for nearly 30 years to monitor and research the impact that hearing loss has on people, and to ensure that support provided is helping them. HHIE-S has been used as a screening tool for hearing loss, but it does not tell the clinician if the patient would benefit from a hearing aid. Someone with a mild hearing loss might have a severe impact recorded on the HHIE-S, and someone with severe hearing loss might have a mild impact – but that does not determine whether they would benefit from a hearing aid. This is the job of the audiologist's assessment and audiogram that they undertake with the patient, so these should be used instead. HHIE-S has never been used as an eligibility 'test' for hearing aid provision or audiology services before. North Staffordshire CCG implemented the use of the HHIE-S as an eligibility test for hearing aids, but it is unclear in practice how it is being used. It is likely an individual will be asked to complete the questions themselves before their audiology appointment, at their GP surgery, either by letter, or in the waiting room. For people who have moderate

[121] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

				hearing loss, this self-assessment, and not the assessment with the audiologist, will then be used to determine whether they get hearing aids. The HHIE-S test has limitations as some of the questions will not be applicable to everyone and therefore would be unfair if determining eligibility for a treatment – if someone is living alone they may not notice if they turn up the TV or radio, or have arguments with family members. There are also wider impacts than these 10 questions can cover – for example on a person's family. Many people will not want to admit that they have these problems, and because of this, they will not be given the hearing aids that they need. Some of these questions will reinforce stigma, and it is also unethical for professionals not to inform patients of the implications of the test beforehand. **The challenge will therefore be ensuring that both audiologists and CCGs are educated in which tools are validated for use in audiology appointments.**
42.	Full	193	General	**We welcome that the guideline states that "*it is a legal requirement for provision to be made such that those with a disability have equality of access to medical services, where possible, and consequently loop systems are generally provided in hospital reception areas".*** In England, all providers of NHS or publicly funded adult social care must meet the legal requirements of the Accessible Information Standard.[122] **Question 1:** This recommendation may be challenging to implement, since evidence from our '*Under Pressure'* report[123] shows that people who are deaf or who have hearing loss might not know that these services are available, and referral routes are often underutilised. These findings are consistent with patient survey results from Monitor's report on NHS adult hearing services in England,[124] which showed that only one in ten respondents surveyed said that they were provided information about additional services and equipment. Providers who were interviewed stated that it is difficult to identify all the other services which are available locally, and that significant investment is needed to build awareness and knowledge of those services. As stated in the full guideline, at present *"liaison between health and social services does not happen routinely and, as a consequence, services are not joined up".* As discussed in comment 54, technology is developing rapidly and the NICE guidelines for hearing loss should take this into consideration. **We recommend adding a research question to "monitor changes in traditional hardware based assistive devices to newer software based solutions in the form of apps on smartphones/tablets."**

[122] NHS England (2017). Accessible Information Standard. DCB 1605. To find out more, please visit www.england.nhs.uk/accessibleinfo
[123] Lowe C. (2015). Under Pressure. London: Action on Hearing Loss. Available from: https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/under-pressure-report/
[124] Monitor. (2015). NHS adult hearing services in England: exploring how choice is working for patients. London: Monitor

				Question 3: Action on Hearing Loss has developed some simple steps for GP practices, hospital and other urgent and emergency care services[125] to help make them more accessible to people with hearing loss and deafness. A recent review of the Accessible Information Standard has found that more work is required to ensure people who are deaf or have hearing loss realise the full benefits of good communication, specifically with regards to hearing loop systems.[126] The review also sets out the implications of the findings for people with hearing loss and our recommendations for future work. We have also developed a nursing practice toolkit for NHS Hospital Trusts, to ensure people with hearing loss receive high quality care in hospitals. The toolkit provides recommendations and resources, based on the findings from our research undertaken in a hospital elderly care assessment unit.[127] Furthermore, our '*Access all Areas'* report[128] shows that, after attending an appointment with their GP, more than a quarter of survey respondents (28%) had been unclear about their diagnosis and over a third (35%) said loop systems were not available. The report recommends GP practices to extend the use of technology that can help improve patient experience for people with hearing loss, such as visual display screens in waiting rooms and induction loop or infrared systems. Our '*A World of Silence'*[129] report also shows that staff in care homes are often unaware of the technology that could help people with hearing loss communicate, such as hearing loops, amplified telephones and personal listeners. The report makes recommendations for carers to help people in care homes with unaddressed and diagnosed hearing loss and improve the quality of care they receive.[130] **As detailed in comment 8 an additional recommendation should be added to this section to encourage audiology services and local authorities to work together to help people who are deaf or have hearing loss access assistive equipment.** Assistive equipment (usually provided by local authority sensory services) can help people who are deaf or have hearing loss communicate well and live safely and independently in their own home, and manage their condition more effectively.

