Worcestershire Acute Hospitals NHS Trust

Audiology Onward Referral to ENT/GP Guidelines

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

To identify when onward referral is required and applicable pathway. This local guideline is to assist audiologist decision making when decided if it appropriate to refer patients to our colleagues in the ENT department, refer to GP or keep within the audiology team under review. It is based on the BAA onward referral guidance for adult audiology service users document, publish September 2023.

This guideline is for use by the following staff groups :

Audiologists

Lead Clinician(s)

Edward Southan	Interim Audiology Manager
Steven Lewis	ENT and Audiology Clinical lead
Approved by *Audiology Governance Meeting* on:	21st July 2026
Review Date: This is the most current document and should be used until a revised version is in place	21st July 2029

Key amendments to this guideline

Date	Amendment	Approved by:
16th Jan 24	New document approved	ENT Directorate Meeting
03rd July 24	Pulsatile tinnitus either unilateral or bilateral was referred to team leader Leah Hannant to be booked into ENT. This process no longer available so are referred in the standard way. Clinical guideline edited to reflect this.	Edward Southan Interim Audiology manager.
17th Mar 26	True rotatory vertigo that is troublesome and has not responded to management in primary care to be referred to ENT Hyperacusis to be kept within Audiology services	ENT Directorate meeting 22/04/26

Referral to GP:

The following conditions, if identified during assessment, require onwards referral to the GP. If there is any query regarding an onwards referral, please consult with the appropriate, on-site principal clinician for further guidance. Hearing aids can still be organised if appropriate and referral back to GP should not delay treatment.

Dizziness- Troublesome true rotatory, dizziness, imbalance and presyncope that has started within the last 90 days.

Persistent pain- Affecting either ear, defined as earache lasting more than 7 days and has not responded to first-line treatment. Avoid fitting hearing aid in the ear that patient complains of pain until this has been resolved by GP.

History of discharge- If the patient refers to a history of discharge or discharge is visible in the ear canal. Avoid fitting hearing aid in discharging ear until this has been resolved by GP.

Obstruction of external auditory meatus- Complete or partial obstruction of wax. If found during a DAHAP/DR/RA/, please refer to GP if wax removal service is available or Audiology led microsection service (If ear is considering routine, please see local microsuction guidelines). Depending on waiting times service users may choose to consider private micro suction.

Fluctuating Hearing loss- When there is no associated colds or flu. Clinic judgement needed. If this is a non-organic loss, then further investigation in audiology will be required initially. If a patient has vestibular symptoms as well as fluctuating loss then a referral to ENT may be required.

Referral to ENT:

The following conditions, if identified during assessment, require onwards referral to ENT. If there is any query regarding an onward referral, please consult with the appropriate, on-site principal clinician for further guidance. Hearing aids can still be organised if appropriate and referral back to ENT should not delay treatment in most cases.

Abnormal otoscopy- abnormal appearance of external auditory meatus, tympanic membrane. Inflammation, polyp formation, perforated eardrum abnormal bony or skin growths, swelling of the outer ear, blood in the ear canal. Clinical judgement needs to be used. If you feel a referral to ENT is unlikely to be beneficial you can take a video otoscopy image and send to Mr. Tom Martin for a 2nd opinion. thomas.martin4@nhs.net
If you decide to proceed without referring to ENT please take an image with video otoscope and send a standard referral advising ENT they may wish to see the patient in clinic due to the attached image. ENT can then choose to reject this referral.

Unilateral Tinnitus- If a patient is presenting with constant, unilateral tinnitus that has persisted for longer than 3 months.

Pulsatile Tinnitus- Either unilateral or bilateral pulsatile tinnitus.

Vertigo - True rotatory vertigo that is troublesome and has not responded to management in primary care. Symptoms of dizziness, light headiness and imbalance should be referred to GP for management.

Sudden Hearing Loss- If hearing loss had developed over a period of 3 days or less within the past 30 days, **bleep (866) to contact junior doctor for urgent referral.**

Unexplained Conductive/Mixed Hearing Loss- This is defined as a 20dB or greater average air-done gap over three of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz (refer to BSA guidelines on unmasked audiometry in reference to 3+4k testing). This excludes long standing conductive/mixed hearing losses which have previously been investigated by ENT. Adults with conductive loss due to Otitis media with effusion (OME) should have 2 x audiograms 3 months apart with flat tympanograms in both ears before referring to ENT. Clinical judgement is again needed. It may not be appropriate to refer all mild conductive losses especially in the presence of normal tympanometry and no subjective patient complaints/history.

