ADVANCED CLINICAL PRACTITIONER (ENT AND AUDIOLOGY) CLINICAL GUIDELINES ASYMMETRICAL HEARING LOSS / TINNITUS

Introduction

The implementation of an Advanced Clinical Practitioner (ACP) clinic within the ENT/Audiology service will establish a streamlined care pathway for adult patients referred to ENT with sensorineural hearing loss and/or tinnitus. Patients referred by GPs or cross-referred from complex audiology with the following conditions will be triaged into the ACP clinic for specialist assessment and management:

- Asymmetrical or unilateral sensorineural hearing loss (excluding sudden-onset cases, which remain under the care of the ENT emergency clinic)
- Bilateral or unilateral tinnitus (excluding pulsatile tinnitus)

The ACP, a highly experienced clinician, will assess, diagnose, and treat this patient group and is authorised to request imaging where clinically indicated. By offering an alternative route through the ENT pathway, the ACP clinic will facilitate timely access to hearing rehabilitation and tinnitus therapy. This targeted intervention also supports the broader ENT service by helping to manage consultant caseloads more effectively, creating additional capacity for surgical cases, two-week-wait referrals, and other complex presentations.

This protocol focuses specifically on patients presenting with asymmetrical hearing loss or unilateral tinnitus, for whom MRI of the Internal Auditory Meatus (IAM) may be indicated to rule out vestibular schwannoma (acoustic neuroma). According to the British Association of Otolaryngologists (2002), “acoustic neuromas should be suspected in patients who present with unilateral or asymmetrical auditory symptoms (hearing loss or tinnitus). Magnetic resonance imaging represents the method of choice for identifying the minority of these patients who have an underlying acoustic neuroma.”

The British Academy of Audiology (2023) defines unilateral and asymmetrical hearing loss as a difference of 15 dB or more at two adjacent air or bone conduction frequencies (0.5, 1, 2, 4, and 8 kHz). Clinical judgment remains essential, and it is not appropriate to refer asymmetries with a clear aetiology, such as those caused by noise exposure.

While Audiologists have traditionally referred such cases to ENT for further investigation, it is now increasingly accepted practice for Audiologists to refer directly to Radiology for MRI IAM. The ACP will carry out direct referrals for IAM imaging when unilateral auditory symptoms suggest the need to rule out an acoustic neuroma.

Worcestershire Acute Hospitals NHS Trust

It is the responsibility of every individual to ensure this is the latest version as published on the Trust Intranet

This guideline is for use by the following staff groups: • Advanced clinical practitioners (ENT and Audiology) • ENT Consultants • Clinical Audiologists	
Lead Clinician(s)	
Abi Clevely	Advanced Clinical Practitioner, ENT and Audiology
Approved by ENT Governance on:	14th May 2025
Review Date: This is the most current document and should be used until a revised version is in place	14th May 2028

Key amendments to this guideline

Date	Amendment	Approved by:

Local agreements
ENT consultant/ Clinical Director for ENT and Audiology
Mr Steven Lewis

Head of Audiology
Mr Edward Southan

Named staff (non-medical) who are authorised to request MRI scans

Name	Professional Body and pin	Education and training	Procedures entitled to request
Abigail Clevely	HCPC Clinical Scientist CS21170 ACP digital badge: CfAP33739439	MSc Advanced Clinical Practitioner (*University of Worcester, 2024*) MSc Neurosensory Science-Audiology (*Aston University, 2018*) MRI Safety e-learning modules (2025) IRMER (2025)	MRI of Internal Auditory Meatus (IAM) only. CT IAM as an alternative to MRI where MRI is contraindicated.

Triaging Referrals

1. Audiology to ENT referrals: All referrals to ENT from Audiology (exception Sedated ABRs) will be sent electronically to a monitored inbox (Audio2ENT). The ACP will be responsible for triaging referrals in this inbox.
    - All ENT referrals from Audiology must be sent electronically to: wah-tr.audio2ent@nhs.net
    - Important: This inbox is for ENT from Audiology referrals only. Any other queries sent here will not be actioned.

