

Evaluation of Audiology Led Clinic (ALC) referrals redirected from AVM and ENT

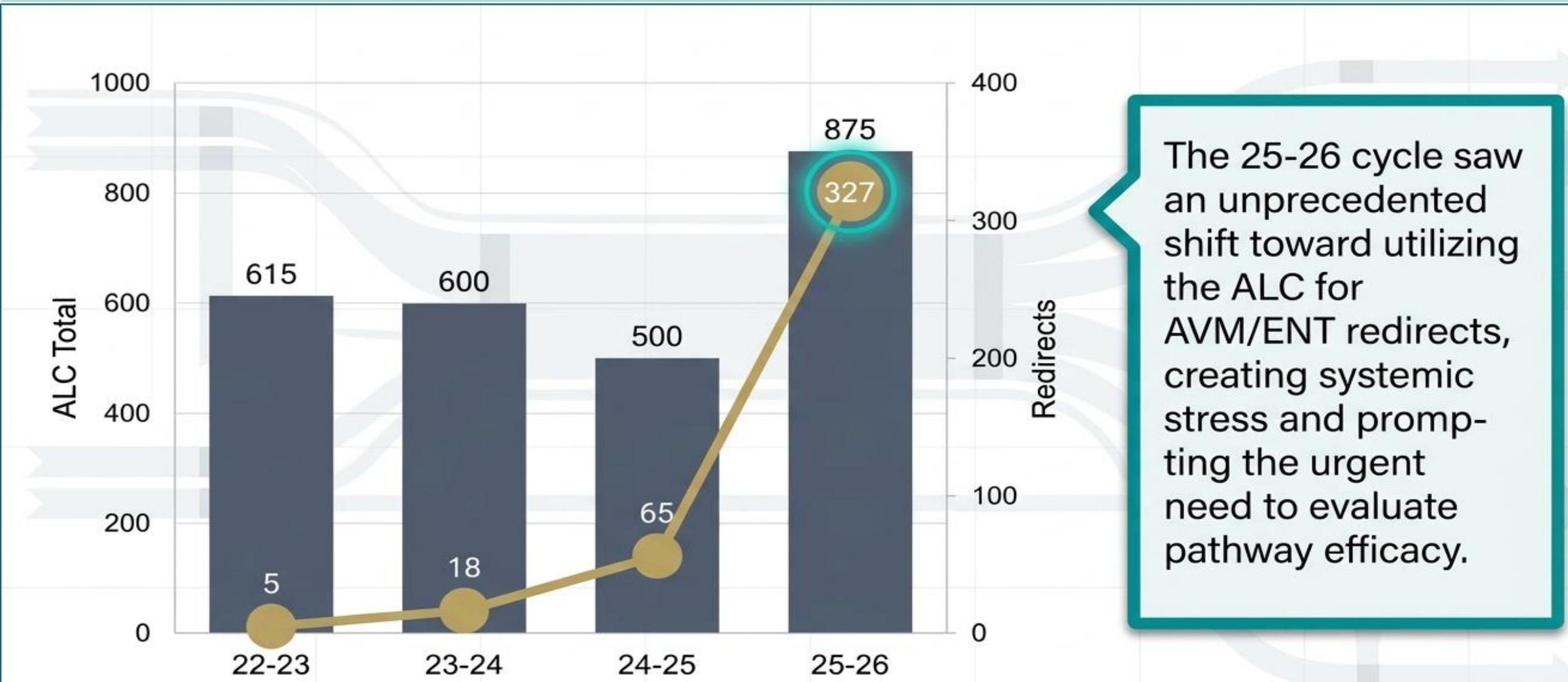
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Population – Consequences

Referral volumes for auditory and vestibular disorders have risen steadily across secondary care pathways. Direct-access Audiology-Led Clinic (ALC) routes were historically limited to primary care and external hospital referrals. In response to growing waiting lists, referrals originally placed on Audio-Vestibular Medicine (AVM) and ENT lists have increasingly been redirected to the Adult Diagnostic Audiology service. This single-centre, one-year clinical audit evaluates the outcomes, pathway efficiency, and clinical validity of these redirected cohorts

Methodology

A total of 1,065 patients were identified within the study window using the Trust's Epic electronic patient record system and cross-referenced with standardised annual audit records. Incomplete records were retrospectively audited and updated. Of the overall cohort, 875 patients attended their scheduled appointments; 190 patients were excluded from the analysis due to Did Not Attend (DNA) episodes, administrative rescheduling, or patient cancellations. Referral-to-assessment waiting times were calculated from the date the initial referral was received to the definitive appointment date.



