Health Needs Assessment: Adult-Onset Hearing Loss

Hampshire and Isle of Wight - December 2025

Introduction

Hearing loss is the commonest sensory deficit affecting the human population[1] and one of the most undertreated disabilities worldwide [2]. It is the sixth leading cause of years lived with disability in England [3], affecting around 1 in 6 people - over 9 million in 2019 [4]. Hearing loss is expected to become an even greater issue in the future due to an ageing population and increased social exposure to noise (such as through prolonged headphone use) [5] [6], and is expected to rise to at least 1 in 5 people by 2035 [7].

Hearing loss may develop at any point in the life course, but its prevalence increases with age. It is estimated that more than 60% of people over 70 would benefit from a hearing aid [1]. However, hearing loss frequently goes unrecognised and untreated, and about 60% of people who need a hearing aid do not have one [5]. People wait an average of 10 years before they seek help for hearing loss, and 30-45% who present to primary care are not referred on for assessment [5].

Scope

This health needs assessment was carried out to address a gap in knowledge about the impact of hearing loss locally, with a particular focus on hearing loss acquired in adulthood. It covers the geographical areas of Hampshire County Council and Isle of Wight Council.

This document discusses hearing loss in adults, presents available data on its prevalence in Hampshire and the Isle of Wight, and draws recommendations to improve its prevention, detection and early diagnosis to improve population health.

What is the impact of unaddressed hearing loss?

Untreated hearing loss impairs communication and presents risks to personal safety. It is associated with social isolation, reduced quality of life, reduced educational and employment opportunities, increased falls, and the risk of misdiagnosis and mismanagement of other health conditions leading to poorer health outcomes [5]. Midlife hearing loss is one of the largest modifiable risk factors for the onset of dementia[8] [9], and accelerates the rate of cognitive decline [10]. People with hearing loss are also 2.5 times more likely to develop depression [11]. However, there is evidence that effective treatment for hearing loss can mitigate these risks [5].

In addition to its impact on the affected person, the partners of people with hearing loss also often experience loneliness, social withdrawal, frustration and reduced quality of life [12].

Hearing loss can also contribute to health inequalities in many areas. Around 40% of people with intellectual and developmental disabilities and 80% of people in care

homes experience hearing loss [4 13], and may face barriers if required to travel to access services [4, 5]. People in the Deaf Signing Community have poorer health than the hearing population, with higher rates of obesity, undiagnosed/uncontrolled hypertension, high cholesterol and prediabetes/diabetes [14]. There may be a 'vicious cycle' between hearing loss, socioeconomic disadvantage and less healthy lifestyles [15].

Unaddressed hearing loss may lead to poorer health outcomes, increased health and social care costs, and worsened healthcare access [5]. It is therefore of critical importance for individuals, families and society that hearing loss be detected early and managed effectively. Owing to the scale of unsupported hearing loss in England, NHSE advise that it should be included in all local Joint Strategic Needs Assessments to facilitate a co-ordinated response across the health and care system [4].

What are the main causes of hearing loss?

Some people experience permanent hearing loss from childhood resulting from genetic factors, birth injury or infections. However, the majority of affected adults acquire the condition later in life [4]. There are two main types of hearing loss – sensorineural and conductive.

> *Conductive hearing loss* accounts for 10% of cases, and results from blockages between the outer and middle ear [4]. Causes include ear wax impaction, infection and inflammatory disease.
>
> *Sensorineural hearing loss* accounts for 90% of cases, resulting from damage to sensory hair cells in the inner ear [4]. There are a range of underlying causes, the commonest being age-related hearing loss (presbycusis) and noise-induced hearing loss [4].

Age-related hearing loss is extremely common, affecting 42% of over 50s and 71% of over 70s in the UK [7]. It associated with obesity, diabetes and cardiovascular risk [16].

Noise-induced hearing loss results from repeated and/or extreme exposure to loud noises. There is a worsening public health risk of hearing loss from increasing recreational exposure to noise from personal listening devices, music venues and sporting events [17]. 25% of 12-35 year olds in middle and high-income countries listen to sound at unsafe levels through personal audio devices, and 40% are exposed through attending loud venues (e.g. bars, clubs) [18].