[125] Actiononhearingloss.org.uk. (2018). Accessible Information Standard. Available at: https://www.actiononhearingloss.org.uk/how-we-help/health-and-social-care-professionals/standards-for-accessible-information-and-communication/accessible-information-standard/

[126] Actiononhearingloss.org.uk. (2018). NHS England's Accessible Information Standard review. Available at: https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/consultation-responses/health-and-social-care/nhs-england-accessible-information-standard-review/

[127] Action on Hearing Loss and Heart of England NHS Foundation Trust. (2014). Caring For Older People with Hearing Loss. A toolkit for change. London: Action on Hearing Loss

[128] Ringham L. (2013). Access All Areas. A report into the experiences of people with hearing loss when accessing healthcare. London: Action on Hearing Loss. https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/access-all-areas-report/

[129] Echalier M. (2012). A World of Silence. The case for tackling hearing loss in care homes. London: Action on Hearing Loss. Available from: http://www.actiononhearingloss.org.uk/-/media/ahl/documents/research-and-policy/reports/care-home-report.pdf

[130] Actiononhearingloss.org.uk. (2018). Guidance for residential care homes. Available at: https://www.actiononhearingloss.org.uk/how-we-help/health-and-social-care-professionals/guidance-for-residential-care-homes/

43.	Full	193	General	**We welcome that the guideline recognises that *"liaison between health and social care services does not happen routinely and, as a consequence, services are not joined up".*** It is vital that NHS audiology services and local authorities work together to ensure that social care services for people with hearing loss can be accessed by all people that need it. The Commissioning Framework for Adult Hearing Loss Services [131] states that *"commissioners should be open to new ideas about how to meet needs and deliver services wherever they come from, including working closely with other parts of the health and social care system".* **Question 3:** Users should refer to the JSNA guidance referred to in comment 6.
44.	Full	205	General	**The two paragraphs included in 'other considerations' are welcomed. The decision to fit hearing aids based on need rather than on hearing thresholds and the cost effectiveness of hearing aids should be highlighted in both the long and short versions of the guidelines.** Hearing aids are the only viable treatment option for sensorineural hearing loss,[132] and are extremely cost effective. The NHS spends an average of £398 for all of a person's appointments, two hearing aids and repairs.[133] This small cost per person enables the NHS to deliver huge benefits in terms of quality of life and reduces the need for more costly interventions in future. As summarised by Access Economics (2006), "the literature shows that hearing aids yield significant benefits for relatively low investments",[134] other studies are in agreement that the benefits of providing hearing aids outweigh the costs, and that hearing aids provided through the NHS are cost effective.[135] By contrast, it costs £3,000 on average to purchase a set of hearing aids privately.[136]

[131] NHS England (2016) *Commissioning Services for People with Hearing Loss: A Framework for clinical commissioning groups*. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

[132] Chisholm et al. (2007). A systematic review of health-related quality of life and hearing aids: Final report of the American Academy of Audiology task force on the health-related quality of life benefits of amplification in adults. Journal of American Academy of Audiology, 18:151-183

[133] Monitor and NHS England. (2013). National tariff information workbook 2014/15. Available at: https://www.gov.uk/government/publications/national-tariff-information-workbook-201415

[134] Access Economics. (2006) Listen Hear: The economic impact and cost of hearing loss in Australia. Canberra: Access Economics

