FREEDOM OF INFORMATION REQUEST – PROVIDERS 2018

IMPORTANT: when answering the questions below please note:

- questions 1-5 are about the **NHS financial year 2017-18**. Question 6 is about changes since 2017/18
- Direct Access Audiology (DAA) is defined by the NHS as an audiology "service where patients are directly referred from primary and community care to the direct access service for both diagnostic assessment and treatment". For more details see here and here]
- adult means any person aged 18 and older
- audiology refers to all audiology care – e.g. DAA, adult hearing services, AQP contracts, ENT support and other services audiologists might deliver
- adult hearing loss means all causes of hearing loss, for example conductive, noise-induced, age-related, complex, non-complex and any other descriptors/causes
- Most questions are written for the audiology department to answer. Questions that refer to currency codes and coding might need to be answered by the finance department and/or audiology.

1) Your details

a) State your organisation's official name here

The Dudley Group NHS Foundation Trust

b) Please list all sites where you provide audiology services. We only need a postcode, site name and location type. Table provided to help answer quickly.

Site name	Postcode	Is this a hospital site **(tick)**
Brierley Hill Health and Social Care Centre	DY5 1RU	☐ Yes ☒ No
Russells Hall Hospital	DY1 2HQ	☒ Yes ☐ No
Stourbridge Health and Social Care Centre	DY8 4HZ	☐ Yes ☒ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

If you need to add additional sites, please attach additional rows

2) About adult audiology services – access criteria etc.

a) At what age can people access your Direct Access Audiology (DAA) service?

18 [state age in years]

b) Please provide the clinical criteria used to determine who is eligible for your DAA service. **Please clearly explain or attach the criteria**.

List or attach:
Direct Access Audiology (Non-AQP)
Conditions treated
Hearing Loss, to include:
Presbyacusis (age related hearing loss)
Sensorineural hearing loss
Procedures Performed

Exclusions
Patients under the age of 18 or over the age of 55
Patients with excessive wax (ear canals should be free of wax)
Perforated ear drum
History of ear discharge other than wax from either ear within the past 90 days
History of ear surgery
Otalgia
Vertigo
Sudden loss of hearing or sudden deterioration of existing hearing loss (sudden = within 1 week, in which case send to A&E or Urgent care ENT clinic)
Unilateral, or asymmetrical, or pulsatile, or distressing tinnitus lasting more than 5 minutes at a time
Asymmetrical hearing loss

AQP

Conditions treated
Hearing Loss, to include:
Presbyacusis (age related hearing loss)
Sensorineural hearing loss

Exclusions
Patients under the age of 55
Patients with excessive wax (ear canals should be free of wax)
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Unilateral, or asymmetrical, or pulsatile, or distressing tinnitus lasting more than 5 minutes at a time
Asymmetrical hearing loss

c) Please provide the clinical criteria used to decide which DAA service patients require onward referral to ENT, Audiovestibular physicians or other consultant led service. **Please clearly explain or attach the criteria.**

List or attach:
BAA Guidance for Onward Referral of Adults with Hearing Difficulty directly referred to Audilogy 2016 is used.

Criteria for onward referral by the Audiologist
History:
Sudden loss or sudden deterioration of hearing (sudden = within 72 hours), unilateral or bilateral, should be sent to A&E or Urgent Care ENT clinic within 24 hours. Due to the variety of causes of sudden hearing loss, the treatment timescale should be decided locally by the medical team. Prompt treatment may increase the likelihood of recovery
Altered sensation or numbness in the face or observed facial droop. Urgent medical advice should be sought if these symptoms have not previously been investigated.
Persistent pain affecting either ear, which is intrusive and which has not resolved as a result of prescribed treatment. (As a general guideline, this includes pain in or around the ear, lasting a week or more in recent months).
History of discharge (other than wax) from either ear within the last 90 days, which has not resolved or responded to prescribed treatment, or which is recurrent.
Rapid loss or rapid deterioration of hearing (rapid = 90 days or less).
Fluctuating hearing loss, other than associated with colds.
Hyperacusis. (An intolerance to everyday sounds that causes significant distress and impairment in social, occupational recreational and other day to day activities).
Tinnitus, which is persistent and which:
• is unilateral
• is pulsatile
• has significantly changed in nature
• is leading to sleep disturbance or is associated with symptoms of anxiety or depression
Vertigo which has not fully resolved, or which is recurrent. (Vertigo is classically described as a hallucination of movement, but here includes any dizziness or imbalance that may indicate otological, neurological or medical conditions. Examples include headaches with associated dizziness, spinning, swaying or floating sensations and veering to the side when walking. For further guidance on vertigo, see www.vestibular.org).
Normal peripheral hearing, but with altered auditory perceptions or abnormal difficulty hearing in noisy backgrounds. This may include having problems with sound localisation, the perception of pitch and loudness or difficulty following complex auditory directions.
Ear examination:
Complete or partial obstruction of the external auditory canal preventing full examination of the eardrum and/or proper taking of an aural impression. If wax is obscuring the eardrum or there is a current infection, local wax care or