The World Health Organisation (WHO) has defined permissible sound levels for safe listening, as reproduced in Figure 1. **WHO recommends no more than 40 hours per week listening to sounds at 80 dB (75dB for children),** and shorter periods for louder sounds [19]. However, sound levels in music venues (e.g. nightclubs) and from personal music players at loud volume is frequently as high as 110dB [18].

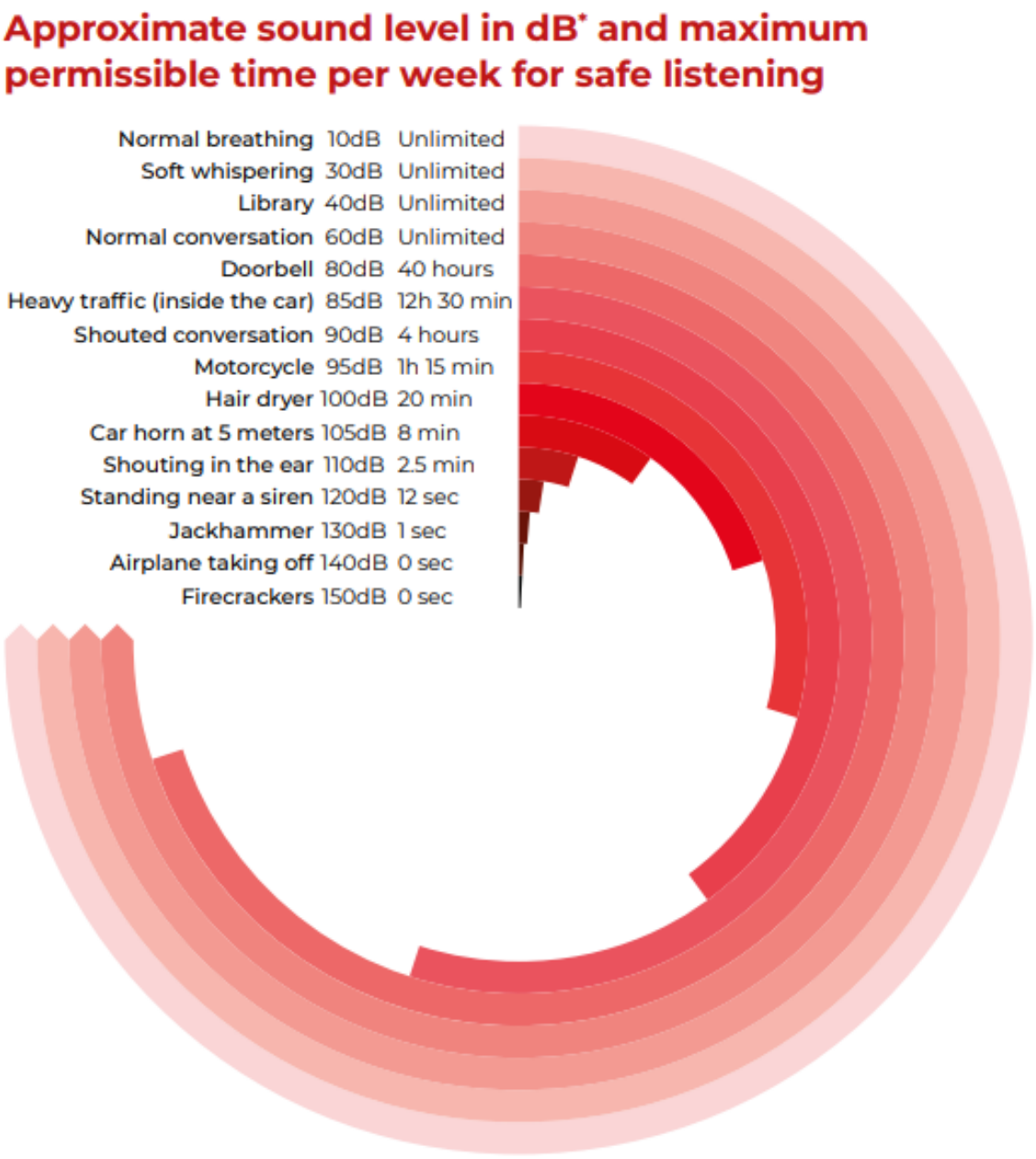

Figure 1: Maximum permissible times per week for safe listening. From World Health Organisation, 2022, Media Brief on safe listening, p22 Media brief on #safelistening [Accessed 11/03/25]

For those using headphones for long periods, including for remote working purposes, WHO recommend [20]:

- Limiting volume to below 60% of maximum
- Using apps to monitor sound levels, such as the NIOSH-SLM app from the US National Institute for Occupational Safety and Health (available for Apple products only).
- Using noise-cancelling and well-fitting headphones

- Taking breaks between calls in a quiet environment to allow ears to rest
- Limiting exposure to noise at other times

Severity of Hearing Loss

The severity of hearing loss can be quantified through audiometric tests, as shown in Figure 2. Hearing is considered impaired if a person is unable to hear sounds below 20 decibels (dBHL), and severely impaired if they cannot hear sounds below 65dBHL in the better ear [4].

