Choice in Adult Hearing Services

The GP Perspective on Age Related Hearing Loss

This research has been commissioned and funded by Monitor.

The reported findings of GP interviews commissioned by Monitor as part of its research project made a number of references to individual providers of NHS-funded adult hearing services, based on the responses of those questioned as part of the interviews.

Monitor has asked us to redact the names of individual providers because it does not consider these relevant to the objective of its research project which is to explore how choice in adult hearing services is working overall and not to evaluate the quality of services offered by individual providers.

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Prepared for:

Monitor

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We should like to thank all the GPs who took part in the research and who shared their experiences of referring patients to Adult Hearing Services. We hope we have reflected these fairly and accurately.

The views expressed in this report are those of the respondents as interpreted by the authors, not necessarily those of Monitor

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1.1 Background and Research Method

The research was commissioned by Monitor, the sector regulator for health services in England. Monitor's aim in commissioning the research was to improve its understanding of the impact that patient choice and the 'any qualified provider' (AQP[1]) approach has had on the quality of NHS-funded adult hearing services and whether or not patients can exercise choice in a meaningful way. To this end, it commissioned an independent research study that included:

- a quantitative survey with users of adult hearing services in England; and
- qualitative research with GPs.

The report sets out the findings of the qualitative research among a sample of GPs. It explores how GPs currently enable patient choice, whether they have sufficient support from CCGs to help with this and their general attitudes to AQP and patient choice.

Depth interviews were conducted either face to face or by telephone with a broadly representative sample of thirty GPs in different CCGs across England. Twenty-three GPs were located in areas where AHS is commissioned using AQP and the other seven GPs were in locations where AHS are not commissioned using AQP.

The following topics were discussed:

- diagnosis of age-related hearing loss and the referral process for AHS
- the range of AHS providers known to the GP, referral patterns relative to these and the reasons for these
- the extent to which, and how, patients are offered a choice of AHS provider
- awareness of the quality of service offered by different AHS providers and whether this is discussed with patients
- awareness and understanding of AQP
- whether there are patients who find it difficult to access AHS and how this might be improved.

Across the topics, respondents were asked about additional information or support that would help them engage with the provision of choice to patients with respect to AHS.

While the sample size provides robust qualitative data, the numbers of GPs are small and care should be taken in extrapolating the findings to the total population.

1.2 Key findings

1.2.1 Diagnosis and referral

The number of patients presenting with age-related hearing loss varied, largely based on practices' patient profiles, but many GPs were seeing an average of around one new patient per week. The general view was that age related hearing loss was fairly

[1] AQP is a way of commissioning NHS-funded services so that patients can choose who provides their care.

straightforward to diagnose based on the patient history and an examination to exclude other causes. Patients were then sent for a hearing test to confirm the diagnosis and if necessary, to be fitted with hearing aids. If patients expressed a reluctance to wear hearing aids, GPs might encourage them to take a hearing test as a first step to assess the severity of the problem but many also took the view that if patients were adamant that they did not wish to wear aids, there was little point in having their hearing tested.

A variety of referral processes for AHS were revealed by the research and GPs felt that whichever they used seemed to work well. A formal referral protocol was in place for only two GPs although the referral forms completed by at least a couple of others contained a checklist giving guidance on whether the referral was appropriate.

Referrals might be made through Choose and Book (C&B) in a variety of ways or the system might not be used at all. C&B might be used by the GP during the consultation with the patient (nearly half of GPs did this) or used by practice admin staff later. Some GPs were using C&B to make a referral but were not discussing choice of provider with their patients as they were wary of the time this could add to the consultation.

Where C&B was not used to make a referral, electronic referral templates were often used (provided either by the practice itself or by a particular AHS provider) or GPs wrote/dictated a referral letter. Three GPs made referrals through a Referral Management Centre (RMC).

GPs were not signposting patients to other services that can help those with hearing loss because they did not know what might be available, they did not think patients needed anything other than hearing aids or they thought that a specialist further along the patient journey was best placed to provide this information.

1.2.2 Patient choice

GPs were rarely aware of all the providers to which they could refer patients for AHS particularly with respect to independent providers. 22 of the 23 GPs in AQP areas were aware of at least one independent provider but awareness was patchy with respect to other providers. It appeared that CCGs had not been active in making GPs aware of the range of providers or recommended referral pathways (or, if they had, this had not registered with the GPs taking part in the research). Two GPs were in practices that offered an AHS clinic within the practice.

A number of factors were identified underpinning why GPs might refer or not refer patients to particular providers. The research suggests that NHS providers (i.e. NHS trusts or foundation trusts) might be selected by GPs out of habit, familiarity and trust, because NHS providers were seen as more expert, unbiased and offering an integrated service and because the GP wished to protect local services. The barriers to referring to NHS providers were less convenient access if patients had to travel to a trust hospital (rather than a community clinic) and longer waiting times. Such barriers to a referral were the main triggers for a referral to an independent provider (i.e. a provider other than an NHS provider). High street providers in particular were often seen as being very convenient for patients and offering short waiting times. Referrals to independent providers were also likely to be prompted by patient requests or by the provision of an easy method of referral such as an electronic template. Barriers to referring to independent providers were a lack of awareness, knowledge and confidence in the service that was on offer, the lack of integration with the wider NHS audiology service and specific, often one-off negative experiences reported by patients or GPs themselves.

GPs offered various levels of choice to patients and gave varying levels of direction as to the most suitable provider. We identified four main types of choice/direction:

- a small number of GPs offered a choice of provider but did not give any direction
- about a quarter of the sample offered a choice of provider and, if asked by the patient, would suggest a provider or would make their own preference clear
- a small number did not offer any choice when with the patient and expected or assumed that this would be done by the practice admin team or RMC at a later point
- about half the sample had a default provider to which they referred unless the patient asked to be referred elsewhere.

Views were mixed as to whether patients were aware of, and interested in, having a choice of health care providers. While GPs in non-AQP areas felt that patients did not differentiate between NHS providers, about half of GPs in AQP areas thought that patients were increasingly aware of having a choice. However, there was also a general view that patients were less interested in choice *per se* and simply wished to be seen promptly at a convenient location. Many were also thought to be happy to be guided by their GP. The willingness to be guided and limited interest in choice was perceived to be particularly characteristic of more elderly patients.

Many GPs had been made aware of independent providers by requests for referral to these by patients and they were often also aware themselves of the marketing activity of such providers. While some expressed disapproval of providers marketing their services, all GPs in the sample in areas using AQP referred to the independent provider if the patient requested it.

It was generally recognised that there might be some elderly patients who were more isolated whose hearing problems were neither identified nor treated. It was felt that a domiciliary service might help with this. In some locations this was being offered; while some GPs in these locations were aware that their local NHS trust audiology department offered home visits, where such a service was being provided by an independent provider, there was a lack of awareness of it.

Some GPs (but by no means all) would like more information about the choice of providers for AHS to help themselves and their patients make a more informed choice and felt that the CCG was the appropriate source for this. However, they did not wish to be overloaded with information that might regularly change and some suggested keeping the practice admin team up to date instead.

