

Community Audiology: Securing safe, high-quality hearing care across the NHS Summary

Hearing loss affects millions of people across the UK, yet NHS audiology remains a service under intense strain. Long waits, variable access, inconsistent commissioning, and uneven quality all undermine patient outcomes and increase long-term costs to the health and social care system. As highlighted by the Kingdon Review, audiology is often “overlooked, undervalued and underfunded” across England.

The NHS Long Term Plan rightly commits to shifting more care into community settings. Audiology is exceptionally well-suited to this model: well-established community audiology services already exist, delivered by NHS hospital departments in GP practices, health centres, and other outreach settings. Wales provides a strong example of mature, high-quality primary care audiology integrated directly into general practice, with safe escalation routes and consistently high patient satisfaction.

However, the current approach to commissioning and quality assurance in England puts community provision at risk. Without decisive national action, the NHS will fail to meet growing demand or ensure patient safety.

The British Academy of Audiology urges MPs to support the following priorities:

1. **A national commissioning framework for audiology** with standardised tariffs and activity planning.
2. **Mandatory, system-wide quality assurance**, including annual independent audits aligned to IQIPS and full adoption of the BAA Quality Standards in Adult Audiology (2025).
3. **Clear national guidance on the role of audiology in community models**, including Neighbourhood Health Services and Community Diagnostic Centres.
4. **Reinstatement of Referral-to-Treatment (RTT) waiting-time reporting** to ensure visibility and accountability.
5. **Investment in the audiology workforce**, including implementation of the Kingdon review recommendations.
6. **Protection of NHS patients from inconsistent provision and unsafe practices**, ensuring all providers (NHS, Any Qualified Provider (AQP), community or hospital-based) meet the same clinical standards.

1. The case for high-quality community audiology

Community audiology is not new. NHS services across the country already deliver assessment, hearing aid provision, rehabilitation, and long-term support in primary care settings, including GP practices, community hospitals, and outreach clinics and on some high streets. These models:

- Reduce travel and barriers to access.
- Increase early identification of hearing loss.
- Free up ENT and hospital-based capacity.
- Align with prevention priorities, especially dementia risk reduction.

The Welsh national model demonstrates the advantages of embedding audiology into primary care:

- Direct access from GPs without referral delays.
- Trained audiologists providing triage, assessment, follow-up, and ongoing support.
- Clear protocols for escalation to ENT or specialist centres.

- Consistent use of quality standards and performance monitoring.

This approach proves that community audiology can be safe, efficient, and cost-effective when properly governed.

2. Risks in the current system in England

a. Local commissioning and outdated tariffs

Local tariff-setting has created deep inconsistencies. In some areas, tariffs have been set below the cost of delivering safe, IQIPS-aligned care (Improving Quality in Physiological Services – IQIPS), forcing providers to compromise essential elements of service delivery, including workforce, bilateral fittings, outcome measurement, or follow-up.

At the same time, activity caps determined by financial envelopes, not patient need, have resulted in predictable waiting list escalation. Some services have been asked to reduce throughput by up to 90% or have paused issuing hearing aids to stay within their caps.

This undermines Integrated Care Boards' statutory duties on patient safety, inequalities, and prevention.

b. Long waits and lack of visibility

Following NHSE's decision to discontinue Referral-to-Treatment (RTT) reporting, there is no longer public visibility of the full audiology pathway. Diagnostic data show that audiology is often the worst-performing diagnostic service, with over 70,000 people waiting and some regions reporting >40-week delays.

Without RTT data, policymakers lack the information needed to assess system performance, risking further deprioritisation of audiology.

c. Inconsistent quality and patient protection

BAA has concerns about variability in quality across all providers. Evidence includes:

- Upselling, where *some* providers have, according to NHS patients, attempted to shift them into private pathways. [Investigating Variation in NHS Hearing Aid Services: A Research Note \(2024\) – RNID.](#)
- Restricted access to appropriate NHS hearing aids.
- Patients being turned away for months because providers have reached local activity limits imposed by ICBs.
- No mandatory quality assurance across services and providers.

3. Mandatory Quality Assurance: A non-negotiable requirement

To ensure patient safety and restore confidence across the system: all NHS-funded audiology services must meet the same quality standards.

This includes:

- Mandatory adherence to the BAA Quality Standards in Adult Audiology (2025) across all provider types.
- Accredited quality assurance through IQIPS, with annual independent audits.
- Defined national standards for assessment, intervention, onward referral, and follow-up, based on the BAA/RNID *What Good Looks Like* framework.

These standards are essential to ensure:

- Safe and appropriate diagnostic environments.
- Comprehensive and person-centred assessments.

- Access to all functions of modern hearing technology.
- Equitable referral routes to ENT, cochlear implant centres, MRI, and social care.
- Ongoing, lifelong support for hearing aid users.

Without national enforcement, variation will continue to grow, and patient safety will remain at risk.

4. Workforce Capacity: A critical constraint

There are fewer than 10,000 audiologists and hearing therapists in the UK, far below the number needed for today's ageing population.

The workforce plan must include:

- Expansion of training places.
- National funding for Continuing Professional Development.
- Measures to improve retention.
- Mandatory registration of audiologists, as recommended in the Kingdon Review. This will support consistent quality in all community settings and ensure patient protection.

5. Improving access, prevention and innovation

Audiology should be central to the NHS shift from treatment to prevention.

Key opportunities include:

- Clear guidance on audiology within Neighbourhood Health Services and CDCs, ensuring that community sites assess and treat, not just diagnose, hearing loss.
- Completion of national self-referral guidance to enable direct access everywhere in England.
- Use of digital and remote technologies for follow-up, hearing aid adjustments, and screening, building on emerging national innovation work.
- Expanded community-based wax removal, ensuring NICE-compliant provision free at the point of use.

6. What MPs Can Ask Ministers

1. Will DHSC introduce a national commissioning framework and tariff for audiology?
2. Will the Government mandate accredited quality assurance (IQIPS) and require all providers to meet the BAA Quality Standards?
3. When will RTT waiting-time reporting for audiology be reinstated?
4. How will audiology be integrated into Neighbourhood Health Services and CDCs?
5. What actions will be taken to implement the Kingdon Review recommendations on workforce and registration?
6. Will DHSC ensure all ICBs provide equitable access to wax removal in line with NICE guidance?

Conclusion

Community audiology does already exist across the NHS and has proven benefits when properly commissioned and quality-assured. Patients, clinicians, and taxpayers deserve a system that is consistent, safe, and sustainable.

With national leadership, through standardised commissioning, mandatory quality assurance, and a strengthened workforce, community audiology can become a cornerstone of prevention, early intervention, and equitable healthcare.