Better ear average hearing level in decibels of hearing loss (dB HL)	Hearing in a quiet environment	Hearing in a noisy environment
20-34 dBHL	Does not have problems hearing what is said	May have real difficulty following/ taking part in a conversation
35-49 dBHL	May have difficulty hearing a normal voice	Has difficulty hearing and taking part in conversation
50-64 dBHL	Can hear loud speech	Has great difficulty hearing and taking part in conversation
65-79 dBHL	Can hear loud speech directly in one's ear	Has very great difficulty hearing and taking part in conversation
80-94 dBHL	Has great difficulty hearing	Cannot hear any speech
Unilateral hearing loss: Up to 20 dBHL in the better ear; at least 35 dBHL in the worse ear	Does not have problems unless sound is near poorer hearing ear	May have real difficulty following/ taking part in a conversation

Source: NHS England's Commissioning Services for People with Hearing Loss: A Framework for Clinical Commissioning Groups[3]

Figure 2: Classification of severity of hearing loss. From NHS England Joint Strategic Needs Assessment Guidance, 2019 [4]

At least 900,000 people in the UK have severe / profound deafness, and 24,000 of these use British Sign Language (BSL) as their first language [7].

The term deaf describes people with severe / profound hearing loss. The capitalised term Deaf may be used to refer to those who identify culturally as part of the Deaf community, typically having been deaf since a young age with sign language as their first language [21].

What treatments and interventions are available for hearing loss?

Adult audiology services provide full hearing assessments, fit hearing aids, and provide follow-up and aftercare (including hearing aid support and repair). These services may be provided by the NHS, independent or voluntary sector providers [5]. They also provide onward referral to social services for support and equipment, and to other local services running support groups, lip-reading classes etc [5]. People with

hearing loss may also be offered assistive technologies including personal loops, telephone devices and doorbell sensors [4].

Treatment When the Underlying Cause is Reversible

Some causes of hearing loss are treatable with medications or minor procedures.

Impacted ear wax can cause hearing loss and pain. Some cases can be managed through self-care (e.g. by applying olive oil), but some require professional removal through minor procedures such as irrigation or micro-suction[22]. According to a 2025 report by the Royal National Institute for Deaf People (RNID), 2.3 million people nationally require professional earwax removal at least once a year, but many are unable to access it on the NHS[23]. Some people self-fund through a private provider, but some attempt invasive wax-removal procedures themselves at home, which may lead to irreversible damage if done incorrectly [23].

NICE Guideline 98 and NICE Quality Standard 185 recommend the provision of NHS earwax removal services where earwax is contributing to hearing loss [24] [25].

> NG98 recommendation 1.2.1:
>
> *"Offer to remove earwax for adults in primary care or community ear care services if the earwax is contributing to hearing loss or other symptoms, or needs to be removed in order to examine the ear or take an impression of the ear canal."* [24]
>
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NICE have also published a management scenario on earwax removal. This suggests that where earwax removal is indicated it should first be managed with ear drops, progressing to irrigation or microsuction where that fails. [26]

There is currently geographical variation in the provision of professional wax removal services in England [23].

Treatment When the Underlying Cause is Not Reversible

Where the cause is not reversible, such as in age-related and chronic noise-related hearing loss, individuals may benefit from the use of hearing aids or implants [27].