[135] Morris et al. (2013). An economic evaluation of screening 60- to 70-year-old adults for hearing loss. Journal of Public Health, 35(1):139 –146; US Preventative Services Task Force. (2012). Screening for hearing loss in older adults: U.S. Preventative Services Task Force recommendation statement. Annals of Internal Medicine, 157(9): 655-661; Action on Hearing Loss / London Economics (2010) Cost benefit analysis of hearing screening for older people. Available at: www.actiononhearingloss.org.uk/supporting-you/policy-research-and-influencing/research/our-research-reports/research-reports-2010.aspx; Chao and Chen. (2008). Cost-effectiveness of hearing aids in the hearing-impaired elderly: a probabilistic approach. Otology and Neurotology, 29(6):776-83; Abrams et al. (2002). A cost utility analysis of adult group audiological rehabilitation: are the benefits worth the costs? Journal of Rehabilitation Research and Development, 39(5):549-558

				Question 3. The Commissioning Framework for Adult Hearing Loss Services should be referenced in this section as a tool to help CCGs design high quality, cost effective audiology services. Please refer to comment 6.
45.	Full & Short	General	General	The draft guideline does not take into account the use of emerging technology such as self-fitting and remote fitting hearing aids and tele-audiology which are suitable for some individuals with non-complex hearing loss. **This should be added into the 'other considerations' section for monitoring and follow up as well as whether such methods are effective as follow ups for people with hearing loss.**
46.	Full	229	General	**We welcome that the draft guidelines for hearing loss states that "*a flexible approach in the delivery of hearing aid services is desirable*" to ensure that those who have difficulty in attending audiology services in person, such as those that live in residential homes and those with learning disabilities can access services.** **Question 3:** Users should refer to the Commissioning Framework for Adult Hearing Loss Services to ensure hearing aid services are accessible to all groups of people. The Framework states that *"it should be the responsibility of the referring clinician and provider to manage between them the appropriateness of referral/treatment according to a person's needs and not automatically exclude them from this service because they have a degree of learning disability or require domiciliary care".*[137] In addition, the Framework also states that *"Commissioners should seek assurance that providers have the necessary qualifications, skills and equipment to accommodate these client groups",* this should include ensuring that providers meet the legal requirements of the Accessible Information Standards.
47.	Full	229	General	**We welcome that the guideline recognises that the ability to use a telephone is one of the issues that needs to be addressed within the follow up, since many hearing aid users struggle on the phone which would impact on the follow up appointment**. **Question 1:** Telephone appointments are not suitable for everyone and would be limiting if the person required hearing aid adjustment or reinstruction which is not possible over the phone. However, this may be challenging to implement when dealing with people who are unable to attend audiology appointments easily, which is not addressed by the guideline.

[136] Which? (2018). Hearing aid prices - Which? Available at: https://www.which.co.uk/reviews/hearing-aid-providers/article/how-to-get-the-best-hearing-aid/hearing-aid-prices

[137] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

48.	Full	229	General	**We welcome that the guideline recognises that "*there is currently no system to recall people for ongoing monitoring and it is up to the individual to self-refer when they need their hearing reassessed or require assistance with their hearing device*".** As detailed within the draft guideline, the recommended procedure is every 3 years for reassessment which is also detailed within the Commissioning Framework for Adult Hearing Loss Services.[137] However, our *'Under Pressure'* report found that only 31% of UK audiology providers automatically recalled people for their reassessment and an annual survey report conducted by RNID (2008) found that people think that they should be recalled for a hearing test.[138] We also welcome that the committee agreed that it is important that *"patients are aware of how to re-access audiology services when needed, and that health professionals update and maintain patient records to facilitate follow up and ongoing monitoring of patients and to improve information sharing between health professionals".* **Question 3:** To avoid local variation across the country, the draft guideline for hearing loss should recommend that whilst further research is required to assess the benefits of ongoing monitoring, including what this should involve, and who it would benefit, the guideline should also recommend that patients are reassessed every 3 years as detailed within the Commissioning Framework for Adult Hearing Loss Services.[139]
49.	Full	231-256	General	**Interventions to support the use of hearing aids also include services provided by the third sector**. This includes, Action on Hearing Loss's '*Hear to Help'* services which provide a range of support for people with deafness, tinnitus and hearing loss in their communities, to enable the continued use of hearing aids. Our '*Hear to Help'* staff and volunteers, carry out minor repairs to hearing aids, and replace batteries, ear moulds and tubing. The service provides training on how to maintain hearing aids, gives information and advice on managing hearing loss, and informs people about services such as lip-reading and hearing therapy. Guidance is also provided on assistive equipment that could benefit people with hearing loss, such as amplified telephones and TV listeners.[140] Services such as '*Hear to Help'*, are crucial in reducing the non-use of hearing aids and ensuring that hearing aids are used effectively. '*Hear to Help'* services are particularly important in enabling services to reach more vulnerable people,

