NICE National Institute for Health and Care Excellence

NICE quality standard

Hearing loss in adults

Quality standard
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This standard is based on NG98.

This standard should be read in conjunction with QS184, QS137 and QS50.

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NICE has developed guidance and a quality standard on adult NHS services (see the NICE Pathway on patient experience in adult NHS services), which should be considered alongside these quality statements.

Other quality standards that should be considered when commissioning or providing hearing loss services for adults include:

- Dementia. NICE quality standard 184
- Mental wellbeing and independence for older people. NICE quality standard 137
- Mental wellbeing of older people in care homes. NICE quality standard 50
- Learning disability: care and support of people growing older. NICE quality standard 187

A full list of NICE quality standards is available from the quality standards topic library.

Quality statement 1: Earwax removal

Quality statement

Adults with earwax that is contributing to hearing loss or other symptoms, or preventing ear examination or ear canal impressions being taken, have earwax removed in primary care or community ear care services.

Rationale

Earwax build-up can cause hearing difficulties and discomfort, and it can contribute to outer ear infections. It is also important to remove earwax quickly because it can prevent ear examination or ear canal impressions being taken, which will delay assessment and management of hearing loss and underlying pathology. Hearing loss caused by impacted earwax can be frustrating and stressful. If untreated, it can contribute to social isolation and depression. Providing earwax removal closer to home, in primary care or community ear care services, will prevent the inappropriate use of specialist services.

Quality measures

Structure

a) Evidence of referral pathways in place to ensure adults with earwax that is contributing to hearing loss or other symptoms, or preventing ear examination or ear canal impressions being taken, have earwax removal in primary care or community ear care services.

Data source: Local data collection, for example, clinical protocols and documented, locally agreed pathways.

b) Evidence of local arrangements for healthcare professionals to have training to use earwax removal methods.

Data source: Local data collection, for example, training records.

c) Evidence of the availability of equipment to remove earwax in primary care or community ear care services.

Data source: Local data collection, for example, service specifications.

Process

Proportion of attendances of adults with earwax that is contributing to hearing loss or other symptoms, or preventing ear examination or ear canal impressions being taken, in which earwax is removed in primary care or community ear care services.

Numerator – the number in the denominator for which earwax is removed in primary care or community ear care services.

Denominator – the number of attendances of adults with earwax that is contributing to hearing loss or other symptoms, or preventing ear examination or ear canal impressions being taken.

Data source: Local data collection, for example, audit of electronic case records.

Outcome

Health-related quality of life for adults with earwax that has contributed to hearing loss or other symptoms, or has prevented ear examination or ear canal impressions being taken.

Data source: Local data collection, for example, a patient survey.

What the quality statement means for different audiences

Service providers (primary care and community ear care services) ensure that locally agreed referral pathways are in place for removing earwax for adults when it is contributing to hearing loss or other symptoms, or is preventing ear examination or ear canal impressions being taken. Service providers also ensure that healthcare professionals are trained to use earwax removal methods, and that they have access to the correct equipment.

Healthcare professionals (such as audiologists, practice or community nurses and GPs) carry out earwax removal in adults when it is contributing to hearing loss or other symptoms, or is preventing ear examination or ear canal impressions being taken. Methods that can be used include ear irrigation, microsuction or manual removal. Ear irrigation may be contraindicated for some people.

Commissioners (clinical commissioning groups) ensure that they commission services with the appropriate equipment, capacity and expertise to carry out earwax removal for adults in primary or community care.

Adults with earwax that is affecting hearing or causing other symptoms, or needs to be removed so that the ear can be examined or an impression of the ear canal can be taken, have the earwax removed in primary care or community ear care services.

Source guidance

Hearing loss in adults: assessment and management. NICE guideline NG98 (2018), recommendation 1.2.1

Definition of terms used in this quality statement

Other symptoms

Although some people are asymptomatic, the most common symptom from impacted earwax is hearing loss. People may also complain of:

- blocked ears
- ear discomfort
- a feeling of fullness in the ear
- earache
- tinnitus
- itchiness
- irritation of the ear canal leading to cough.

[Adapted from NICE's clinical knowledge summary on earwax]

Equality and diversity considerations

Access to hearing care services for care home residents was highlighted by the committee as an equality and diversity consideration. It is important that staff are aware that people in care homes have the same right to access healthcare as people living independently in the community. This is stated in the NHS Constitution for England. Housebound people with hearing loss may also have limited access to hearing care services.