Hearing aid use has been shown to mitigate the effects of hearing loss, improving quality of life, reducing loneliness, improving mental and physical health, slowing cognitive decline and improving economic prospects [5]. Hearing aids are cost-effective, with UK studies estimating their cost as £1300-1500 per QALY [5]. As hearing aids are particularly cost-effective when used early, NICE recommend that clinicians have a low threshold for referral, and have highlighted the need to increase awareness of the benefits of hearing aids [4, 30**Error! Bookmark not defined.**]. However, it is e stimated that only around 40-60% of people who would benefit from hearing aids have them [5, 4]. This low uptake is thought to be due to the following [4]:

- Negative stereotypes around hearing loss and hearing aid use [28]
- Stigma [29]

- Delayed help-seeking, and the incorrect assumption that the consequences of hearing loss are inevitable [4]
- Insufficient referrals from primary care to audiology [30]
- Difficulties in seeking help or accessing services [5]. This may particularly affect people with long-term conditions, learning disabilities, communication and memory problems, caring responsibilities, and mobility problems.

How Prevalent are Diagnosed and Undiagnosed Hearing Loss in Hampshire and IoW?

OHID National General Practice Profiles Data [31]

The OHID National General Practice Profiles summarise data collected directly from practices on reported / diagnosed hearing loss. The percentage of over-16s reporting deafness or hearing loss at ICB level is:

- Frimley ICB 5.0% (CIs 4.6-5.5) in 2023 - stable from 4.9% in 2020
- Hampshire and IOW ICB 6.4% (CIs 6.1-6.7) in 2023 - stable from 6.7% in 2020

These rates are similar to the England average of 6%.

However, this data reflects only those cases reported to or investigated by GPs. The population prevalence of hearing loss is thought to be around 4 times higher based on extrapolation of hearing test data, as summarised in the NHSE data that follows.

NHSE Hearing Loss Tool Data [32]

This section contains data from the NHSE hearing loss tool, which provides estimates of the numbers of people affected by hearing loss based on extrapolation of prevalence estimates from a 1995 Pure Tone Audiometry study [33] onto the population structure of local areas. As such, it provides an estimate of the total number of people in each age group affected by hearing loss, whether or not they have reported this to a GP. However, these data are not sensitive to local variations in prevalence, or to changes in the prevalence of hearing loss by age group over the last 30 years. As social noise exposure has increased over this time, and hearing loss prevalence is projected to increase in line with this [5,6], they may represent conservative estimates.

Mild Hearing Loss

Table 1 and Figure 3 show the estimated prevalence of at least mild hearing loss in the populations of Hampshire and Isle of Wight between 2015 and 2035. An estimated 30% of Hampshire residents and 34% of Isle of Wight residents are expected to have at least mild hearing loss by 2035. Both are higher than the national and regional averages, due to the higher age demographics of Hampshire and Isle of Wight.

Table 1: Estimated prevalence (%) of hearing loss of 25 dBHL or more in the adult population (people aged 18 and over) [32]

	2015	2020	2025	2030	2035
Hampshire	23	25	27	28	30
Isle of Wight	27	29	31	33	34
South East	22	23	25	26	27
England	21	22	23	24	25