treatment procedures should be followed.
Abnormal appearance of the outer ear and/or the eardrum (Examples include: inflammation of the external auditory canal, perforated eardrum, active discharge, eardrum retraction, abnormal bony or skin growths, swelling of the outer ear or blood in the ear canal).
Tympanometry (performed if there is any indication of middle ear effusion): Unilateral flat tympanogram, regardless of the associated level of hearing loss.
Audiometry:
Conductive hearing loss, defined as 20 dB or greater average air-bone gap over three of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz. A lesser conductive hearing loss in the presence of bilateral middle ear effusion may be referred at the discretion of the Audiologist.
Unilateral or asymmetrical sensorineural hearing loss, defined as a difference between the left and right bone conduction thresholds (masked as appropriate) of 20 dB or greater at two or more adjacent frequencies: 500, 1000, 2000, 4000 or 8000Hz. (Other frequencies may be included at the discretion of the Audiologist). In the absence of recordable bone conduction thresholds, air conduction thresholds should be considered instead.
Evidence of deterioration of hearing by comparison with an audiogram taken in the last 24 months, defined as a deterioration of 15 dB or more in bone conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz. In the absence of recordable bone conduction thresholds, air conduction thresholds should be considered instead.
Other findings:
Any other unusual presenting features at the discretion of the Audiologist or according to the requirements of the service to which the adult is being referred. Audiologists are expected to use their professional judgement and relevant guidance to make appropriate onward referrals for adults requiring Audiology services beyond their own scope of practice (for example, due to hearing loss complexity or co-existing conditions). Such referrals may be made in addition to a referral for a medical opinion.
Adults with sensorineural hearing loss which does not appear to be age related should, where appropriate, be offered a referral for aetiological investigation.

This is currently only used for a number of GP localities within the area but following a succesful pilot project is to be rolled out to all GP localities during 2019.

d) Please provide the clinical criteria used to decide which patients accessing the DAA service require referral back to their GP. **Please clearly explain or attach the criteria**

List or attach:
Criteria for onward referral by the Audiologist
History:
Sudden loss or sudden deterioration of hearing (sudden = within 72 hours), unilateral or bilateral, should be sent to A&E or Urgent Care ENT clinic within 24 hours. Due to the variety of causes of sudden hearing loss, the treatment

timescale should be decided locally by the medical team. Prompt treatment may increase the likelihood of recovery.
Altered sensation or numbness in the face or observed facial droop. Urgent medical advice should be sought if these symptoms have not previously been investigated.
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Conductive hearing loss, defined as 20 dB or greater average air-bone gap over three of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz. A lesser conductive hearing loss in the presence of bilateral middle ear effusion may be referred at the discretion of the Audiologist26.
Unilateral or asymmetrical sensorineural hearing loss, defined as a difference

between the left and right bone conduction thresholds (masked as appropriate) of 20 dB or greater at two or more adjacent frequencies: 500, 1000, 2000, 4000 or 8000Hz. (Other frequencies may be included at the discretion of the Audiologist). In the absence of recordable bone conduction thresholds, air conduction thresholds should be considered instead.
Evidence of deterioration of hearing by comparison with an audiogram taken in the last 24 months, defined as a deterioration of 15 dB or more in bone conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz. In the absence of recordable bone conduction thresholds, air conduction thresholds should be considered instead.
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Any other unusual presenting features at the discretion of the Audiologist or according to the requirements of the service to which the adult is being referred. Audiologists are expected to use their professional judgement and relevant guidance to make appropriate onward referrals for adults requiring Audiology services beyond their own scope of practice (for example, due to hearing loss complexity or co-existing conditions). Such referrals may be made in addition to a referral for a medical opinion.
Adults with sensorineural hearing loss which does not appear to be age related should, where appropriate, be offered a referral for aetiological investigation.

e) Do you have an audiologist led clinic – i.e. non-consultant led – to manage tinnitus that falls outside of the DAA service above?

☒ Yes, answer f
☐ No, go to g

f) please provide details of the service including:
- inclusion/exclusion criteria
- service specification

List or attach:
All patients referred for Tinnitus must be referred via an ENT Consultant.

g) Do you have an audiologist led clinic – i.e. non-consultant led – to manage asymmetric hearing loss that falls outside of the DAA service above?