2. All referrals sent to the ENT inbox will be reviewed and triaged into one of three categories:
    - ENT Consultant Clinic – for complex or higher-risk presentations requiring consultant input.
    - ACP Clinic – suitable for:
        - Asymmetrical hearing loss
        - Tinnitus (bilateral and unilateral, but not pulsatile)
        - Children with persistent OME and no other complications
3. Rejected – if the referral is not in line with the locally agreed protocol.
    - These cases will be recorded in the auditbase journal by SS
    - A letter will be sent to both the patient and their GP explaining the decision
4. The ACP will have access to the Electronic Referral System (ERS) and will systematically review patient referrals on a weekly basis. Referrals will be diverted into the ACP clinic if they meet the following criteria:
        - Asymmetrical hearing loss
        - Tinnitus (bilateral and unilateral, but not pulsatile)
        - Children with persistent OME and no other complications
5. The OPA ENT bookings team will schedule patients into either the ACP clinic or a routine consultant clinic, depending on capacity.

6. **All other referrals to ENT:** Patients who present with the following symptoms will be referred directly to an ENT Consultant clinic. This is in accordance with BSA clinical guidance "Aud 001 Onward Referral":
    - Fluctuating hearing loss not associated with upper respiratory tract infections (colds)
    - Adult conductive hearing loss, including asymmetry, defined as an average air-bone gap of ≥20 dB across three frequencies (0.5, 1, 2, 3 or 4 kHz)
    - Pulsatile tinnitus (unilateral or bilateral)
    - Abnormal otoscopic findings
    - Ear pain or otorrhoea not successfully managed in primary care

ACP Clinic Workflow

1. Audiology on Arrival: All patients receive pure tone audiometry and tympanometry.
2. Results Review: ACP reviews audiology results prior to consultation.
3. Demographic Check: Confirm patient identity and contact information.
4. Clinical History: Document presenting complaint, medical history, medications, prior investigations, social/emotional impact.
5. Otoscopy: Perform otoscopic examination and record findings.
6. Video Otoscopy (unusual presentations): Capture and save images using Interacoustics Viot; email for upload to patient records. Video otoscopy will be used for any abnormal presentations of ears that need ENT attention.
7. Wax Management: Microsuction if tympanic membrane not visible; rebook if drops needed.
8. Diagnosis & Treatment Pathway: Follow structured matrix based on symptoms/audiology.

	Symptoms/PTA results	Treatment plan
Hearing loss	Asymmetrical hearing loss >20dB in two consecutive frequencies, not including 6 and 8kHz)	MRI Scan (CT where MRI is contraindicated). + Refer to complex audiology for hearing aid provision where clinically indicated
	Unilateral hearing loss >20dB in two consecutive frequencies, not including 6 and 8kHz)	MRI Scan (CT where MRI is contraindicated) + Refer to complex audiology for hearing aid provision where clinically indicated
	Bilateral hearing loss, symmetrical	Discharge to ICB AQP alternative provider
	Conductive/mixed hearing loss (unilateral or asymmetrical)	Refer to ENT consultant
	Conductive hearing loss (bilateral) with flat tympanograms (indicative of OME)	Request 3 month follow up in consultant clinic
Tinnitus	Pulsatile tinnitus	Refer to ENT consultant
	Bilateral bothersome tinnitus	Refer to tinnitus therapy
	Asymmetrical bothersome tinnitus	Refer to tinnitus therapy
	Unilateral tinnitus	MRI Scan (CT where MRI is contraindicated) + Refer to tinnitus therapy if bothersome
	Bilateral tinnitus (not bothersome)	Discharge with signposting, advice and guidance.

9. GP Communication: A letter will be dictated and sent to the support secretary for typing.

10. Image Upload: Viot images will be emailed to the secretary and included in the ACP report.

11. Clinical Documentation: Reports will include clinical history, examination findings, tympanic membrane images, diagnosis, and treatment plan.