[138] Lowe C. (2015). Under Pressure. London: Action on Hearing Loss. Available from: https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/under-pressure-report/

[139] NHS England, Office of the Chief Scientific Officer. (2016). Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf

[140] Action on Hearing Loss. (2015). Hearing Matters. London: Action on Hearing Loss. Available at: http://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/hearing-matters-report/

				as well as reducing the pressure on audiologists' capacity.[138] Findings from Action on Hearing Loss's '*Under Pressure'* report show that approximately two in five providers (39%) reported that basic hearing aid repairs and replacements were delivered via trained third sector volunteers, such as through Action on Hearing Loss's Hear to Help service.[141]
50.	Full & Short	General	General	As mentioned in comment 2 early identification and management of hearing loss is crucial in tackling the growing public health challenge of hearing loss. **To target those who are at high risk of hearing loss the guideline should recommend hearing assessments to be undertaken as part of the following:** • **Health assessment for older adults** • **Falls risk assessment** • **Assessment after stroke** • **Diagnosis of dementia**
51.	Full	General	General	**The guideline should include recommendations for audiology services to identify patients where hearing aids are contraindicated, not appropriate or unable to provide sufficient benefit**. Patients who are unable to gain benefit from conventional hearing aids may be suitable for hearing implants including: middle ear, cochlear and auditory brainstem implants and bone anchored hearing aids. **The guideline should recommend audiology services to consider onward referral to specialised services when appropriate.** Furthermore, the final scope and the draft guideline identifies the '*Cochlear implants for children and adults with severe to profound deafness' (2009)*[142] and '*Auditory brain stem implants' (2005)*[143] as related NICE pathways. However, it does not refer to access to these treatment options within the recommendations. In addition, this recommendation is within the scope of this guideline since it falls under the areas 'Further assessment of hearing and communication needs' and 'Management of hearing difficulties' covered by the guideline, and therefore should be included. **It is relevant to the sections 'Urgent and routine referral' and 'Monitoring and follow-up', and should be included within these sections.**
52.	Full & Short	General	General	**We welcome mention of how hearing loss affects employment prospects, as outlined in the guidelines introduction. However, we recommend that more emphasis is given to the link between hearing loss and**

[141] Lowe C. (2015). Under Pressure. London: Action on Hearing Loss. Available from: https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/under-pressure-report/
[142] NICE. (2009). Cochlear implants for children and adults with severe to profound deafness. Technology appraisal guidance [TA166]. Available at. https://www.nice.org.uk/guidance/ta166
[143] NICE. (2005). Auditory brain stem implants. Interventional procedures guidance [IPG108]. Available at: https://www.nice.org.uk/guidance/ipg108