☐ Yes, answer h
☒ No, go to i

h) please provide details of the service including:
- inclusion/exclusion criteria
- service specification

List or attach:

i) Does your audiology clinic manage earwax?

☐ Yes

☒ No

3) About how audiology services work with GPs, ENT and other services

a) what proportion (%) of **all adult hearing assessments** that you did in 2017/18 were

- referred by ENT/Audiovestibular physicians 25.3 %
- referred by GPs (i.e. Direct Access Audiology) 74 %
- self-referred/patient initiated 0 %
- other route(s) 0.7 % **Please state what these are:** Palative care physician/oncologist

If the above do not add up to 100% please explain why here:

b) what proportion (%) of all **DAA pathways** in 2017/18 resulted in

- assessment only – i.e. no treatment and discharged 35 %
- hearing aid(s) fitted and no referral required – i.e. managed by audiology 64.5 %
- other outcomes 0.5 % **Please state what the most common 'other outcomes' are here:** Further testing required i.e.ABR.

If the above do not add up to 100% please explain why here:

c) what proportion (%) of all **DAA pathways** in 2017/18 resulted in

- referral back to a GP 22.3 %
- referral to ENT/Audiovestibular physician 0 %

4) About adult hearing loss and adult hearing aid fits

a) what proportion (%) of all adults that you fitted with hearing aids in 2017/18

- had age-related hearing loss Unable to provide - not recorded %
- had noise-induced hearing loss Unable to provide - not recorded %
- had a different cause of hearing loss Unable to provide - not recorded %

estimate if specific data not recorded.

b) what was the average (mean) age of the adults you fitted with hearing aids in 2017/18

70 years average (mean) age

[Optional: if you have additional data, then please also provide the mode

range (min-max)
Other]

c) what proportion (%) of adults that you fitted with hearing aids were provided with two hearing aids?

65.8% **adults** fitted with two hearing aids

Please do **not** state all suitable adults are offered two aids. If the proportion is not known provide an estimated bilateral fitting rate above. If not known or cannot estimate local fitting rate, tick here ☐

5) About payment and coding (you may require finance department support for this section)

We do not require any commercially sensitive information, only high level data – i.e. this question is not exempt from an FoI request

a) **This is only about consultant-led clinics**. When an audiologist **supports a consultant led clinic**, are the cost allocated to the consultant led (e.g. ENT) clinic?

☒ Yes the costs are allocated to the consultant led clinic, and therefore funded by the NHS via consultant led clinic budgets/tariffs

☐ No the costs are not allocated to the consultant led clinic, and therefore funded by the NHS via audiology or other contracts

☐ None of the above, please explain here how costs are allocated and then billed to the NHS)

b) **This is only about your audiology, non-consultant led, clinics**. Tick all funding models that applied in 2017/18

Please tick ALL that apply

☐ Block Contract
☐ National tariffs for audiology led services - e.g. diagnostic tests etc.
☐ Non-mandated national tariff for adult hearing services
☒ AQP tariff for adult hearing services
☐ AQP tariff for other services – NOT including adult hearing services
☐ Cost per case
☒ Other (if ticked please specify here: Locally agreeed tariff - same for every contact)

c) Do you assign the code CA37A to hearing assessments performed in the DAA clinic?

☐ Yes
☒ No. If no how do you record assessments done in the DAA clinic All recording is done via Auditbase

d) Who is responsible for assigning the codes AS05 and AS06 at your organisation?

Please tick <u>ALL</u> that apply

☒ Coding department/finance team – i.e. non clinical
☐ Audiology – i.e. clinical
☐ Both of the above
☐ Other (if ticked please specify here:)

e) How is the adult hearing service – hearing assessment, hearing aid fits, ongoing care etc. – commissioned?

Please tick <u>which option applies at your organisation</u>

☐ We do not have an AQP contract for adult hearing services (proceed to part 6)

☒ We have an AQP and non-AQP contracts for adult hearing services (please answer f below)

☐ We only have an AQP contract for adult hearing services (please answer f below)

☐ Other (if ticked please specify here:) (please answer f below)

f) Please provide the process for coding AS05 and AS06 at your organisation?

For example please provide any and all copies of instructions given to staff to code adults as being eligible/ineligible for any local AQP adult hearing contract.

6) About material changes during the 2018/19 financial year?

The questions above related to the 2017/18 financial year only. Have there been any material – i.e. significant – changes to your local audiology services in the 2018/19 financial year so far?

☐ **Yes, if yes please explain here**
☒ No