12. Information Sharing: Reports will be sent to the GP and uploaded to Xerox for digital record scanning.

13. Follow-Up: Follow-up requests will be submitted to the ENT bookings team

Red Flags

Patients exhibiting any of the following red flags should be referred directly to an ENT consultant:

- Recurrent outer or middle ear infections
- Active tympanic membrane perforation or mastoid cavity
- Aural polyps or suspected foreign bodies
- Persistent otalgia
- Pulsatile tinnitus
- Sudden sensorineural hearing loss
- True rotational vertigo

MRI Referrals (Non-Medical Referrers)

- ACPs must be IR(ME)R-compliant and registered with Radiology as authorised non-medical referrers.
- Referrals must be clinically justified and appropriately timed.
- Imaging must contribute to the diagnostic pathway or treatment decision.
- Previous imaging should be reviewed to avoid duplication.
- Referrals must include relevant, accurate clinical information.
- MRI contraindications must be screened for and documented.
- Referrals should be discussed with ENT or Radiology in cases of uncertainty.
- All imaging referrals must be documented in the patient's clinical plan.

MRI Contraindications (examples, not exhaustive):

- Pacemakers or cochlear implants (check device compatibility)
- Aneurysm clips or neurosurgical shunts
- Metallic foreign bodies or implants
- Occupational exposure to metal fragments (e.g., welding)
- Pregnancy
- Claustrophobia or inability to lie flat
- Anxiety or poor compliance

CT Scanning as Alternative

- CT IAM may be used instead of MRI in the following cases:
- MRI contraindicated due to implanted devices or metallic fragments
- Claustrophobia
- Other clinical scenarios preventing MRI

MRI Reporting and Outcomes

- The ACP must ensure Radiology receives relevant clinical context when requesting MRI IAM.
- Once results are available:
- If normal: Write to patient and discharge (include GP copy).
- If abnormal (e.g., neuroma): Refer to ENT consultant for further management.
- If incidental findings: Refer to ENT consultant for further management.
- If delayed: Follow up with Radiology.
- Update the patient's written care plan with all actions and outcomes.

Refusal of MRI by patient

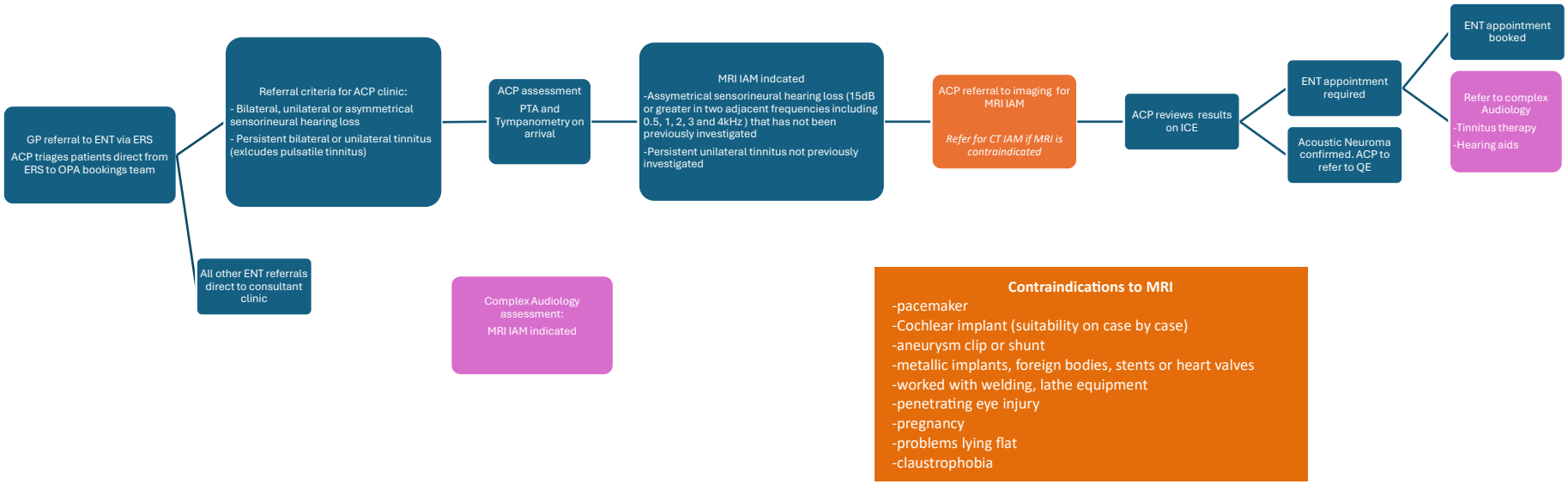
- The ACP will explain fully the reasons behind requesting an MRI scan and what the investigation is looking for.
- If a patient declines MRI referral, alternative investigations will be discussed (CT scan).
- If all options are declined, then this will be documented in their notes and GP letter.