				employment in the guidelines. Doing so would usefully reinforce the government's message in the recent command paper *'Improving Lives: The Future of Work, Health and Disability'*, that health care professionals are: *"Trusted advocates [that] help set the expectations that disabled people and people with long-term health conditions have about themselves, and support them to manage their conditions; minimising the risk of this being a barrier to work."*[144] The Improving Lives command paper asserts that CCGs and healthcare professionals should include work as a health outcome and that work outcomes should be incentivised. **The guideline should recommend the promotion of work as a health outcome. It should also be highlighted (as is also outlined in the Improving Lives paper) that CCGs and local authorities include employment when developing JSNA and health and wellbeing strategies.** **We recommend that the guidelines include the link between hearing support (including hearing aids) and employment.** There is good evidence that hearing aids and other equipment to improve hearing, can lead to improved employment prospects, in addition to improving quality of life, social activity and mental health.[145] Moreover, there is evidence that those without aided hearing, experience higher rates of unemployment and may experience an overall reduction in quality of life (i.e. anxiety, depression, social isolation) which may negatively impact job performance.[146] The Improving Lives paper highlighted that responses to the consultation noted a lack of conversations and collaboration between GPs, employers, other healthcare professionals, and Jobcentre Plus. The command paper therefore outlines commitments that the government has made to promote further inter-agency working, which the NICE guidelines should promote. For example, the government have committed to doubling the number of Work and Health Champions – occupational therapists trained to deliver work and health tools and techniques to healthcare professionals.[147]

[144] Department for Work and Pensions and Department of Health and Social Care. (2017). Improving Lives: the Future of Work, Health and Disability. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/663399/improving-lives-the-future-of-work-health-and-disability.PDF

[145] Kochkin S. (2007) The Impact of Untreated Hearing Loss on Household Income. Alexandria VA: Better Hearing Institute; Mulrow et al (1990) Quality-of-life changes and hearing impairment, a randomized trial". Annals of Internal Medicine 113(3): 188-94; National Council on the Aging. 2000. "The consequences of untreated hearing loss in older persons. Head & Neck Nursing 18(1):12-6

[146] Kochkin S. (2005). The impact of untreated hearing loss on household income. Better Hearing Institute

[147] Department for Work and Pensions and Department of Health and Social Care. (2017). Improving Lives: the Future of Work, Health and Disability. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/663399/improving-lives-the-future-of-work-health-and-disability.PDF

53.	Full & Short	General	General	**The guideline should include more information about the advantages of lip-reading classes, in order that commissioners consider this solution when commissioning services**. Lip-reading classes teach people with hearing loss to recognise lip shapes and patterns and how to use context and facial expressions to help them make sense of conversations. Lip-reading classes also provide information and advice on assistive technology and other services that can help people with hearing loss. They also provide an opportunity for people with hearing loss to meet, support each other and share their experiences. Action on Hearing Loss's *'Not Just Lip Service'* [148] report identified a range of benefits lip-reading classes can bring for people with hearing loss, such as: • Improvements in people's ability to recognise lip shapes and patterns and a better understanding of communication skills to help people understand speech. • Increased confidence and assertiveness in talking to others about their hearing loss and asking them to change their behaviour to facilitate good communication. • Feeling less negative about their hearing loss and being able to manage their hearing loss better in social situations and in the workplace. Action on Hearing Loss was also funded by the Department of Business, Innovation and Skills (BIS) to test out innovative ways of delivering lip-reading classes for working age people with hearing loss. The project found that online resources can improve access to information on lip-reading and face-to-face interactions through workshops, and have an important role to play in encouraging people to seek help for their hearing loss.[149]
54.	Full & Short	General	General	We welcome that hearing loss is increasingly being recognised as a national priority within the UK. This is demonstrated by the Government's Action Plan on Hearing Loss, NHS England's Commissioning Framework for Adult Hearing Loss Services and now the draft NICE guideline for adult hearing loss. Although NICE guidelines cover health and care in England only, recommendations within this guideline should also be considered by health and care

[148] Ringham L. (2013). Not Just Lip Service. London: Action on Hearing Loss. Available at: https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/not-just-lip-report/