Balance (Vestibular)

Cohort Size: 96 patients
Mean Age: 54.3 years (Oldest group)
Gender: 71% Female
Key Diagnoses: Probable Vestibular Migraine (VM), Central Positional Nystagmus (CPN), Multifactorial dizziness.

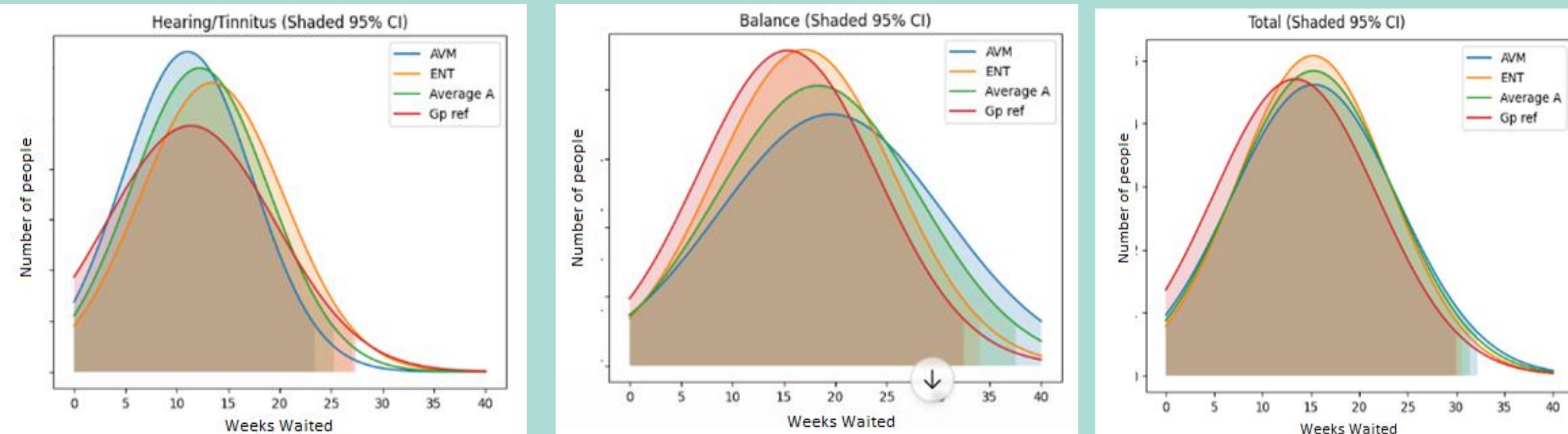
Hearing Loss

Cohort Size: 67 patients
Mean Age: 53.3 years
Gender: 54% Male
Key Diagnoses: Asymmetrical SNHL, Bilateral SNHL.

Tinnitus

Cohort Size: 164 patients
Mean Age: 48.4 years (Youngest group)
Gender: 51% Male / 49% Female
Key Diagnoses: Bilateral/Unilateral Tinnitus, Tinnitus with SNHL.

Referral-to-Assessment Timelines: Wait times within the Audiology-Led Clinic were substantially shorter than standard secondary care routes, where the average ENT wait time exceeded 52 weeks at the time of audit



Clinic Type	Average Weeks			
	AVM	ENT	Average AVM/ENT	GP ref
Hearing/Tinnitus	11.03	13.42	12.23	11.36
Balance	19.6	16.99	18.30	15.37
Redirect Total	15.32	15.205	15.26	13.37