Quality assurance of imaging requests by ACP

The referring ACP will record all cases where patients have been referred directly from Audiology to Imaging. All outcomes will be recorded and compared to outcomes of patients referred for imaging from Audiology via ENT. Quality assurance topics should include the following:

- Quality of referrals from Audiology to Radiology
- Appropriateness of decision not to refer
- Appropriate recording of results
- Appropriate clinical action taken
- Management of adverse incidents and near misses

ENT and Audiology ACP pathway



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?
	All patients referred for MRI are suitable candidates based on their audiogram and medical history.	Audit of medical notes, review of Pure Tone Audiogram results	Every 3 months	Abi Clevely	Presented to Audiology Governance meeting	Twice a year

References

National Institute for Health and Care Excellence (NICE). (2023) Hearing loss in adults: assessment and management (NG98). Originally published 21 June 2018, updated 2 October 2023. NICE

British Association of Otorhinolaryngologists – Head and Neck Surgeons Clinical Practice Advisory Group. Clinical Effectiveness Guidelines Acoustic Neuroma (Vestibular Schwannoma) 2002. BAO-HNS document 5.

Contribution List

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

Designation
Steven Lewis- Clinical Director ENT
Edward Southan= Interim Head of Audiology
Claire Carwardine- Principal Audiologist
Kim Doughty- Principal Audiologist
Jessica Scully- Paediatric Audiology Manager

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

Committee
ENT governance and audit

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.

NHS Worcestershire Acute Hospitals NHS Trust

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	

Details of individuals completing this assessment	Name	Job title	e-mail contact
	Abi Clevely	Advanced Clinical Practitioner	abigail.clevely1@nhs.net
Date assessment completed	13.03.25		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	Title: New service design			
What is the aim, purpose and/or intended outcomes of this Activity?	Improve the pathway for patients with asymmetrical hearing loss, or unilateral tinnitus. To be assessed, sent for an MRI scan, and treatment started (tinnitus therapy or hearing aids).			
Who will be affected by the development & implementation of this activity?	❑ Service User ❑ Patient ❑ Carers ❑ Visitors		❑ Staff	
Is this:				

	❑ New activity
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.	RTT times in ENT- breaching and new RTT waiting time imposed by new government has resulted in new activity needed to reduce numbers Pilot of ACP clinic data collected by myself over a 3 year period of the potential impact this service could have on ENT wait times
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 with clinical director, head of audiology, working with quality transformation team (led by Oli Schoolcraft), digital transformation (Steven Price), Zoe- Scott Lewis, Laura Manners, QIA Panel
Summary of relevant findings	Safe and efficient pathway

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		x		
Disability		x		
Gender Reassignment		x		
Marriage & Civil Partnerships		x		
Pregnancy & Maternity		x		
Race including Traveling Communities		x		No impact
Religion & Belief		x		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
				No impact
Sex		x		No impact
Sexual Orientation		x		No impact
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		No impact
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)		x		No impact

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
	No risks identified	.		
How will you monitor these actions?	Audit			

When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	ANNUALLY

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	AECLEVELY
Date signed	13.3.25
Comments:	
Signature of person the Leader Person for this activity	AECLEVELY
Date signed	13.3.25
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	
2.	Does the implementation of this document require additional revenue	
3.	Does the implementation of this document require additional manpower	
4.	Does the implementation of this document release any manpower costs through a change in practice	
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	
	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.