Healthcare professionals should adapt their communication style to the person's hearing needs. This will help to ensure that the adult has the opportunity to be involved in decisions about their earwax removal.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible information standard.

Quality statement 2: Sudden onset of hearing loss

Quality statement

Adults with sudden onset of hearing loss in one or both ears that is not explained by external or middle ear causes are referred for immediate or urgent specialist medical care.

Rationale

Sudden onset of hearing loss in one or both ears that is not explained by external or middle ear causes is an emergency. This means that referral for immediate or urgent specialist medical care in appropriate healthcare services is needed. Sudden hearing loss (occurring over 3 days or less) that developed within the past 30 days needs immediate referral so that the person is seen by a specialist within 24 hours. Sudden hearing loss that developed more than 30 days ago needs urgent referral to ensure that the person is seen by a specialist within 2 weeks.

Sudden-onset sensorineural hearing loss needs immediate or urgent investigation for treatable causes such as autoimmune disease, chronic infection, rapidly expanding vestibular schwannoma or stroke. Idiopathic sudden sensorineural hearing loss is typically treated with oral steroids as soon as possible. Delayed management can lead to increased morbidity.

Quality measures

Structure

Evidence of referral pathways in place to ensure adults with sudden onset of hearing loss in one or both ears that is not explained by external or middle ear causes are seen immediately or urgently by an ear, nose and throat (ENT) service, an audiovestibular medicine service or an emergency department for specialist medical care.

Data source: Local data collection, for example, clinical protocols and documented, locally

agreed pathways.

Process

a) Proportion of adults with hearing loss in one or both ears that has developed over 3 days or less within the past 30 days, who are referred for immediate (seen within 24 hours) specialist medical care in an ENT service or an emergency department.

Numerator – the number in the denominator who are referred for immediate (seen within 24 hours) specialist medical care in an ENT service or an emergency department.

Denominator – the number of adults with hearing loss in one or both ears that has developed over 3 days or less within the past 30 days.

Data source: Local data collection, for example, audit of electronic case records.

b) Proportion of adults with hearing loss in one or both ears that developed over 3 days or less more than 30 days ago who are referred for urgent (seen within 2 weeks) specialist medical care in an ENT or audiovestibular medicine service.

Numerator – the number in the denominator who are referred for urgent (seen within 2 weeks) specialist medical care in an ENT or audiovestibular medicine service.

Denominator – the number of adults with hearing loss in one or both ears that developed over 3 days or less more than 30 days ago.

Data source: Local data collection, for example, audit of electronic case records.

Outcome

Morbidity rates for adults who have sudden onset of hearing loss.

Data source: Local data collection, for example, audit of electronic case records.

What the quality statement means for different audiences

Service providers (such as primary, community and secondary care) ensure that locally agreed referral pathways are in place for adults with sudden onset of hearing loss in one or both ears to be referred for immediate or urgent specialist medical care at an appropriate healthcare service such as ENT, emergency department or audiovestibular medicine services. Service providers also ensure that healthcare practitioners have training and expertise to recognise symptoms and signs of sudden onset of hearing loss in adults.

Healthcare practitioners (such as GPs, audiologists and community care nurses) refer adults with sudden onset of hearing loss in one or both ears for specialist medical care at an appropriate healthcare service such as ENT, emergency department or audiovestibular medicine services. Practitioners have a checklist or table of symptoms and signs with the recommended action, referral pathway and timeframe.

Commissioners (clinical commissioning groups) ensure that services they commission have the expertise to refer adults with sudden onset of hearing loss in one or both ears for specialist medical care.

Adults with hearing loss that starts suddenly in one or both ears are referred to a specialist, unless the hearing loss can be explained by a condition such as swimmer's ear, which affects the outer ear, or a cold affecting the middle part of the ear. They are seen by the specialist within 24 hours if the hearing loss started within the past 30 days, or within 2 weeks if the hearing loss started more than 30 days ago.

Source guidance

Hearing loss in adults: assessment and management. NICE guideline NG98 (2018), recommendation 1.1.2

Definitions of terms used in this quality statement

Sudden onset of hearing loss

Hearing loss that has developed over 3 days or less. [NICE's guideline on hearing loss in adults, recommendation 1.1.2]

Referral for immediate or urgent specialist medical care

Adults with sudden onset of hearing loss are referred as follows:

- If the hearing loss developed suddenly (over 3 days) within the past 30 days, refer immediately (to be seen within 24 hours) to an ENT service or an emergency department.
- If the hearing loss developed suddenly more than 30 days ago, refer urgently (to be seen within 2 weeks) to an ENT or audiovestibular medicine service.