1.2.3 Quality of service

GPs had little awareness of the quality of service offered by AHS providers with many assuming that it must be satisfactory because of a lack of complaint by patients. Some also assumed (and hoped) that the quality of service must be monitored by a body such as CQC.

GPs were specifically prompted about three elements of service; waiting times, the quality of hearing aids and aftercare. Again, the majority had little knowledge of these. With respect to waiting times, information on C&B and from an occasional independent provider might give them an indication of these but many GPs felt that unless it was very long, waiting time was not critical because age-related hearing loss is a condition

that patients have often lived with for some time. However, examples were seen whereby GPs had changed their referring behaviour in response to waiting times.

GPs often had little idea of the process of fitting hearing aids, including, in some cases, whether independent providers did this and whether patients were charged for their hearing aids. The assumption was that hearing aids offered by all providers free to patients were comparable and GPs said they would try to reassure patients of this if the patient was concerned that NHS-funded hearing aids might be inferior compared to aids they would have to pay for.

Again, the quality of aftercare was often unknown to GPs although a few had the view that support from NHS providers was on-going while the support offered by independent providers was time limited. However, it was also noted that some NHS providers were putting restrictions on how long they offered aftercare before another referral was required (in response to AQP it was suggested).

Some concerns were expressed about the service offered by independent providers and specific examples were cited that involved requests for additional or retrospective referrals and the fitting of hearing aids when the level of hearing loss in the GP's view did not merit them. More general worries were voiced about independent providers persuading patients to pay more for non-NHS hearing aids, the fact that they are not integrated with the NHS and that they may lack the expertise of NHS providers.

Some GPs would like to have comparative information about the above aspects of service quality along with the relative costs of providers to help them identify what would be in the best interests of their patient and the CCG. Others did not welcome this however, feeling that they are already overwhelmed with information and that for AHS, there is little critically difference between providers. It was felt that any information should come from the CCG or an independent body, should be a succinct summary and might be offered as a comparative table, electronically via C&B or other website (to which patients could also be directed) or initially face to face to make GPs more aware of the choices.

1.2.4 Any qualified provider

Most GPs seemed to have a good understanding of AQP although only about half of GPs in AQP areas were aware that AHS was being offered there under AQP. There was a lack of clarity however about some features of AQP such as the nature of any standards laid down for providers and how these were monitored and enforced, and the basis on which providers were selected and contracted. It was clear that GPs in the sample had either not received communications from CCGs or any other body that set out AQP and the new options open to them for referrals or, if they had received information (only a very small number thought they might have), it was such that they recalled it only in vague terms, if at all.

A range of views and levels of enthusiasm were expressed for AQP and we identified five clusters of GPs based on these, from the very enthusiastic to the very negative. The majority of GPs, despite their misgivings, acknowledged that AQP had the potential/was delivering benefits for patients in terms of shorter waiting times and greater convenience, as well as sometimes driving improvements in AHS services offered by the NHS.

More negative attitudes were often based not only on the concerns cited above (at 1.2.3) but on a view that there was not a 'level playing field' for all providers and that

independent providers were able to ‘cherry pick’ the services that were easy to provide (leaving the NHS to deal with the more complex) and were able to advertise their services and drive referrals (creating more revenue for themselves and more work for GPs). Many GPs, (including the most enthusiastic about AQP) voiced uncertainty about the long-term consequences for the NHS and whether the service it offers might be undermined, and whether AQP might lead to a decrease rather than an increase in choice, for example, through the closure of NHS audiology departments or because an independent provider ends up monopolising the market. It was also suggested that ‘fragmentation’ of the service among many different providers might not be in the interests of patients. Some GPs were concerned that if a number of services were being delivered under AQP by a range of providers, this could make it difficult to track the patient pathway and define lines of responsibility. It could also result in an increased workload for GPs if independent providers refer patients back to their GP rather than referring them directly to other parts of the NHS (in the case of AHS, to the ENT department, for example).

AHS were seen by some GPs as more suitable for AQP than other therapy areas because it is a relatively straightforward service. However, for some, there was a perception that age-related hearing loss is not an urgent problem for patients which meant that the benefits that AQP might bring are less critical.

1.3 Conclusions

Age-related hearing loss was considered a low priority relative to the many other conditions that GPs were dealing with, which meant that many of the GPs in the sample had little engagement beyond the initial referral. Adult hearing loss is seen by GPs as relatively straightforward to diagnose, GPs are only involved at the outset of the ‘patient journey’ for a condition that is not seen as critical, and unless there is reason to think otherwise, it is assumed that all providers offer a satisfactory service. While GPs are aware of the policy of patient choice, many appear to be limiting the choice they offer or steering patients towards their own ‘default’ choice.

The research has shown that GPs are not the only ones who facilitate choice. It has revealed in particular, the importance of practice admin staff who are often involved in the referral process, including accessing C&B, and in some cases may be in the best position to know about the range of available providers. They too, are therefore a key audience for information about choice and the comparative quality of providers and about other support services that might be relevant. Moreover, for those GPs who feel they do not have the time to engage with information themselves, informing practice admin staff is a potential way to alert GPs to changes they should be aware of.

The research suggests that GPs need to be better informed about how providers are selected and the terms and conditions under which they operate. This may help allay fears that the playing field is not level and assure them of the credibility of all the providers commissioned to provide the service.

Within the sample, patient requests were one of the main drivers of referrals to specific providers, although currently this was not happening very frequently. This suggests that patients can be targeted directly to ensure they are informed of the options open to them. However, in doing this, potential unintended consequences should be considered. For example, if patients are only made aware of certain providers, the outcome is likely to be that they ask to be referred only to these without being aware of the full range of providers.

Similarly, if one provider facilitates the referral process by providing GPs with an electronic referral template, the danger is that GPs will channel more referrals to this provider rather than offering patients a choice. Ensuring equal ease of referral across providers is therefore another issue to consider.

The research has shown that there is no single factor that prevents or inhibits GPs from offering their patients choice but that a range of barriers exist.

Many of these are not just applicable to AHS but potentially to all or most healthcare services delivered under AQP. These concerns include perceptions that independent providers could damage NHS services in the longer term and perceptions that independent providers could be driving demand for services unnecessarily.

GPs' perceptions of what is most important for their patients were often based on anecdotal feedback from some of their patients. This included the perception that choice is not a priority for patients and that the absence of complaint means patients are satisfied with the service they receive.

In contrast to some other healthcare services, GPs commented that they had received little, if any, guidance about referral pathways and so this seems to be an area where greater guidance and direction could be provided.

A number of the barriers to offering choice relate to the referral process itself. The research suggests that anything that might increase the consultation time is likely to be resisted. Conversely, anything that helps keep the consultation short and/or makes the process of referral easier, is likely to be embraced by GPs. If they are to have a discussion with their patients about choice, both GPs and patients need not only a list of providers that are conveniently located, they also need comparative information on key indicators of quality. Choose & Book only offers the first of these and not all GPs are using it. Alternatives include a standardised electronic referral template and information in an electronic form that GPs could print out and give to patients or which could be sent to patients together with details about how to use Choose and Book themselves or which patients could access directly from the internet.