Unexplained Asymmetry- Where there is asymmetry of 15db+ at 2 adjacent, air or bone conduction frequencies using frequencies, of 0.5, 1, 2, 4 and 8 kHz. Clinic judgement needed. It is not appropriate to refer asymmetrical hearing loss that have a clear cause. E.g. Noise damage.

Service users of Chinese or south-east Asian family origin- Who have hearing loss and middle ear effusion not associated with an upper respiratory tract infection. **bleep (866) to contact junior doctor for urgent referral.**

Immunocompromised adults- with otalgia and otorrhoea who have not responded to treatment within 72 hours **bleep (866) to contact junior doctor for urgent referral.**

Adults with hearing loss and localising symptoms or signs- (such as facial nerve weakness) that might indicate a vestibular schwannoma or CPA (Cerebellopontine angle) lesion, irrespective of pure tone thresholds.

Subjective asymmetry as main complaint- Patients who complain of significant, distressing asymmetry irrespective of PTA results. Patients who are just aware of an asymmetry and this is not impacting on them do not need to be referred for further investigation.

Acquired unilateral hearing loss- With altered sensation or facial droop on same side A&E or emergency ENT **bleep (866) to contact junior doctor.**

Keep within Audiology Service:

Bilateral Tinnitus - If tinnitus is a primary concern and is described bilateral, bothersome, non-pulsatile and has a duration of more than 5 minutes, the patient is to be directed to tinnitus counselling service. We do not require approval from ENT to proceed with Tinnitus retraining therapy anymore.

Bilateral Sudden hearing loss- which developed more than 30 days ago. Keep with audiology however write letter to ENT advising them they may wish to see the patient in clinic. Unilateral sudden hearing loss would meet the criteria for asymmetry hence would be referred to ENT as standard.

Sensorineural Hearing Loss that is not age related- It is unlikely that ENT will be able to offer an underlying diagnosis. Make sure Nonorganic loss has been ruled out. Proceed with a hearing aid if required. Clinical judgment needed. Patient can be referred to ENT if etiological investigations are likely to be beneficial in patient management.

Hyperacusis- (intolerance to everyday sounds that causes significant distress and affects a service user's day-to-day activities).

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.
3-5	Referrals are sent via email to audiology tr.audio2ent@nhs.net. These emails are checked before sending onto ENT booking office.	Each email is review by Audiology manager or Advanced Clinical Practitioner. Referrals that are not meeting the criteria can be send back to referrer with an explanation as to why this has not been accepted	The inbox should be checked and emails reviewed once per week as a minimal	Advanced clinical Practitioner Abi Clevely & Audiology manager Edward Southan	After email referral viewed inappropriate referrals will be directed back to colleagues.	At least once a week.

References

BAA onwards referral Criteria
Wax removal clinic departmental protocol
BSA recommended guidelines for unmasked audiometry

Contribution List

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
ENT Consultants

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
N/a

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Edward Southan**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Edward Southan	**Interim Audiology Manager**	**edward.soutan@nhs.net**
Date assessment completed	**17/01/2024**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Clinical guideline**				
What is the aim, purpose and/or intended outcomes of this Activity?	Assist audiologists with clinic decision making regarding onward referral on their patients.				
Who will be affected by the development & implementation of this activity?	❑✓ ❑ ❑ ❑	Service User Patient Carers Visitors	❑✓ ❑ ❑ ❑	Staff Communities Other _____	
Is this:	❑✓ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?				

What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	This document is based on the BAA onward referral guidance for adult service users Onward-Referral-Guidance-for-Adult-Audiology-Service-Users-Sept-23.pdf (baaudiology.org)
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Discussed within ENT directorate meeting.
Summary of relevant findings	Edits to document mainly around keeping some servicer users within audiology who we felt do not require an onward referral into ENT

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		✓		
Disability		✓		
Gender Reassignment		✓		
Marriage & Civil Partnerships		✓		
Pregnancy & Maternity		✓		
Race including Traveling Communities	✓			Document highlights that some ethnic groups are more susceptible to some medical conditions and encourages urgent referral
Religion & Belief		✓		
Sex		✓		
Sexual Orientation		✓		
Other Vulnerable and Disadvantaged		✓		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)				
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		✓		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

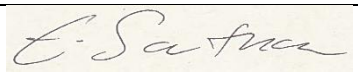
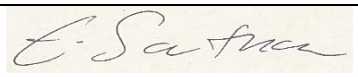
Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	17/01/2024
Comments:	
Signature of person the Leader Person for this activity	
Date signed	17/01/2024
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.