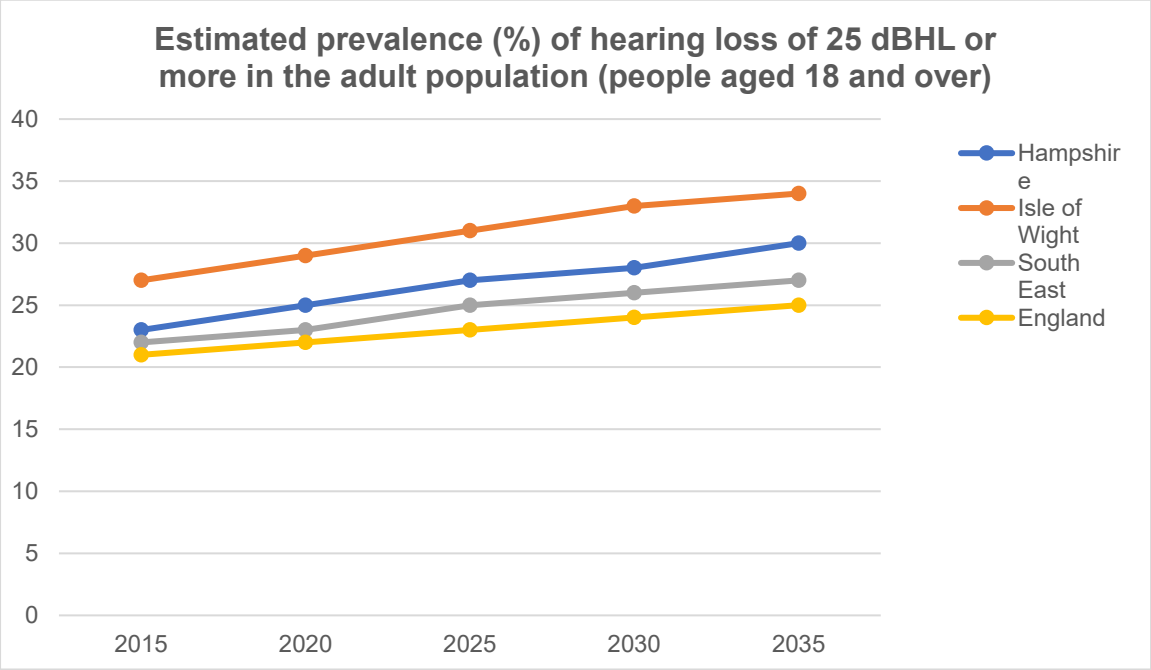

Figure 3: Estimated prevalence of at least mild hearing loss in the adult population

By 2035, almost 360,000 adults in Hampshire will have at least mild hearing loss. Around 127,000 of those affected will be aged 18-70, and 233,000 aged over 71. A detailed breakdown by age group is shown in Table 2 and Figure 4.

Table 2: Estimated number of adults with hearing loss of 25 dBHL or more by age group in Hampshire [32]

Age	2015	2020	2025	2030	2035
18-30	3,408	3,377	3,285	3,382	3,556
31-40	4,373	4,499	4,640	4,656	4,419
41-50	16,189	14,572	13,919	14,357	14,791
51-60	35,192	38,145	37,238	33,845	32,704
61-70	59,952	59,445	66,810	72,768	71,579
71-80	66,600	82,905	89,892	90,260	102,262
>80	64,106	74,635	89,054	115,642	130,563
Total	249,819	277,578	304,838	334,911	359,873