[149] Arrowsmith L. (2016). Managing hearing loss when seeking or in employment report. London: Action on Hearing Loss. Available at: https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/managing-hearing-loss-when-seeking-or-in-employment-report/

				services in Wales, Scotland and Northern Ireland to reduce health inequalities across the UK. Recently hearing loss was recognised as a global health issue by the World Health Assembly (WHA), which approved and adopted a resolution to intensify action to prevent deafness and hearing loss.[150] The resolution calls upon governments to integrate strategies for ear and hearing care within the Framework of their primary health care systems, implement prevention and screening programmes for high-risk populations, establish training programmes for health workers, and improve access to high-quality cost-effective assistive hearing technologies and products.[150] The World Health Organisation (WHO) are planning to produce a global report on hearing and provide support to countries to help them reduce hearing loss.[150] As the draft guidelines have come at a critical time when we have seen budget cuts to hearing aid services and proposals to cut provision of hearing aids; **it is imperative that the guidelines are disseminated and used widely to help reduce the local variation in access and quality of hearing aid services across the UK.** The guidelines should not be used in isolation, but should be used in conjunction with the Commissioning Framework for Adult Hearing Loss Services. Audiology services should work with their local CCGs and local authorities to help ensure that money is invested properly; services are more cost effective; more integrated; person-centred and people are easily able to access a range of high quality audiology care and support locally. The draft guidelines have highlighted that primary, secondary and tertiary staff working with people with hearing loss need to be properly trained and equipped to recognise the signs of hearing loss, to help ensure that those with hearing loss get the right support they need at the right time. **It is important that this is recognised and steps are taken to ensure that this is incorporated into the training of primary, secondary and tertiary staff, who have the information, incentives, training and screening tools they need to recognise hearing loss – and encourage people with hearing loss to seek help.** The Action Plan on Hearing Loss states that *"hearing loss is not just a health issue- it is societal and requires an integrated approach across a range if Government departments, non-departmental, public bodies and stakeholder organisations across the public, private and third sectors, including children, young people and adults with hearing loss themselves."* **It is imperative that NHS England, PHE, Department of Health, other Government departments, key stakeholders across the voluntary, professional, private sectors and people with hearing loss continue to collaborate to ensure that the objectives of the Action Plan on Hearing Loss are being worked towards and met; the Commissioning Framework for Adult Hearing Loss Services and the NICE guidelines for hearing loss**

[150] World Health Organization. (2018). Seventieth World Health Assembly update, 30 May 2017. Available at: http://www.who.int/mediacentre/news/releases/2017/vector-control-ncds-cancer/en/

				is promoted, implemented and used effectively in local CCG areas. **We urge NICE to promote and support the implementation of the guidelines, through producing resources and providing practical support for users.** Whilst we very much welcome the NICE guidelines on Hearing Loss for adults, it is important to note that the guidelines serve for the now and do not take into consideration the rapidly changing landscape of technology and the inevitable and significant changes that will occur in the delivery of audiology and social care services. Throughout the health and social care sector, there has been an increasing use of innovative digital technology, such as m-health, e-health and telehealth/medicine. Specifically, within audiology, we have seen trials of self-fitting hearing aids, remote fitting hearing aids and telehealth.[151] In addition to this, hearing aids have become better connected with other devices, such as mobile phones through Bluetooth, and many now can connect to apps that allow better self-control of the devices. Assistive listening devices are better designed through streamers and apps to improve access to speech and help individuals communicate. The draft guidelines make little or no reference to these changes and therefore, some sections could soon be considered as redundant and not relevant. **It is therefore recommended that the draft guideline states that changes in technology and service provision should be monitored; services should be encouraged to innovate, trial and research effectiveness of new technologies devices and delivery of services. A review of the NICE guidelines for hearing loss should be agreed by the committee to ensure the latest developments are incorporated.**

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include page and line number (not section number) of the text each comment is about.

[151] Convery E, Keidser G, Seeto M, McLelland M. (2016). Evaluation of the Self-Fitting Process with a Commercially Available Hearing Aid. Journal of American Academy of Audiology; Davis A, Smith P, Ferguson M, Stephens D, Gianopoulos I. (2007). Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. Health Technology Assessment, 11(42):1-294.

Hearing loss in adults: assessment and management

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 5pm on 12/01/18 **email:** **hearingloss@nice.org.uk**

- 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.
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You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

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