[NICE's guideline on hearing loss in adults, recommendation 1.1.2]

Equality and diversity considerations

Healthcare practitioners should adapt their communication style to the hearing needs of the person with sudden onset of hearing loss. This will help to ensure that the person understands the need for an urgent or immediate referral for specialist medical care and is able to make decisions about their own care.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible information standard.

Quality statement 3: Rapid worsening of hearing loss

Quality statement

Adults with rapid worsening of hearing loss in one or both ears that is not explained by external or middle ear causes are referred for urgent specialist medical care.

Rationale

Hearing loss that has worsened over a period of 4 to 90 days in one or both ears and is not explained by external or middle ear causes needs urgent medical care. An urgent referral to appropriate healthcare services is needed to ensure that the person is seen by a specialist within 2 weeks.

Rapidly deteriorating hearing needs urgent investigation for treatable causes such as autoimmune disease, chronic infection, vestibular schwannoma or intracranial tumours. Delayed management can lead to increased morbidity.

Quality measures

Structure

Evidence of referral pathways in place to ensure adults with rapid worsening of hearing loss in one or both ears that is not explained by external or middle ear causes are seen urgently by an ear, nose and throat (ENT) service or an audiovestibular medicine service for specialist medical care.

Data source: Local data collection, for example, clinical protocols and documented, locally agreed pathways.

Process

Proportion of adults with hearing loss in one or both ears that has worsened over a period of 4 to 90 days who are referred for urgent (seen within 2 weeks) specialist medical care in an ENT or audiovestibular medicine service.

Numerator – the number in the denominator who are referred for urgent (seen within 2 weeks) specialist medical care in an ENT or audiovestibular medicine service.

Denominator – the number of adults with hearing loss in one or both ears that has worsened over a period of 4 to 90 days.

Data source: Local data collection, for example, audit of electronic case records.

Outcome

Morbidity rates for adults who have rapid worsening of hearing loss.

Data source: Local data collection, for example, audit of electronic case records.

What the quality statement means for different audiences

Service providers (such as primary, community and secondary care) ensure that locally agreed referral pathways are in place for adults with rapid worsening of hearing loss in one or both ears to be referred for urgent specialist medical care at an appropriate healthcare service such as an ENT or audiovestibular medicine service. Service providers also ensure that healthcare practitioners have training and expertise to recognise symptoms and signs of rapid worsening of hearing loss in adults.

Healthcare practitioners (such as GPs, audiologists and community care nurses) refer adults with rapid worsening of hearing loss in one or both ears for specialist medical care at an appropriate healthcare service such as an ENT or audiovestibular medicine service. Practitioners have a checklist or table of symptoms and signs with the recommended action, referral pathway and timeframe.

Commissioners (clinical commissioning groups) ensure that services they commission

have the expertise to refer adults with rapid worsening of hearing loss in one or both ears for specialist medical care.

Adults with hearing loss that gets worse rapidlyin one or both ears are referred to be seen by a specialist within 2 weeks,unless the hearing loss can be explained by a condition like swimmer's ear that affects the outer ear, or a cold affecting the middle part of the ear.

Source guidance

Hearing loss in adults: assessment and management. NICE guideline NG98 (2018), recommendation 1.1.2

Definitions of terms used in this quality statement

Rapid worsening of hearing loss

Hearing loss that occurs over a period of 4 to 90 days. [NICE's guideline on hearing loss in adults, recommendation 1.1.2]

Referral for urgent specialist medical care

Adults with rapid worsening of hearing loss (over 4 to 90 days) should be referred urgently (to be seen within 2 weeks) to an ENT or audiovestibular medicine service. [NICE's guideline on hearing loss in adults, recommendation 1.1.2]

Equality and diversity considerations

Healthcare practitioners should adapt their communication style to the hearing needs of the person with rapid worsening of hearing loss. This will help to ensure that the person understands the need for an urgent or immediate referral for specialist medical care and is able to make decisions about their own care.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible information standard.

Quality statement 4: Audiological assessment

Quality statement

Adults presenting for the first time with hearing difficulties not caused by impacted earwax or acute infection have an audiological assessment.