Almost without exception, GPs in the sample were not signposting patients to groups and organisations that provide services that can help people with hearing loss as this was not seen as relevant before the diagnosis of age-related hearing loss had been confirmed. This suggests it might be more appropriate to find other ways to make patients aware of these services. If GPs are to be asked to do this, they will need easily accessible, up to date information that they can give or send to their patients.

One of the reasons for the lack of engagement with the patient journey once a referral has been made for a hearing test is an information vacuum and the research has identified an unmet need on the part of some GPs for relevant and succinct information on the quality of service from AHS providers. To be credible, this has to come from an independent source such as the CCG or a hearing loss charity.

2 Background and Research Method

2.1 Background

Over the summer in 2014, as part of an examination of how having a choice of NHS adult hearing services impacts patients, **Monitor** invited views from a range of stakeholders. Monitor is the sector regulator for health services in England whose primary duty is to protect and promote the interests of people who use healthcare services.

It also commissioned Creative Research and Accent to undertake additional research to ensure that a representative cross-section of service users and GPs were consulted and to gain deeper insights on how choice was working in **adult hearing services** (AHS). AHS are for adults, typically aged 55 years or over, with suspected or diagnosed age-related hearing loss. Services are usually accessed following a referral from a GP, and may include a number of service elements including an appointment to assess the patient's condition and suitability for hearing aids; a hearing aids fitting (where required); a follow-up visit (to assess whether needs have been met); and aftercare (including advice, maintenance and review).

Any Qualified Provider (AQP) is a way of commissioning healthcare services funded by the NHS. The approach has been used to offer choice in adult hearing services in England. It allows any provider meeting the qualification requirements specified by a commissioner in a given area to deliver services in that area. As a result, when a patient is referred to the service, he or she can choose who provides their care from a list of qualified providers in the area. Patients can choose a provider based on what is important to them, such as somewhere that is close to home or work, is easy for them to access, has shorter waiting times, or good customer service. Commissioners were initially required to roll out AQP to three community-based services from April 2012. Over half of commissioners in England chose AHS as one of those services.

Data from NHS England indicates that around half a million referrals are made to adult hearing services in England each year (covering both AQP and non-AQP areas). In addition, there will be others already with hearing aids who require on-going aftercare services from providers. Providers of AHS include NHS trusts and foundation trusts and independent sector providers. In the report, we use the term 'independent provider' to

refer to organisations other than NHS trusts or foundation trusts who provide NHS-funded AHS. We define this to include private companies, GP-led organisations, social enterprises, and charities. The term 'private provider' is used to refer to organisations offering services which patients have to pay for[2]. Sometimes GPs used the term 'private provider' when, in fact, they were referring to an independent provider; we have retained this language when reporting verbatim comments from GPs.

2.2 Aims and Objectives

Monitor's aim in commissioning the research was to improve its understanding of the impact that patient choice and AQP has had on the quality of NHS adult hearing services and whether or not patients can exercise choice in a meaningful way. To this end, it commissioned an independent research study that included:

- a quantitative survey with users of adult hearing services in England;
- and qualitative research with GPs.

With respect to service users, the key issues were to probe on matters relating to patients' understanding and experience of services, and patients' awareness of choice and ability to exercise choice (including switching away from an existing provider if they are unhappy with the quality of services received).

With respect to GPs, the key issues were to explore how GPs currently enable patient choice, whether GPs have sufficient support from CCGs and others to enable patient choice, and GPs' general attitudes to AQP and choice more generally.

This report sets out the findings from the research among GPs; the findings of the service user research are provided in a separate report.

2.3 Research Method

The research was conducted by means of depth interviews, 30 in total. There is a law of diminishing returns with research of this nature such that the main themes and findings emerge from the early interviews and subsequent interviews mainly serve to confirm these. A sample size of 30 GPs was sufficient to ensure that the breadth and range of

[2] In some cases, the same organisation may act as both an 'independent' and a 'private' provider.

views were captured. The interviews were piloted in five face to face interviews of 45-60 minutes duration. After some small changes to the discussion guide, a further 25 interviews were conducted by telephone; these lasted 30-45 minutes. The interviews were conducted during late September and October 2014.

Quotas were set both in terms of the practices and individual GPs to ensure that the sample was broadly representative. Details of the quotas and how these were set are provided in the appendices (see 8.1). A summary of the quotas are given in 2.3.1 and 2.3.2.

GPs were identified as possible candidates by calling/emailing practices that met certain criteria based on information provided by Monitor. GPs were then taken through a recruitment screening questionnaire to ascertain their eligibility; this is included in the appendices (see 8.2).

2.3.1 Sample: Practices

Only one practice per CCG was recruited to ensure that as many different CCGs were included as possible. Of the 30 practices involved, 23 were in CCGs where AHS are operating under AQP (referred to in the report as AQP locations/practices/respondents) and 7 CCGs were not operating AHS under AQP (referred to as non-AQP locations/practices /respondents).

Quotas were set for the practices with respect to:

- NHS England region (North, Midlands and East, South, London)
- the nature of the catchment area (whether urban or mainly urban, rural or mainly rural, or mixed)
- the number of providers of AHS within the AQP locations and whether or not independent providers are delivering NHS AHS within non-AQP areas
- the proportion of the practice's patients aged 40+/75+
- the proportion of the practice's patients of Black and Minority Ethnic heritage
- the number of partners in the practice

- whether referrals are handled via a referral management centre (RMC).

The achieved sample is shown in Table 1.

Table 1: Practice Profiles

		AQP	Non-AQP	Total
	n=	23	7	30
Region	London	3	2	5
	South	6	1	7
	Midlands and East	7	3	10
	North	7	1	8
Catchment	Largely/mainly Urban	13	4	17
	Mixed	7	3	10
	Largely/mainly Rural	3	-	3
No. of Providers	1-3	8		8
	4-5	8		8
	6+	7		7
Independent Provider Present?	Yes		2	2
	No		5	5
% of practice patients aged >44 years old	>40% of patients	8	2	10
	<41% of patients	15	5	20
% of practice patients aged 75+ years old	<10%	16	3	19
	10%+	7	4	11
% of practice's patients of BME heritage	very few	7	-	7
	up to 10%	9	4	13
	over 10%	7	3	10
No. of partners in practice	1	1	-	1
	2-4	5	2	7
	5+	17	5	22
Referrals via RMC?	Yes	3	-	3
	No	20	7	27

2.3.2 Sample: GPs

All respondents had referred at least one patient with age related hearing loss to AHS in the last 12 months. Quotas were set with respect to GPs in terms of:

- how long respondents had been practising as a GP

- their attitude towards AQP/patient choice
- the number who were attached to a residential care home.

The achieved sample is shown in Table 2.