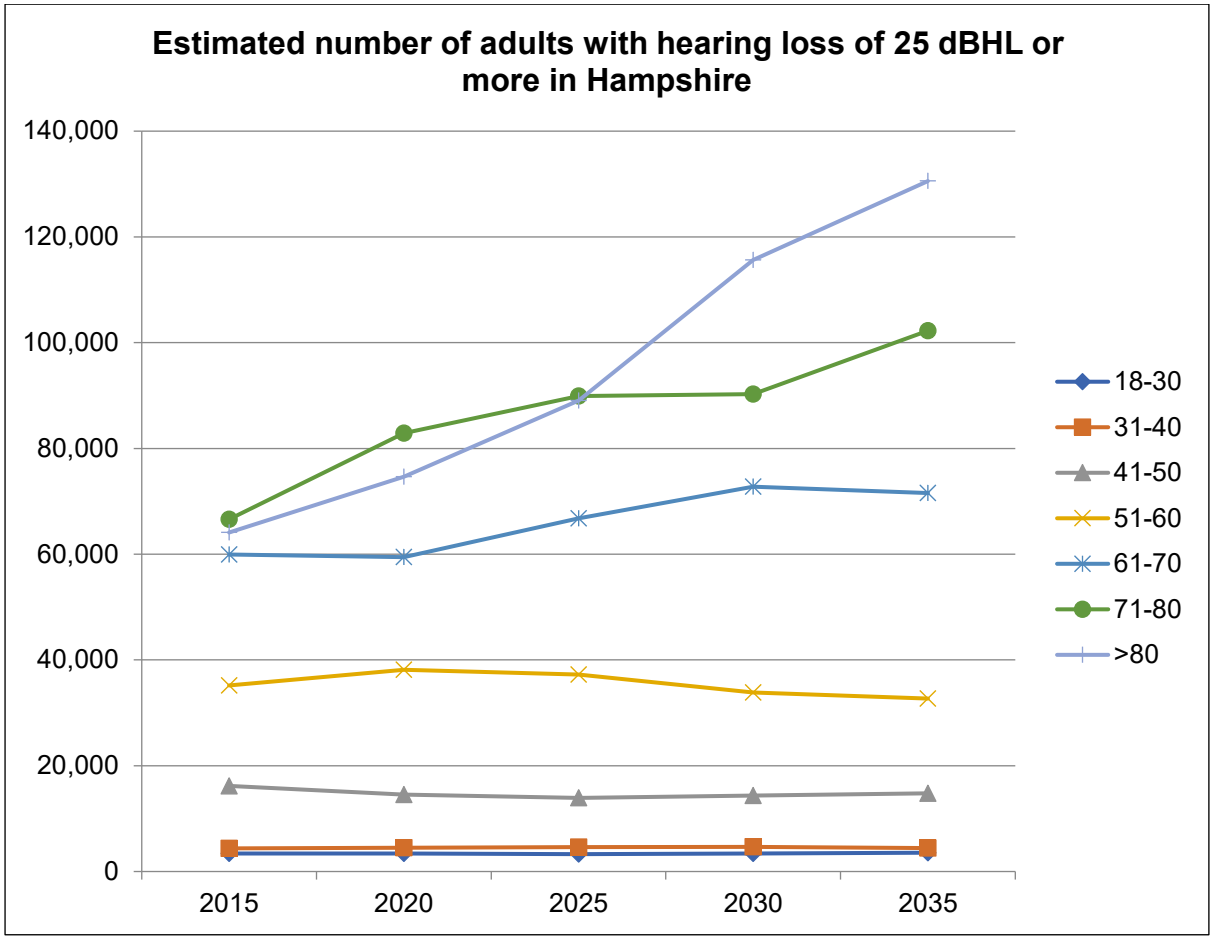

Figure 4: Estimated numbers of people with at least mild hearing loss in Hampshire by year [32]

By 2035, almost 43,000 adults in Hampshire will have at least mild hearing loss. Around 13,000 of those affected will be aged 18-70, and 29,000 aged over 71. A detailed breakdown by age group is shown in Table 3 and Figure 5.

Table 3: Estimated number of adults with hearing loss of 25dBHL or more by age group in IoW [32]

Age	2015	2020	2025	2030	2035
18-30	321	310	292	293	308
31-40	364	387	405	404	376
41-50	1,532	1,298	1,221	1,292	1,345
51-60	3,724	4,042	3,924	3,422	3,280
61-70	7,851	7,502	8,152	8,914	8,762
71-80	8,822	11,036	11,741	11,568	12,781
>80	8,334	9,138	10,969	14,226	15,911
Total	30,948	33,713	36,703	40,120	42,764