Rationale

Audiological assessment, which includes a full history and assessment of hearing and communication needs, can identify any hearing loss and associated difficulties. The audiologist can then advise on management options, which might include the use of hearing aids. Early identification of progressive hearing loss in adults is important because early management can minimise the effect of hearing loss on social interaction, work, family relationships and quality of life.

Quality measures

Structure

a) Evidence of referral pathways in place to ensure adults presenting for the first time with hearing difficulties have an audiological assessment.

Data source: Local data collection, for example, referral criteria and documented, locally agreed pathways.

b) Evidence that healthcare practitioners have training and access to information to enable them to recognise hearing and communication difficulties for which referral for an audiological assessment is needed.

Data source: Local data collection, for example, training records and clinical protocols.

Process

Proportion of adults presenting for the first time with hearing difficulties not caused by impacted earwax or acute infection who have an audiological assessment.

Numerator – the number in the denominator who have an audiological assessment.

Denominator – the number of adults presenting for the first time with hearing difficulties not caused by impacted earwax or acute infection.

Data source: Local data collection, for example, audit of electronic case records.

Outcome

Hearing-specific health-related quality of life for adults presenting with hearing difficulties not caused by impacted earwax or acute infection.

Data source: Local data collections, for example, a patient survey. NHS England's Adult hearing service specifications (2016) include outcome 2 on improvement in service-user-reported quality of life using validated self-reporting tools such as the Glasgow Hearing Aid Benefit Profile (GHABP) or the Client-Orientated Scale of Improvement (COSI).

What the quality statement means for different audiences

Service providers (such as primary care services) ensure that locally agreed referral pathways are in place for adults who present for the first time with hearing difficulties not caused by impacted earwax or acute infection to be referred for an audiological assessment. Service providers also ensure that healthcare practitioners have training and access to information to help them recognise hearing and communication difficulties for which referral for an audiological assessment is needed.

Healthcare professionals (such as GPs and practice or community nurses) arrange an audiological assessment for adults who present for the first time with hearing difficulties after impacted earwax and acute infections, such as otitis externa, have been excluded. This assessment includes a full history and assessment of hearing and communication needs by the audiologist to identify any hearing loss and associated difficulties.

Commissioners (clinical commissioning groups) ensure that the services they commission include audiological assessment for adults with hearing difficulties not caused by impacted earwax or acute infection.

Adults who go to healthcare services for the first time with hearing difficulties have a hearing assessment, unless the hearing problem is caused by a build-up of earwax or an ear infection.

Source guidance

Hearing loss in adults: assessment and management. NICE guideline NG98 (2018), recommendation 1.1.1

Equality and diversity considerations

When assessing an adult presenting for the first time with hearing difficulties, healthcare professionals should be aware of the link between hearing loss and mild cognitive impairment, dementia and learning disability. Hearing loss can affect performance in cognitive function tests, which can lead to misdiagnosis. People with mild cognitive impairment, dementia or a learning disability may not be aware of their hearing loss, or may not have the capacity to ask for help. Their families and carers may not consider that hearing loss is a compounding factor given their other health needs. However, hearing loss that is not addressed will significantly affect understanding and social interactions and will exacerbate underlying cognitive difficulties.

Quality statement 5: Provision of hearing aids

Quality statement

Adults presenting with hearing loss affecting their ability to communicate and hear are offered hearing aids.

Rationale

The primary management option for permanent hearing loss is hearing aids. Hearing aids can reduce the impact of hearing loss, improving communication and participation in everyday life. People should be offered the number of hearing aids that they need. In most cases hearing loss affects both ears. If a person has hearing impairment in both ears, there is significant benefit to wearing two hearing aids rather than one. Binaural amplification gives better sound quality and improved intelligibility of speech in background noise.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with hearing loss affecting their ability to communicate and hear are offered hearing aids.

Data source: Local data collection, for example, key performance indicators from local contracts that include service specifications.

Process

a) Proportion of adults presenting with hearing loss affecting their ability to communicate and hear who have aidable hearing loss in one ear who are given one hearing aid.

Numerator – the number in the denominator who are given one hearing aid.

Denominator – the number of adults presenting with hearing loss affecting their ability to communicate and hear who have aidable hearing loss in one ear.

Data source: Local data collection, for example, audit of electronic case records.

b) Proportion of adults presenting with hearing loss affecting their ability to communicate and hear who have aidable hearing loss in both ears who are given two hearing aids.

Numerator – the number in the denominator who are given two hearing aids.

Denominator – the number of adults presenting with hearing loss affecting their ability to communicate and hear who have aidable hearing loss in both ears.