Table 2: GP Profiles

		AQP	Non-AQP	Total
	n=	23	7	30
Years as a practising GP	<3	1	-	1
	3-15	12	3	15
	16-30	9	4	13
	>30	1	-	1
Attitude towards AQP/patient choice	Strongly support	7	-	7
	Broadly support	6	4	10
	Have concerns	10	3	13
	Opposed	-	-	-
Attached to residential care home?	Yes	10	4	14
	No	13	3	16

2.4 Outline of Discussions

The full discussion guides (for the face-to-face and telephone depth interviews) are provided in the Appendices (see 8.3). We have outlined the main topics covered below:

- **the referral process**: experience of age related hearing loss, the referral process, how the GP responds when a patient is resistant to the idea of wearing hearing aids, whether the GP directs patients to other support services
- **the range of providers**: which providers of AHS the GP is aware of and to which s/he refers patients; what could be done to ensure GPs are familiar with all the providers of AHS to whom they could refer patients
- **patient choice**: whether GP explains to patients they have a choice of AHS provider; whether patients are aware of/wish to exercise their choice; whether they direct patients to certain suppliers; whether they feel they/patients have enough information to exercise choice; what would make it easier to GPs to offer patients a choice

- **quality of service**: awareness of the quality of service offered by different providers of AHS especially in relation to waiting times, the quality of hearing aids and aftercare; whether quality of service is something they discuss with patients; what additional information about quality of service they would like
- **the Any Qualified Supplier approach**: awareness and understanding of AQP including (for those in areas where AHS is provided under AQP) awareness that AHS is provided under AQP; views on AQP and its perceived impact on service delivery
- **isolated elderly**: which types of patients may find it difficult to access AHS as well as suggestions for improving access.

2.5 Interpreting the Findings

This is a qualitative study which means the opinions of a relatively small number of GPs have been explored in considerable depth. The researchers used a topic guide to ensure that the relevant issues were covered; they also followed up particular points to ensure they understood these, and they may also have explored relevant additional points that were made by the respondent. The views of different respondents have been used to 'triangulate' the findings. Answers were not recorded in the form of tick boxes or head counts since the aim was to explore the range of opinions expressed rather than to 'measure' how many respondents had expressed a particular view. One reason for this is that people do not always express their answers in black and white terms. Another reason is that it is not possible to explore every issue in every interview; some issues may only have arisen in certain interviews.

In analysing the data, one of the things that has been looked for is where there is a consensus of opinion or a similar view on an issue and this is expressed using language such as 'all', 'most', 'widespread', 'widely held', 'many GPs', etc. However, it is also important to look for the range and variety of opinion that is expressed; these might be opinions offered by just 'a few' respondents as well as those opinions mentioned by 'some' of the sample (i.e. more than a 'few' but less than 'many'). It is also useful to report things that may only be mentioned by one or two people if these seem to offer relevant and insightful observations. This would normally be made clear by stating something along the lines 'one respondent/GP said…'

It should be noted that the use of terms such as ‘most’ or ‘few’, etc., relate only to the sample under consideration and should not be taken to apply to the total population.

A number of verbatim quotes have been used to illustrate key findings. Occasionally, quotes have been edited to improve comprehension; references to places and specific AHS providers (such as hospital names) have been deleted in order to preserve respondent anonymity. Square brackets [ ] have been used where a quote has been edited in this way. Researcher comments are shown in bold. At the end of each quote, an attribution is provided to indicate which part of the sample it is from:

- location
  - **AQP**: respondent’s practice is in an area where AHS are commissioned using AQP
  - **non-AQP**: respondent’s practice is in an area where AHS are not commissioned using AQP
- offering patients choice (see 4.4 for an explanation of the four categories)
  - **Choice, no direction**: respondent offers patients a choice of provider without giving any direction
  - **Choice with direction**: respondent offers patients (some) choice and gives direction if asked
  - **Assumes choice**: respondent not offering patient choice but assumes this is done by others
  - **Default provider**: respondent refers patients to a ‘default’ provider unless the patient requests something else
- attitude to AQP (see 6.4 for an explanation of the five categories)
  - **Mainly negative**: not rejecting AQP but most negative based on poor anecdotal experience or fears about privatisation of the NHS

- **Uncertain**: can see both positives for the patient in the short-term and negatives for NHS services in the longer term and have concerns
- **Unaware of impact**: unaware of the impact of AQP and have some concerns
- **Fairly enthusiastic**: as long as safeguards are in place and there is a 'level playing field' with the NHS
- **Very enthusiastic**: about AQP in general although one GP did not see that it was necessary for AHS.

The project was conducted in compliance with ISO 20252:2012, the international standard for market research.

2.6 Structure of the Report

Section 3 sets out how GPs make an initial diagnosis of age related hearing loss and how they go about referring patients to AHS. It includes a summary of their use of Choose & Book and the extent to which they might signpost patients to other support services.

Section 4 looks at the issue of choice; it begins by considering respondents' awareness of the various providers of AHS to whom they could be referring their patients, together with the main triggers and barriers that influence which suppliers they actually refer patients to. Respondents were grouped into one of four categories based on the extent to which they were offering their patients choice and providing them with direction, if patients asked for this. It also reports GPs' views on the extent to which their patients were aware of, and wanted to exercise, choice of provider. GPs' views of the impact of independent provider marketing are summarised. Respondents' thoughts on how access to AHS could be improved for isolated and/or elderly patients who might otherwise find access difficult are also set out. Finally, we cover the extent to which respondents were interested in having more information to help themselves and/or their patients make a more informed decision about choice of AHS provider.

Section 5 considers respondents' appreciation of the quality of service provided by suppliers of AHS, together with any concerns they had about this, and what information

might help GPs better understand the quality of service offered by providers' available in their areas.

Section 6 looks at respondents' awareness and understanding of, and attitudes towards, Any Qualified Provider.

Section 7 sets out the main conclusions.

3 Diagnosis and Referral

3.1 Introduction

In this section we report on:

- patient presentations and the steps involved in arriving at an initial diagnosis of age related hearing loss, the choice of referral pathways, the extent to which patients might be resistant to the idea of hearing aids and how GPs deal with this
- the referral process being followed, including the role of RMCs
- the use of C&B
- the outcomes from a referral
- the extent to which respondents were referring patients to other support services and what could be done to encourage more GPs to do this.

3.2 Presentation and Initial Diagnosis

The number of new presentations seen by GPs in the sample varied between less than one, to more than thirty per month. This variation reflects differences in the patient profile of practices. For most GPs, it worked out on average at around one new presentation per week.

A very consistent picture was painted of how patients presented with hearing difficulties. Commonly, patients were motivated to present by others in their family or neighbours who had become aware of an increase in TV volume or the patient having problems hearing what people were saying.

> *"The common presentation is they can't hear the TV very well. I think the most likely presentation is either the partner saying it or the neighbour saying, 'why are you keeping the TV loud?' These are the two complaints which they come with." (AQP; Default provider; Unaware of impact)*

> *"It would be a very soft conversation in that you'd take the history. Obviously if it's been there a week or two, whether they've got sinusitis you might treat it, if it's been there three months, six months and it's a gradual process where the television is louder, the wife is not happy or vice versa. [ ] So you listen to the history and they say, 'I'll go out and I can't hear my friends if I'm in a pub', or whatever, background noise. So let's say they have a six month history of something, the obvious signs that we both know, you accept the patient's comments and clearly it's a very routine referral. So it's a very gentle, what I*

would call medically, a very soft consultation." (AQP; Choice with direction; Fairly enthusiastic)

In most cases, the patient presented assuming they had some degree of hearing loss but they might also assume that they had wax in their ears or were concerned about tinnitus/hearing a pulsating noise at night. In some cases, the patient presented with other complaints and hearing loss only arose later in the consultation; this had implications in terms of how much time was available for discussion including any choice of providers for AHS.