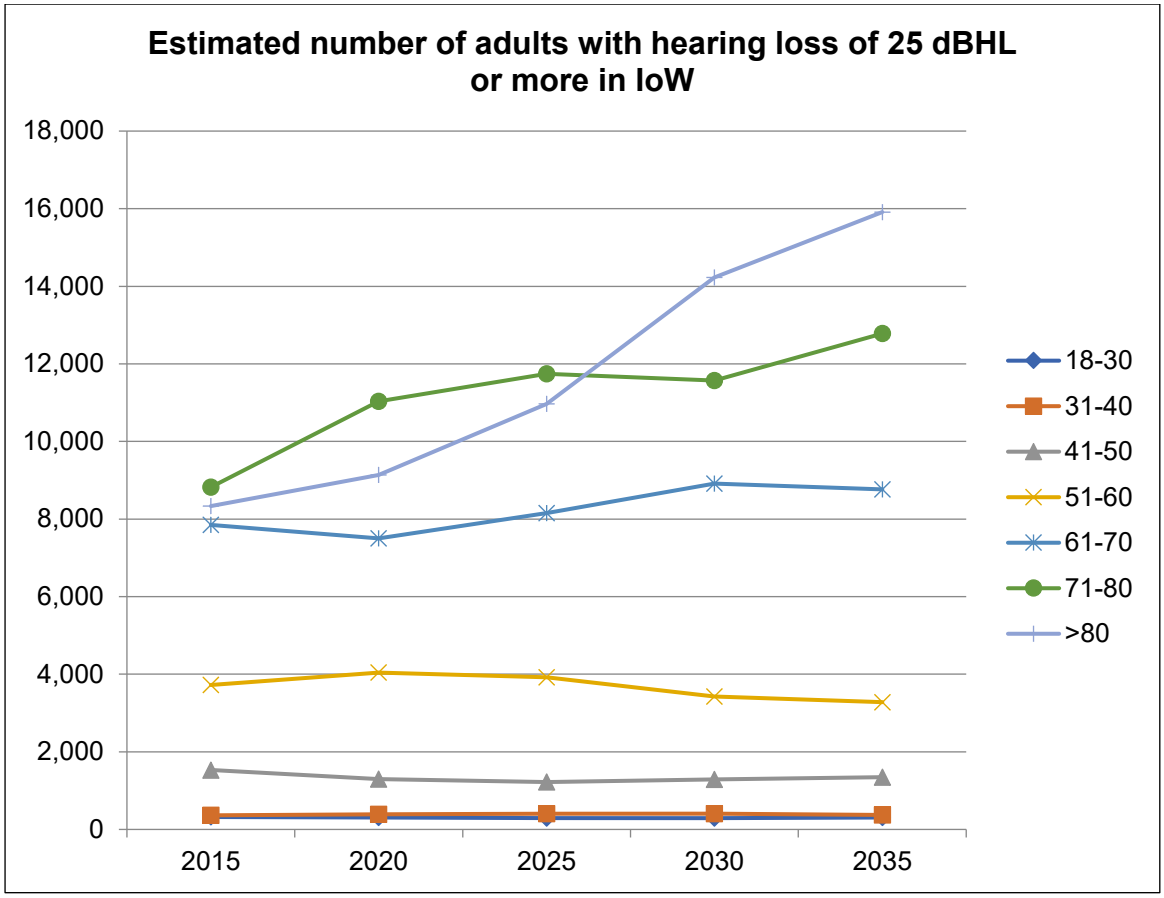

Figure 5: Estimated number of adults with hearing loss of 25 dBHL by age group in the Isle of Wight [32].

Severe Hearing Loss

Over 45,000 people in Hampshire and over 5,000 people in the Isle of Wight are projected to have severe hearing loss by 2035, as detailed in **Error! Reference s ource not found.**. This represents a greater than 60% increase over 20 years, highlighting a need for increasing support provision.

Table 4: Estimated number of adults with hearing loss of 65 dBHL or more in Hampshire and IoW [32]

Age	2015	2020	2025	2030	2035
Hampshire					
18-70	7,108	7,190	7,618	7,849	7,677
71 and over	19,724	23,319	27,225	33,574	37,957
Total	*26,832*	*30,509*	*34,843*	*41,423*	*45,634*
IoW					
18-70	815	806	842	868	847
71 and over	2,575	2,914	3,398	4,175	4,647
Total	*3,390*	*3,720*	*4,240*	*5,043*	*5,494*

Hearing Loss by Geographical Area

Table 5 shows Royal National Institute for Deaf People estimates of the number of people with hearing loss by local area, by applying age-specific prevalences to the demography of each borough[34]. Estimates are highest in the New Forest, Isle of Wight and Basingstoke and Deane.

Table 5: Numbers of people affected by hearing loss by local area, based on prevalence projected onto local population structure. RNID, 2019 [34]

Local Authority Area	**Total population in 2019** (according to ONS 2019 projection)	**Estimated number with hearing loss in 2019** (rounded to the nearest 500)
Basingstoke and Deane	184,396	32,000
East Hampshire	120,941	27,000
Eastleigh	135,094	25,500
Fareham	118,104	26,000
Gosport	85,533	16,500
Hart	95,384	18,500
Havant	124,398	27,500
New Forest	184,782	47,500
Rushmoor	97,530	15,000
Test Valley	120,051	25,500
Winchester	124,095	25,500
Isle of Wight	142,280	35,000

What Services are Available to Support People with Hearing Loss?

Local Audiology Services

Audiology is commissioned separately for complex and non-complex services. Non-complex (routine) audiology services may be delivered by a range of providers under various different contract procurement processes and contracting types.

Hampshire and Isle of Wight ICB

Hampshire and Isle of Wight ICB are currently reviewing their non-complex (routine) adult audiology services. There is variation in eligibility, access and routes of referral between geographies, resulting from historical variation in commissioning arrangements.

In Hampshire and Isle of Wight ICB, microsuction of earwax where it contributes to hearing loss is not routinely available on the NHS - it is provided only in cases which also meet additional locally-specified criteria (e.g. previous ear surgery, recent infection) [35].

Frimley ICB

Frimley ICB have contracts for non-complex adult hearing services for those aged 55 years and over who require hearing assessment and management with hearing aids.

For more complex cases, covered by the Hearing and Balance service specification [36], Frimley ICB currently accepts initial audiology referrals from healthcare professionals and self-referral from existing hearing aid users already registered with their service. Appointments are offered within individual homes when GPs provide confirmation that the patient is house bound.