Data source: Local data collection, for example, audit of electronic case records.

Outcome

Hearing-specific health-related quality of life for adults with hearing loss.

Data source: Local data collection, for example, a patient survey. NHS England's Adult hearing service specifications (2016) include outcome 2 on improvement in service-user-reported quality of life using validated self-reporting tools such as the Glasgow Hearing Aid Benefit Profile (GHABP) or the Client-Orientated Scale of Improvement (COSI).

What the quality statement means for different audiences

Service providers (audiology services) ensure that processes are in place for adults with hearing loss affecting their ability to communicate and hear to be offered hearing aids. They ensure that healthcare professionals are aware that they should offer one or two hearing aids depending on whether the person has aidable hearing loss in one or both ears.

Healthcare professionals (audiologists) discuss and agree hearing aid options with the adult based on their communication and hearing needs, and as part of an individual

management plan. They offer one or two hearing aids depending on whether the person has aidable hearing loss in one or both ears.

Commissioners (such as clinical commissioning groups) ensure that services they commission have the capacity and expertise to give hearing aids to adults with aidable hearing loss. They monitor whether services restrict hearing aids by not offering them to people with aidable hearing loss in one ear or both ears, or by only offering one hearing aid to adults with aidable hearing loss in both ears.

Adults with hearing loss that affects their ability to communicate, and that can be improved by a hearing aid, are offered a hearing aid, or two hearing aids if they have hearing loss in both ears.

Source guidance

Hearing loss in adults: assessment and management. NICE guideline NG98 (2018), recommendations 1.6.1 and 1.6.2

Equality and diversity considerations

Healthcare professionals should adapt their communication style to the hearing needs of the person with hearing loss. This will help to ensure that the person has the opportunity to be involved in decisions about their hearing management options, which should be documented in their personalised care plan.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible information standard.

Quality statement 6: Follow-up audiology appointment

Quality statement

Adults with hearing aids have a follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted.

Rationale

A follow-up audiology appointment is important for assessing how someone is adapting to their hearing aids and whether they fit well. It also provides an opportunity to resolve difficulties at an early stage, review the personalised care plan and give additional advice based on progress. Face-to-face appointments should be offered first, with the option to attend this appointment by telephone or electronic communication if the person prefers. Face-to-face appointments are preferred so that the audiologist can check the fitting and handling of the hearing aids and make any necessary adjustments. Without this service, people may stop using their hearing aids, which can reduce their quality of life as their ability to communicate and participate in everyday situations decreases.

Quality measures

Structure

a) Evidence of local arrangements to ensure that adults with hearing aids have a follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted.

Data source: Local data collection, for example, service specifications.

b) Evidence of local arrangements to ensure that adults with hearing aids have their personalised care plan reviewed and updated if necessary during a follow-up appointment 6 to 12 weeks after the hearing aids are fitted.

Data source: Local data collection, for example, service specifications.

Process

a) Proportion of adults who have a follow-up audiology appointment 6 to 12 weeks after new hearing aids are fitted.

Numerator – the number in the denominator who have a follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted.

Denominator – the number of adults with new hearing aids.

Data source: Local data collection, for example, audit of electronic case records.

b) Proportion of adults who have a face-to-face follow-up audiology appointment 6 to 12 weeks after new hearing aids are fitted.

Numerator – the number in the denominator who have a face-to-face follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted.

Denominator – the number of adults with new hearing aids.

Data source: Local data collection, for example, audit of electronic case records.

c) Proportion of adults who have a telephone follow-up audiology appointment 6 to 12 weeks after new hearing aids are fitted.

Numerator – the number in the denominator who have a telephone follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted.

Denominator – the number of adults with new hearing aids.

Data source: Local data collection, for example, audit of electronic case records.

d) Proportion of adults who have a follow-up audiology appointment by electronic communication 6 to 12 weeks after new hearing aids are fitted.

Numerator – the number in the denominator who have a follow-up audiology appointment by electronic communication 6 to 12 weeks after the hearing aids are fitted.

Denominator – the number of adults with new hearing aids.

Data source: Local data collection, for example, audit of electronic case records.

Outcomes

a) Proportion of adults continuing to wear new hearing aids after first follow-up, and at 12 and 24 months.

Numerator – the number in the denominator continuing to wear new hearing aids after first follow-up, and at 12 and 24 months.

Denominator – the number of adults with new hearing aids.