> *"The difficulty for me is that people almost invariably, you know, come with a list of problems and say, 'by the way, you know I'm going deaf' and I've got about a minute, you know, just to do it all really, just to print the paperwork. So quite commonly it's not the problem the patient's actually come with so do I just try and whip through it really quickly or do I bring them back and use another appointment? So I will often sort of do it as quickly and speedily as I can so not necessarily spend a long time going into it." (AQP; Choice with direction; Mainly negative)*

A couple of GPs reported receiving phone calls from patients asking for a referral for a hearing test, usually because they had been prompted to do so by an independent provider. In these cases, they asked them to come in to see them so they could carry out the necessary checks.

An initial diagnosis of age related hearing loss was unanimously felt to be relatively straightforward. The key steps included:

- taking a patient history
- excluding other causes by examining the ear canal e.g. wax, inflammation
- ruling out other hearing disorders e.g. asymmetric loss
- referral for a hearing test to confirm the diagnosis and to have hearing aids fitted if required.

3.2.1 Choice of pathway

Respondents tended to talk about referring patients to 'audiology' rather than 'Adult Hearing Services', although when talking to patients, some GPs thought they would probably say that they were referring the patient for a 'hearing test'. Although younger patients would generally be referred to the Ear, Nose and Throat (ENT) department at a

trust hospital for further investigation, most respondents were not aware of a precise age threshold above which they should refer a patient to AHS with suspected age related loss. While six GPs identified 55 as the age threshold, the majority had an age 'in their head' ranging from 50 to 70 which informed their initial diagnosis[3].

Most practices relied on the patient's assessment of whether they were experiencing hearing loss and referred them on this basis, however three practices conducted hearing tests themselves[4] as part of the initial diagnosis to help decide whether patients should still be referred for a 'formal' test and what pathway they might follow (ENT or AHS).

> *"So we've got a little machine we use where they say when they hear the sounds and it's different frequencies and you have to write what the frequency is that they can hear." (AQP; Assumes choice; Mainly negative)*

3.2.2 Willingness to wear hearing aids and referrals

It was reported that the issue of whether a patient was prepared to wear hearing aids as the most likely solution for age related hearing loss might come up during the initial consultation, raised either by the patient or the GP; some GPs seemed to ask routinely but others did not.

> *"I mean I don't tend to go into talking about hearing aids at that point unless they directly ask me. I've had a few people who go, 'do I need a hearing aid?', and I'll talk about it then, but I don't often kind of raise that as an initial thing…*
>
> ***…Any particular reason why not?...***
>
> *… I guess possibly that might be partly because I'm not sure of my diagnosis, you know, I'm possibly thinking maybe they don't need one. But thinking about it realistically I think it's a little bit of my own confidence in making sure I'm right and partly a little bit because I don't think, I've not really thought about, you know, kind of actually if the patient is scared of that, they are worrying about a hearing aid I just kind of think, okay let's just do a hearing test and try and find out exactly what it is." (AQP; Default provider; Very enthusiastic)*
>
> *"I guess that's one thing I always ask, 'would you be interested?' or 'would you actually consider wearing a hearing aid?' and I think occasionally patients will say 'oh well no, I don't want to' and even if I sort of advise them that ' the modern hearing aids are very discreet, most people are never going to know or even see*

[3] Different CCGs have set the age threshold at different levels however our sense was that GPs' views were not based on CCG defined thresholds but on their own perceptions about the age at which a diagnosis of 'age related hearing loss' was appropriate.

[4] Note: these practices did not include either of the two practices that housed an AHS clinic; see 4.2.2

that you're wearing one', occasionally patients say 'well I'm not quite ready, I don't think I want one of those' so they are probably the one example where I'd suspect they have age related hearing loss and don't get a referral." (AQP; Default provider; Uncertain)

GPs acknowledged that patients sometimes had reservations about wearing hearing aids perhaps driven by a perception that NHS hearing aids were somewhat 'old fashioned' or difficult to adjust (whistling etc.) as well as a reluctance to admit that they were 'getting old'. However, resistance to wearing aids was thought to be rare as such patients were unlikely to present in the first place (unless persuaded to do so by a significant other).

"Well they always do come because they're not happy with their hearing so I've not had a situation where I've seen a patient that's not wanted to be referred about their hearing loss. So yeah, they always want to be referred, sometimes they get seen and decide actually they don't want to wear hearing aids after all but at the point that they come to see me they always want the referral." (AQP; Assumes choice; Mainly negative)

Where a patient had some reservations, respondents said they would do their best to address these and encourage them to have a test to confirm the initial diagnosis in the hope that once they started on the journey, they would decide to follow it through.

"I'd strongly encourage them to go for the test and go from there and if the audiologist advises them to have hearing aids and they say 'no, I'm better off without them', then that's up to them I think. But I would be wanting to know, quantify through the audiology test, what was actually going on." (AQP; Choice, no direction; Uncertain)

Nevertheless, if a patient was adamant that they did not want to wear hearing aids, many GPs would not refer them for a hearing test on the grounds that it was a waste of everyone's time and money and that age-related hearing loss is a condition rather than an illness; if the patient decides they can manage without aids, this is their choice to make.

"It's their choice, if they are suffering and they want to do something about it then that's what's available for them. If they really don't want to wear a hearing aid then I'm afraid there's not much else that we can offer really but the main thing is to get assessed anyway so that's what I tell them and then they can make a decision after that." (AQP; Default provider; Very enthusiastic)

"A lot of patients would rather put off wearing a hearing aid, yes. People often say, 'oh can I go for a hearing test?' so I'm saying to them, 'well there's not much point having a hearing test. Do you actually want a hearing aid or not?' So if people say well they just want a hearing test, I would dissuade them from referral – it's a waste of time really for someone just to tell them they've got, you know, x

decibels of hearing loss when they don't probably want a hearing aid anyway." (AQP; Choice with direction; Mainly negative)

The scenario was sometimes described where patients 'could not get on with' their new hearing aids and chose not to wear them after being fitted. This might be revealed in subsequent patient presentations and was perceived to be a greater waste of resources.

"If we're going to invest quite a lot of money in having them assessed and provide what is a rather expensive device and they're not going to wear it it's a shame so I try and sound them out and make sure that they're not under major pressure and it is what they want." (AQP; Choice with direction; Uncertain)

3.3 Overview of the Referral Process

There was considerable variation in the referral process adopted by practices and it seemed, individual GPs within a practice. However, respondents generally felt the referral process they followed worked well.

