



## **Provision of Services for Adults with Tinnitus – A Good Practice Guide’ DH Document: January 2009.**

### **Response of the BSA Rapid Review Panel, March 2009**

#### **Summary**

This Department of Health publication is a welcome and timely document that raises the profile of Tinnitus Services in England at a time when Audiology departments are under increasing pressure to meet tight financial and waiting list targets. The aims of the Good Practice Guide (GPG) are laudable in that they aspire to deliver equitable and accessible Tinnitus services to all regions of England. The purpose of this review is to assess the Tinnitus GPG both in terms of the accuracy of its content and to look at any challenges to implementation. As a framework for discussion between commissioners and providers it sets a standard of care that this ‘Cinderella’ service currently rarely meets across the country.

#### **Foreword**

The statement in the second paragraph ‘We recommend that tinnitus which lasts for more than 5 minutes or is there most of the time increases not only with deterioration of hearing but also with age and in some form or another affects large numbers of people in the population’ could benefit from re-phrasing.

#### **Part One: Delivering the vision for services for people with Tinnitus**

11. Although there is comment here regarding lack of referral from primary care (33%) this issue is not addressed in the Tinnitus GPG

12. There exists concern that Modernising Scientific Careers will not be able to deliver a sufficiently trained workforce in time to meet the immediate need of tinnitus service delivery. Meanwhile there is a risk that the current cohort of trained and experienced Hearing Therapists may leave the profession without passing on their skills and knowledge.

**Figures 1 & 2** are not referenced in the accompanying text

#### **Systems and processes:**

13. Again, the mechanism for ‘Clarifying and improving referral criteria, and ensuring that they are consistently applied by well informed primary care practitioners’ is not clearly articulated. As this lack of training and referral is one of the most consistent concerns of patient groups and charities such as the British Tinnitus Association there needs to be a clear path for implementing this aspiration.

#### **Planning capacity**

17 – 18. Significant additional resources will be required to promote a shift from negative to positive attitudes to tinnitus management and audit any consequent increase in referral rates.

#### **Clear referral criteria**

19 – 23. Perhaps more realistic to provide GP’s with a self-explanatory referral form in the same format as the TTSA Direct Access referral form. Referral of some patients to a 1<sup>st</sup> level centre may change capacity for local Audiology and ENT services. This potential shift in capacity may benefit from greater consideration in the guide.

## **Technology**

**30 – 31.** Very positive step to see funding for White Noise Generators and assistive listening devices (ALD's) clearly articulated in the Tinnitus GPG as this has often been a post code lottery. Some care may be needed in the terminology as ALD's encompass devices such as flashing doorbells and TV loop systems.

## **Workforce**

**32 – 3.** Developing multi-disciplinary teams within Audiology, ENT and Audio-Vestibular Physician services can be achieved with relative ease. Engaging the interest and access to other disciplines, in particular Psychology services may require support and guidance within that profession to drive change. However in order for the appropriate funding and referral pathways to be in place it is essential that Psychology services are commissioned by regional SHA's as part of the core Tinnitus multidisciplinary team.

It is questionable whether administrative staff are appropriately trained and skilled to manage Tinnitus follow up over the telephone.

## **Part Two: Good practice commissioning pathway for adults with Tinnitus**

### **Patient self-management**

**39 – 40.** There exists a question about where the Tinnitus information provided in GP's surgeries should come from, local PCT's, the British Tinnitus Association or the DoH.

### **Primary care**

**41 – 45.** GPs are often referred to in the literature and patient groups as the source of negative information and barriers to referral. Developing a specific programme of training in Tinnitus would be costly and would compete directly with the other demands placed on GP surgeries. Without additional funding for training, financial incentives or government targets it would seem unlikely that significant changes can be made in this area. The general principle of triage is however fully supported.

### **The first level of care: community based audiology service**

**46 – 50.** Self-referral to the 1<sup>st</sup> level of care should be viewed with caution. Not only may inappropriate referrals occur but also there may be a further delay in triage to 2<sup>nd</sup> or 3<sup>rd</sup> level care if patients enter through this route. Suitably triaged patients however may well benefit from a group approach in terms of speed of access to a 1<sup>st</sup> level of care where there exists provision for further support following the group if required by the patient. There is concern that without ongoing accreditation and quality assurance that variation in services offered will continue. More emphasis here may be useful on the types of interventions offered for hyperacusis and any related processing disorders as well as for Tinnitus.

### **The second level of care: the specialist centre**

**51 – 61.** There is some ambiguity here in paragraph 52 where it asserts that the members of the 2<sup>nd</sup> level are, in comparison to paragraph 62 which states that members that a multi-disciplinary team may include. There are examples of good practice included in the guide that do not meet the requirements of the model. Perhaps broader categories may be of benefit.

There was felt to be a bias here towards assessment over rehabilitation. The challenge will be to develop an appropriately trained workforce of psychologists with an interest in Tinnitus, or Tinnitus practitioners trained in appropriate psychological techniques such as CBT in order to meet the needs of the patients assessed.

As there is a variety of outcome measures here suggested which are measuring different aspects the data acquired may be of little use in assessing the efficacy of a particular service locally or nationally. This may make it difficult to demonstrate to commissioners that the service is providing value for money.

### **The third level of care: the supra-specialist centre**

**62 – 67.** Whilst the development and existence of 3<sup>rd</sup> level supra-specialist centers is very much to be desired it should be acknowledged that the majority of this category of patient is currently being managed at the 2<sup>nd</sup> level. Rather than risk a duplication of services emphasis should be given to developing and establishing the standards of care available in England at the 2<sup>nd</sup> level, with 3<sup>rd</sup> level centers being the exception rather than the norm of care.

### **Conclusion**

**68.** The Tinnitus GPG is a great step forward in articulating the needs of and support required for people in England with Tinnitus. As a framework for discussion between commissioners and providers it sets a standard of care that this 'Cinderella' service currently rarely meets across the country. There are however significant challenges which need addressing further. Namely the issue of developing a sufficient number of suitably trained practitioners, setting standardized targets and outcome measures for services and funding the increase in referrals and the development of multi-disciplinary treatment pathways.

### **Annex 1: Suggested components of the tinnitus network**

Clarity here is needed here on the management of patients with Auditory Processing Disorder, the majority of whom can be managed successfully at the 2<sup>nd</sup> level. There is a typo under primary care column – 'red flagsr'

### **Annex 2: Third sector patient support groups**

The British Tinnitus Association is third in this list but suggested as the patients 1<sup>st</sup> point of contact in paragraph 39.

---

### **Panel Members:**

**Tim Husband (Chair)** Audiologist, Dewsbury and District Hospital

**Amanda Casey** Director of Audiology Programmes, Life and Health Sciences, Aston University

**Susannah Goggins** Audiologist, North East Wales NHS Trust

**Victoria Kennedy** Audiovestibular Physician, Bolton NHS Trust