Data source: Local data collection, for example, data logging and self-reporting. NHS England's Adult hearing service specifications (2016) include a key performance indicator on the proportion of patients continuing to wear hearing aids after first follow-up, and at 12 and 24 months.

b) Hearing-specific health-related quality of life for adults with aidable hearing loss.

Data source: Local data collection, for example, a patient survey. NHS England's Adult hearing service specifications (2016) include outcome 2 on improvement in service-user-reported quality of life using validated self-reporting tools such as the Glasgow Hearing Aid Benefit Profile (GHABP) or the Client-Orientated Scale of Improvement (COSI).

What the quality statement means for different audiences

Service providers (audiology services) ensure that pathways, protocols and processes are in place for adults with hearing aids to have a follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted. Services are configured to offer the person an appointment face-to-face as the first option, or the option of follow-up by telephone or electronic communication if preferred.

Healthcare professionals (audiologists) work in partnership with adults with hearing aids (and their family or carers if appropriate) at the face-to-face, telephone or electronic

communication follow-up audiology appointment to assess how the person is adapting to their hearing aids and resolve any difficulties at an early stage. They provide further advice and support, and onward referral if needed. They review and update the personalised care plan, ensuring that any unmet needs or goals are addressed, and provide the person with a copy.

Commissioners (clinical commissioning groups) ensure they commission services with the capacity and expertise to provide a follow-up audiology appointment that is either face-to-face as the first option, or by telephone or electronic communication, if preferred, 6 to 12 weeks for adults after their hearing aids are fitted.

Adults who have hearing aids fitted are offered a follow-up appointment with the audiology service 6 to 12 weeks after their hearing aids are fitted. They can go to the appointment in person, or have it by telephone or electronic communication such as email or messaging. At the appointment their hearing aids will be checked and their personalised care plan updated. The healthcare professional will ask about any problems with the hearing aids and give advice and support, if needed, to help the person use them.

Source guidance

Hearing loss in adults: assessment and management. NICE guideline NG98 (2018), recommendation 1.7.1

Definition of terms used in this quality statement

Audiology appointment

At the follow-up audiology appointment for adults with hearing aids:

- Ask the person if they have any concerns or questions.
- Address any difficulties they have with inserting, removing or maintaining their hearing aids.
- Provide information on communication, social care or rehabilitation support services if needed.

- Tell the person how to contact audiology services in the future for aftercare, including repairs and adjustments to accommodate changes in their hearing.
- Ensure that the person's hearing aids and other devices meet their needs by checking:
  - the comfort, sound quality and volume of hearing aids, including microphone and noise reduction settings, and fine-tuning them if needed
  - hearing aid cleaning, battery life and use with a telephone
  - use of assistive listening devices
  - hours the hearing aid has been used, if shown by automatic data logging.
- Review the goals identified in the personalised care plan and agree how to address any that have not been met (for information on the personalised care plan, see recommendation 1.5.2 in NICE's guideline on hearing loss in adults).
- Update the personalised care plan and provide them with a copy.

[NICE's guideline on hearing loss in adults, recommendation 1.7.2]

Equality and diversity considerations

Healthcare professionals should adapt their communication style at the follow-up appointment to the hearing needs of the person with hearing loss. They should ensure that communication is effective enough to discuss any concerns or questions the person has about their hearing aids, resolve difficulties at an early stage and review the goals identified in the personalised care plan.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible information standard.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standard advisory committees for details of standing committee 1 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the quality standard's webpage.

This quality standard has been included in the NICE Pathway on hearing loss, which brings together everything we have said on a topic in an interactive flowchart.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes for adults with hearing loss:

- hearing ability
- patient experience of primary, community and secondary care
- health-related quality of life for adults with hearing loss, their families or carers and communication partners
- level of social functioning
- levels of participation in education
- employment rates.

It is also expected to support delivery of the Department of Health and Social Care outcome frameworks:

- Adult social care outcomes framework
- NHS outcomes framework

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact template and resource impact report for the NICE guideline on hearing loss in adults.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local

context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- British Academy of Audiology
- British Association of Audiovestibular Physicians (BAAP)
- National Association of Deafened People
- National Community Hearing Association (NCHA)
- Royal College of General Practitioners (RCGP)
- Royal College of Nursing (RCN)
- deafPLUS
- ENT UK
- Royal College of Physicians (RCP)
- The British Society of Audiology
- Action on hearing loss
- British Society of Hearing Aid Audiologists