Only two respondents (both in AQP areas) indicated that they followed a **formal referral protocol:**

- in one case, it had been provided by the local NHS trust's audiology department
- in the other, it was set down by the RMC and was kept by the GP on the wall above his desk; it lists (see below) the circumstances when he should **not** refer to AHS.

- anyone under 55 should be seen by a consultant
- persistent pain affecting either ear defined as an ear ache lasting more than 7 days and in the past 90 before the appointment
- a history of discharge other than wax from either ear in the last 90 days.
- a sudden or rapid loss or deterioration of hearing in which case send to A&E or urgently to the ENT clinic
- fluctuating hearing loss other than associated with colds
- uni-lateral or asymmetrical or pulsatile or distressing tinnitus lasting more than 5 minutes at a time, troublesome tinnitus which may lead to sleep disturbance or be associated with symptoms of anxiety or depression
- vertigo inducing dizziness, swaying or floating sensations
- if (on the basis of an ear examination) there is complete or partial obstruction of the external auditory canal preventing proper examination or abnormal appearance of the outer ear canal or eardrum, e.g. inflammation of the external auditory canal, perforated eardrum or active discharge.

Five other GPs spoke about having a referral form to complete; these were often provided by individual service providers although one covered all referrals within a metropolitan area and may have been developed by the CCGs operating within the area. Two of these GPs commented that the referral forms included a checklist of things to rule out before referring to the provider. Such forms made the referral process simpler.

> *"The form's really easy to fill out, it's very simple, it captures all the important information and the demographics of the patient itself and it also helps the clinician to pinpoint and make sure that they've done a preliminary diagnosis itself before just sending over every single patient to the audiologist, so it works well." (non-AQP; Choice with direction; Mainly negative)*

Some commented that while the CCG had provided referral guidelines for some therapy areas, they had not done so for AHS.

> *"No we don't at present [have a formal protocol]. I mean this is something which is tending to happen quite a bit at the moment where we are getting kind of pathways given to us from the CCG. But at present we have no formal kind of pathway or how we should be managing these people [patient with age related hearing loss], not that I'm aware of…*
>
> ***…And is it useful to have that from the CCG out of interest?...***
>
> *…Yeah it certainly can be, provided we all agree, because there are situations that come along where we're like, 'oh god, we don't agree with this'. It's just a nightmare, but I do quite like having sort of a guideline of what we can … I mean an example recently we were given kind of a pathway of what to do with patients with shoulder problems. I think the aim of doing it that way was to try and save money from the CCG side of doing it the right way and referring to the right people, but it's quite useful to have that and I've got it printed out and up on my wall. Just so I know whenever I've got the shoulder problem, I kind of look at it and go 'ooh am I doing the right thing?'" (AQP; Default provider; Very enthusiastic)*

When making a referral, respondents may or may not discuss **choice of provider** with the patient. When asked a direct question about this, GPs often suggested they were discussing choice; however, when describing what they typically did, they often spoke about making a referral to a default provider and possibly only referring elsewhere if the patient requested it. The default provider was often the local NHS audiology department/community clinic but in some cases, a local independent provider. This is covered in greater detail in section 4.

Some GPs made the referral electronically via **Choose and Book** (C&B) during the consultation (see 3.5 below for more detail on the use of C&B) or using an **electronic**

referral template (this may have been provided by the practice or by a particular AHS provider). They might also dictate/write a referral letter while with the patient or later. Commonly, a GP's secretary or the practice admin team processed the referral and this might involve the use of C&B. Some referral forms/letters etc. might be sent in the post or faxed to providers if not done electronically.

One respondent in a non-AQP area where both NHS providers and an independent provider were available, described a two stage referral process; this was an exception however. The process comprised an initial referral for a hearing test followed by a second referral for hearing aids if required. If he refers the patient to the NHS provider for the hearing test, he can ask if they are happy to also go there for the fitting and if they are, he does not need to make the second referral. If he refers the patient to the independent provider and hearing aids are required, he has to make a second referral to the NHS (he thinks the independent provider only conducts hearing tests).

3.4 Referral Management Centres (RMC)

Referrals from practices in three areas were handled via an RMC (all in areas where AHS are delivered under AQP).

Case 1

This GP has a formal protocol and a bespoke electronic referral form. He is aware that patients can be referred to two local hospitals and an independent provider and tells them this. If patient preference is not recorded on the referral form, they will be referred to the provider with the shortest waiting time so if patients want to be seen quickly, he leaves it blank.

Case 2

This GP does not have a formal protocol or *pro forma* referral form and does not discuss choice with the patient; he simply refers them to the referral management centre. The respondent is unsure what happens next but assumes the referral management centre uses C&B and sends the patient details of their options and how to book an appointment.

Case 3

This GP also does not have a formal protocol or a *pro forma* referral form. She uses C&B to initiate the referral but is not discussing choice with the patient as she only refers to the local hospital. Appointments are arranged by the RMC and the respondent was unsure if staff within the RMC might offer the patient a choice.

> *"So if the doctor there [in the RMC] was aware of the other providers then they could perhaps pass that information onto the person that phones the patient back and says, 'do you want to make them aware that they could choose [independent provider a] or they could choose somebody else if they'd rather?'" (AQP; Default provider; Unaware of impact)*

3.5 Use of Choose and Book

In this section we look in more detail at how C&B was being used. GPs fell into one of three groups; where C&B was used by the GP, where it was used by admin staff in the practice, and where it was not used at all.

3.5.1 C&B used by the GP

Thirteen GPs in the sample (10 AQP/3 non-AQP) were themselves using C&B during the patient consultation when making a referral to enable themselves and/or their patients to identify the nearest provider(s) and sometimes to assess waiting times. Only one respondent commented that they were encouraged to use C&B by their CCG.

In at least three cases, C&B was only used when referring to certain providers. In one case, the local hospital audiology department was not on C&B and in the other two cases, C&B was only used for referrals to NHS providers while referrals to independent providers were done directly using a *pro forma* referral letter which was sent directly to the provider; this was perceived to be quicker and easier to do.

> *"We don't even have to do Choose and Book, we just fill in a pro forma that is faxed or sent to them directly." (AQP; Default provider; Fairly enthusiastic)*

Use of C&B during the consultation did not necessarily mean GPs were discussing the choices it offered with the patient:

- some commented that they did not have enough time in a consultation to discuss choice and would only do so if initiated by the patient

> *"I can give them an appointment but it's just more long winded so I simply just give it to the patient to make their own appointment. Otherwise you just end up in*

lengthy negotiations, 'well, I don't want to go here and I'd prefer to go there', and then you book and they say, 'oh thinking about it, oh I can't get there on the bus'. And so, you know, you've booked and then you've got to cancel it and start again and so I do the minimum I have to do." (AQP; Choice with direction; Mainly negative)

- sometimes C&B was used simply to initiate a referral i.e. as an aid for the GP
- at least one GP who was opposed to using independent providers ignored any that appeared on C&B
- at least a couple of GPs chose the preferred provider with the patient simply because patients often had problems with using the system and this created more work for the practice, for example, by taking up time helping patients arrange their appointment.