In Frimley ICB, NHS-funded irrigation / microsuction of earwax where it contributes to hearing loss may be available in primary/community care (after exhausting self-care options) [37].

Waiting lists

Table 6 shows the waiting lists for NHS audiology services locally. In Hampshire and Isle of Wight in November 2024, 26% of those referred waited more than 13 weeks.

Table 6: Waiting list data for NHS Audiology services, November 2024. Statistics » Monthly Diagnostics Data 2024-25

ICB	Total Waiting List	Number waiting 6+ weeks	Number waiting 13+ weeks
Frimley	1,458	419 (29%)	122 (8%)
Hampshire and IoW	4,811	2,266 (47%)	1,235 (26%)
England	109,667	46,373 (42%)	28,551 (26%)

Inequalities in access

At the time of writing, no available data was identified that could be used to further explore patient experience, service outcomes or inequalities in access to audiology services locally.

What are the Experiences of People with Hearing Loss using Health and Care Services?

Hearing loss in health and care settings

Studies in social care settings have highlighted failures to communicate with people with hearing loss, reducing opportunities for social interaction and making care less person-centred [38]. Issues identified include adverse environmental factors (such as background noise from televisions), failure to identify hearing loss, limited access to hearing services and inadequate staff training at communication and hearing aid management [39] [38]. The RNID 'a world of silence' report into hearing loss in care homes called for improved detection of hearing loss and improved management of hearing aids and other communication needs [40].

In healthcare settings, unaddressed hearing loss risks misdiagnosis, compromises people's ability to participate in decision-making, reduces their ability to follow clinical advice, and increases their risk of falls and of delirium (an acute confusional state) [41]. This may lead to clinical worsening/complications, poorer health outcomes, increased cost and length of hospital stay and repeat attendances [41].

Studies have suggested that clinicians fail to identify more than half of people with hearing needs in healthcare settings [42]. Some healthcare professionals lack confidence and skills in communicating with people with hearing loss, and may be unaware how to assist them with day-to-day hearing aid management [43]. In hospitals, hearing aids may also frequently be lost or run out of battery [44].

Research by Healthwatch Hampshire [45] explored the experiences of d/Deaf people in Hampshire using healthcare services. It identified that:

- Many d/Deaf people have faced difficulties accessing appropriate BSL interpreters. Many needed to use family members, or were allocated registered interpreters that they know in other social contexts, compromising their confidentiality.
- Many were unable to book appointments independently due to a telephone requirement.
- Half of D/deaf people surveyed did not know how to feedback or complain about NHS services, meaning that accessibility issues may go unreported.
- 60% of those surveyed felt that GP and hospital services did not understand their deafness or their needs. In many cases communication support was unavailable, and staff did not take action to ensure they could be understood (e.g. speaking clearly and facing the D/deaf person). Only 8% were offered support by hospital staff if they did not understand what had been said.

Healthwatch recommend that NHS frontline staff should receive training to understand the needs of deaf people, how to reduce the barriers they face, and how they can be supported through interpreters, technology, and signposting of accessible formats. NHS and adult social care providers are legally required to provide communication support meeting the NHS Accessible Information Standard.

Currently available sources of support for those caring for people with hearing aids include:

- Short online videos, such as those produced by Hampshire Hospitals Foundation Trust in 2015:
  - https://youtu.be/Ks-D64yWDMI?si=Adz9G3ybFET7XQJ0 Hearing aid insertion, 2015
  - https://youtu.be/0ab5ZV5DD4A?si=qTOBgjvd-afHFcYQ Switching on and off, 2016
- Written guidance on the Royal National Institute for the Deaf (RNID) website:
  - Written guidance from RNID A1422_Hear_to_Care_Guide_A4.pdfProducts and technology - RNIDProducts and technology - RNID
- Commercial training courses

Conclusion

Hearing loss is very common, and its prevalence is projected to rise. It is associated with a range of serious negative physical and mental health outcomes, as well as

reduced wellbeing and quality of life. Hearing loss is both under-diagnosed and under-treated, despite evidence that timely intervention can reduce its sequelae. People with hearing loss often report difficulties in health and care settings.

Intervention may assist in prevention by reducing individuals' noise exposure, increase the recognition and effective management of hearing loss, and support health and care staff to provide the best possible care for those affected.

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