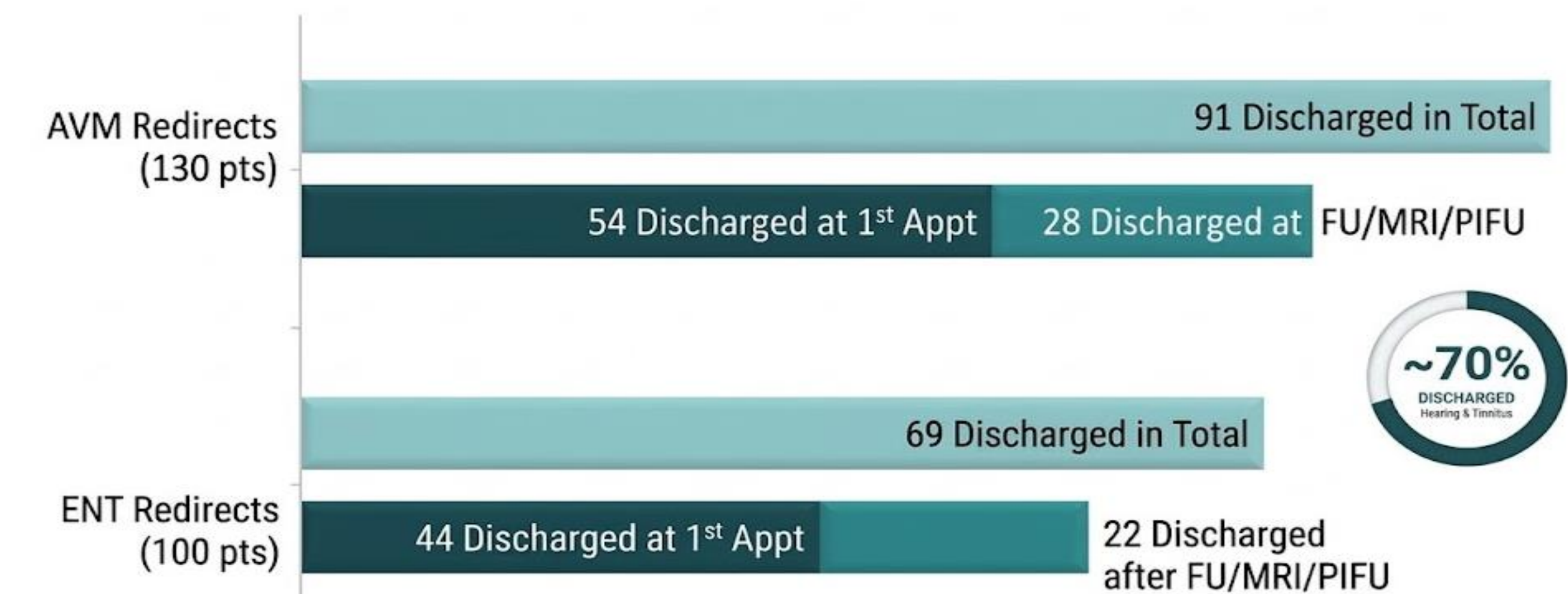
65%

Hearing and Tinnitus Discharge via GP/ External NHS trust only
311 Patients

- ✓ 201 Patients required 0% onward referrals to AVM or ENT
- ✓ 117 Patients discharged after 1st Appt
- ✓ 70 Patients discharged after Follow up, MRI or PIFU

Success outflow: Managing Hearing and Tinnitus Redirects

ALC successfully manages and discharges ~70% of hearing and tinnitus redirect patients. The clinic excels at ruling out pathology via MRI, with incidental findings referred accordingly.



The Vestibular bottleneck

While the ALC achieved high discharge rates for hearing and tinnitus redirects, balance presentations posed a notable clinical bottleneck. Of the 101 patients redirected from AVM and ENT into the ALC balance clinic, 64 (63.4%) required onward re-referral back to secondary care. The primary indications for secondary escalation were complex neuro-otological presentations predominantly Vestibular Migraine (VM) and Central Positional Nystagmus (CPN) which require specialist medical oversight and targeted pharmacotherapy based on symptom severity. ALC review significantly accelerated access, completing essential baseline vestibular test batteries in advance and providing AVM clinicians with comprehensive objective findings prior to secondary assessment.

This is representation of the flow of the ALC triage.

Master Flow: The ALC as a Precision Triage Engine



Strategic Roadmap: Tuning the Engine for Pathway Efficiency

Objective: Adjust triage criteria to increase appropriate ALC scope, refine audiological competency, and reduce AVM workload (Target: Improve overall discharge rates beyond the current 70% H/T baseline).

Pillar 1: Templates & Guidelines

- ALC template review.
- Develop recommended guidance for Probable VM, APD, and CPN.
- Implement agreed "smart phrases" for VM.

Pillar 2: Redefining Criteria

- Develop defined diagnostic advice for GPs to ensure better initial routing.
- Create a clearer, shortened pathway for Pulsatile Tinnitus pathology.

Pillar 3: Proactive Care Prep

- Capitalize on reduced wait times by managing complex Balance conditions via standardized testing and advice prior to AVM appointments, reducing the severity of symptoms while waiting.

Pillar 4: MDT Integration

- Introduce a dedicated Multi-Disciplinary Team (MDT) session for specific complex patients every 4th Thursday of the month to streamline case reviews.

Conclusion and what does the future hold

The ALC successfully manages and discharges the vast majority of non-complex hearing and tinnitus redirects, effectively removing low-complexity caseloads from ENT and AVM clinics and mitigating secondary care waiting list pressures. Looking forward, expanding advanced audiological practice could enable clinicians to manage more complex presentations autonomously. Through standardised clinical protocols and structured prescribing recommendations to primary care, non-surgical symptoms can be optimised earlier, reducing downstream demand on consultant-led AVM and ENT clinics.