> *"So we do the choosing and the patient does the booking. You've no idea how many appointments are generated and wasted across the whole NHS by issues with Choose and Book. I would reckon I do two face to face consultations a day because patients can't work Choose and Book." (AQP; Choice with direction; Mainly negative)*

3.5.2 C&B used by secretary/admin

Ten GPs (8 AQP/2 non-AQP) said that C&B was used after the patient consultation by their secretary/admin team/RMC to process a referral. In these instances, GPs were often not discussing choice with their patient and they might not be aware which providers appeared on C&B. They were often unsure about exactly how C&B was being used and while they sometimes assumed patients would be given the opportunity to exercise a choice, they did not know for sure if this was happening.

3.5.3 C&B not being used

There were seven practices (5 AQP/2 non-AQP) that were not using C&B for referrals to AHS or not using it at all:

- a recently qualified GP said the practice uses C&B for other conditions but not AHS – he was unsure why this was
- in another case (in an AQP area), an independent provider was perceived to be the 'main provider' of AHS and referrals were made directly to them using a *pro forma*

- one practice used to use C&B but found it was 'doubling the consultation time' and stopped using it

> *"It actually takes up a lot of time, you know the decision has to be made with the patient in front of you. You have to choose an appointment time or a date and you have a patient fiddling round with their diary and then also they're aware then of how long the wait is, you know sometimes it will say, 'oh I think you'll be seen within 4-6 weeks' but when in fact the waiting list is 10-12 weeks or 6 months and it's better that they go away and find that out themselves later on rather than us having a big argument or a discussion about it with us. It would add another 100% time on the consultation. I know some people do have receptionists or managers who can take on that thing but it just slowed everything down when we did use it." (AQP; Default provider; Unaware of impact)*

- two practices had stopped using C&B because referrals 'got lost' and they had to spend time trying to work out what had happened. They also found the hospital audiology department was not providing slots or keeping the system up to date which meant patients either could not book an appointment or appointments were subsequently changed by the hospital audiology department.

> *"We find that Choose and Book not uncommonly was losing the referral letter and the referral process just stopped after you've made the actual Choose and Book booking, as it were. And that is difficult then to track down afterwards and so it's difficult then to perform an audit to find out where the booking has gone. And obviously the responsibility of that still lies with the practice. What we're also finding is that once the referral has been made, quite often the hospitals haven't put on appointments, specific Choose and Book appointments, in order for the patient to be booked in. So we will do the choose part of it but the book part of it, the patient will have to ring a central number to be able to get booked in. And once they ring that number, they're often being told there are no appointments available and they have to go back to the practice and that's where yet again, more workload is being created for us." (non-AQP; Default provider; Uncertain)*

> *"Also Choose and Book isn't up to date, it doesn't really have the appointment availability and the majority of times when you do take the time to book them into an appointment, they get a letter saying 'actually, you know what, we've changed your appointment anyway', and then they come back to the GP rather than phoning up the Choose and Book which means that we get lumbered with kind of sorting their kind of issues out when we had nothing really to do with it. So it's easier just to send them a letter and fax it through to the audiology service who then will contact the patient either by phone or letter." (non-AQP; Choice with direction; Mainly negative)*

- Two GPs were mainly referring patients directly to a 'default' provider; C&B would only be used if a patient wanted to go somewhere else. In one case the default provider did not appear on C&B.

> *"We use Choose and Book, but we don't use Choose and Book for audiology. I think I have looked in the past and I couldn't find, I could find audiology clinics in*

the big hospitals but a small kind of cottage hospital where, I don't think I've found it there, that's why I've never referred because I'm quite a fan of Choose and Book if I can. But I don't think it's on there so therefore I do a kind of letter to that place and just do it that way." (AQP; Default provider; Very enthusiastic)

3.6 Outcome from Referrals

Respondents were not routinely asked about any outputs they might receive following a referral to AHS so we do not have a complete picture of this. Some respondents indicated that they received some form of notification of the test results and whether hearing aids were required/had been supplied while others were unaware of what the outcomes were.

"I feel as a GP I don't actually have that much involvement. It's a case of examining their ears just to make sure that there isn't any obvious cause of wax blockage or other that would cause a hearing loss and then they get referred onto an audiologist, usually get seen within a fortnight and then the next I hear about it is just a report from the audiologist saying what they've done and whether hearing aids have been provided, or not." (AQP; Default provider; Uncertain)

"We get audiology letters after children's tests to say this, this and this was the case, the decibels on the graph and so on. But with adults I don't think we get a letter saying they've issued a hearing aid or not." (non-AQP; Default provider; Uncertain)

3.7 Signposting to other Support Services

3.7.1 Incidence and reasons for not signposting

Although several GPs described how they regularly accessed and printed off information for patients from such systems as EMIS[5], almost without exception, GPs in the sample were not signposting patients to groups/organisations that provide services to support people with hearing loss (for example, hearing therapy, self help groups, lip reading classes, etc). This was because:

- most were unaware of any support groups or had never thought about it
- if they thought it a good idea, they felt they did not have the time to make themselves aware of all the services that might be available

"Well I think it's about making us aware that there could be a local service. Again the emphasis on local because if it's too far away, you know, this type of patient

[5] EMIS is an electronic patient record system which is used by a number of GP practices.

probably couldn't access it. And I think that's important to say and the second thing is to say how would GPs be made aware of that? There are probably hundreds of services locally going on that we probably should be aware of but due to the sheer number and sheer workload that we have in the surgery, it's sometimes almost impossible to be aware of absolutely everything." (non-AQP; Default provider; Uncertain)

- they did not see this as their role which was to refer the patient for a hearing test. They felt other people on the patient journey were better placed to do this once the patient's condition was fully diagnosed (e.g. the local NHS trust's audiology department)

> *"I have never had to, like not really, because again, I think the audiology team would do that for us. So they would do that for us, so I've never had a need to organise for other supportive services." (AQP; Default provider; Fairly enthusiastic)*

- they did not perceive a need – support groups are more appropriate for those with more severe hearing loss or for patients who already have hearing aids but continue to experience problems (and again, specialist departments are better able to offer this guidance). It was anticipated that typically, hearing aids would improve the patient's situation.

Most were unaware if there was any information available in their patient waiting area and while most would not object to displaying such material, they thought there was considerable competition for space.

The main exception to this prevailing attitude was a GP who had begun his career in ENT. He directs patients to the Action on Hearing Loss website and there are leaflets in reception to help with this. In cases of more severe hearing loss, he may refer patients to the Council's sensory deficit team who can arrange to have things such as hearing loops installed in their homes.

One or two other GPs commented they might provide pointers to such support if a patient initiated a request, for example, by suggesting they search online or by printing out information from sites such as NHS Choices.

> *"I think there are some fabulously well-written leaflets on there and I'm quite proud of giving them out to people during morning and afternoon surgery, and they often will guide people towards their services so I don't often talk about it directly unless they ask about it but I often give the leaflet and then say, 'look,*

have a look through this, there's some associations and contact numbers at the back'." (AQP; Choice, no direction; Uncertain)

One GP commented that her patients were often more knowledgeable about local support services than she was. If necessary, she might signpost them to a general website for the city which was a portal for all the local charities and support groups.

"The patient population where I work will usually come in telling me what exists beforehand. I mean even the elderly in our practice, we've got a huge number of over 90 year olds so between kind of 50 and 80, people will be online and be pretty savvy and have a supportive family that might pick stuff up already. So I can't say they need a lot of prompting." (AQP; Assumes choice; Uncertain)

3.7.2 Encouraging GPs to signpost to other support services

As noted above, not all respondents felt this was a priority or an appropriate use of their time. Some felt they did not have the time to research and/or keep on top of the relevant information. Moreover, relative to other therapy areas with which they need to keep up to date, age related hearing loss was seen as a lower priority.

Others however, were more receptive to the idea. They were aware that patient information was sometimes available, for example, on EMIS or the practice intranet, or websites such as NHS Choices or Patient.co.uk and the preference was for such information to be made available in this way or via C&B.

Some felt the CCG should make such information available (and inform GPs that it is there). A couple of GPs spoke about their CCG developing a GP portal and felt patient resources/information could be provided on this.

However, the research also suggests that GPs will be less likely to engage with anything that is perceived to lengthen the consultation period and this is likely to include having to take time to access and then print off such information.

This implies that ways of providing the information that minimise the use of GP time will be more effective, such as having patient resources available via C&B which patients can either download and print off, or which can be sent to them by admin staff along with details of how to book their appointment.

4 Patient Choice

4.1 Introduction

GPs' views on patient choice are summarised under the following headings:

- GPs' awareness of the different providers of AHS to whom they could be making referrals
- the key triggers and barriers that were influencing their behaviour
- the degree of choice being offered by GPs and the extent to which they were providing direction
- patients' awareness of, and interest in exercising, choice (as perceived by GPs)
- the perceived impact of independent provider marketing
- how the needs of elderly and/or isolated patients could be better addressed
- the extent to which GPs were interested in having more information about choice.

4.2 GP Awareness of Providers

Two sources of information were used to try and establish which providers of AHS were available to respondents: a database provided by Monitor and the Locate and Rate page of Action on Hearing Loss's website. For the latter, we used the practice postcode and a radius of 5 miles. Both of these sources have limitations.

The **Monitor database** identifies the number of different providers but not the number of outlets. NHS providers are identified at the level of the trust rather than individual hospitals/clinics. Audiology may be offered at some but not all hospitals as well as via community based clinics and GPs tended to talk in terms of individual hospitals/clinics. Moreover, the list relates to the whole of the CCG whereas GPs were mainly referring patients to providers that were local to the practice/the patient's home.

Locate and Rate lists all the different outlets within a five mile radius. NHS service providers are identified at the level of the individual hospital and/or clinic (without indicating which trust they fall under). It is also not clear if a hospital provides only

consultant led services in an ENT department or AHS via an audiology department/ community clinics, or both.

The degree of choice available at each location varied but, with one exception, there was a choice of at least two providers. Based on the Monitor database:

- within AQP areas there was, as a minimum, a choice between two providers (see Table 1)
- within four of the non AQP areas there was also, as a minimum, two providers offering services; the database did not provide details for two of the CCGs however, Locate and Rate suggested that there was a single NHS trust providing services in both these locations and, in one of these, the trust had more than one hospital/clinic that patients could be referred to.

Respondents mentioned specific providers of AHS both spontaneously and when asked to name those they were aware of. Because of the range of issues to be covered in the interviews, it often was not possible to prompt respondents about every possible provider identified (this varied from just one or two to more than 10). Taken together, this makes it difficult to assess the level of awareness of all the possible providers of AHS across the sample.

4.2.1 GP awareness of NHS providers

With respect to NHS providers, all respondents mentioned at least one NHS provider and this was typically the NHS provider closest to their practice. Several mentioned two or three additional NHS providers that were within the area. Respondents were also aware that in principle, patients could be referred to any NHS provider i.e. just because particular providers were not mentioned, this does not mean respondents were unaware that they offer AHS.

4.2.2 GP awareness of independent providers

Table 3 below illustrates in the 23 locations included in the research where AHS was provided under AQP which independent providers had been commissioned and how many respondents were aware of this. 22 of the 23 respondents based in AQP areas were aware of at least one independent provider; seven could name two providers and two were aware of three. In a handful of cases, these providers were only recognised

after prompting or some time into the interview when the respondent suddenly recalled a patient asking for a referral.

An independent provider of AHS was operating in two of the six locations where AHS was not provided under AQP; one of the two GPs was aware of this[6].

Table 3: Levels of Awareness of Independent Providers of AHS

Provider	No. of GPs in sample based in location where organisation is providing AHS under AQP	No. of GPs in sample who were aware that they could refer patients to the organisation
Independent Provider a	22	21
Independent Provider b	12	5
Independent Provider c	9	2
Independent Provider d	6	0
Independent Provider e	2	1
Independent Provider f	2	0
Independent Provider g	1	1
Independent Provider h	1	1
Independent Provider i	1	1
Independent Provider j	1	1
Independent Provider k	1	0
Independent Provider l	1	0
Independent Provider m	1	0
Independent Provider n	1	0
Independent Provider o	1	0

With the exception of [independent provider a], levels of awareness of independent providers were patchy. The high level of awareness of [independent provider a] probably reflects the number of outlets – in the larger towns and cities, Locate and Rate

[6] In non-AQP areas, commissioners will have commissioned these services from the independent provider but this would not have been under the terms of AQP.

often identified a number of local branches. Respondents also spoke about the level of advertising and in-store promotion that they had noticed themselves as well as the number of patients who were aware that they offered hearing tests and hearing aids.

Several respondents commented that the first time they became aware of independent providers of AHS was when a patient requested a referral. In at least a couple of cases, they had had to contact the provider to check that they could refer NHS patients to them.

> *"The patient asked me whether I could do the referral and I spoke to [independent provider a] saying that, I asked the secretary to ring, whether it is true that you are doing [hearing tests]? Then we did the referral [ ] and it worked." (AQP; Default provider; Unaware of impact)*

> *"I think a lot of doctors wouldn't be aware because unless you are actually doing it, you don't get letters in the post saying 'we've now got this service,' you just find out by chance, you know. The first patient who came to me, 'can I go to [independent provider a] for hearing?' I thought they were having a bit of a laugh, you know, having a joke with me. So I said, 'oh, are you sure?' and he said, 'yeah my friend did', and I went, 'oh yeah fine.' I went to Choose and Book and there it was, but no one had ever told me." (AQP; Choice with direction; Fairly enthusiastic)*

Although we do not have a consistent picture across the sample, our impression was that either CCGs had not informed GPs of the independent providers that had been commissioned to deliver AHS or, if they had, this had not registered with respondents (see also 6.3).

A small number commented that, unlike other services where the CCG had provided guidelines about recommended referral pathways, they did not think this was happening with AHS.

Two respondents were based in **practices that housed a clinic** providing AHS; they adopted different approaches:

Case 1: the respondent adopted a neutral attitude and did not make any attempt to influence patients' decision making in favour of the 'in-house' clinic which was provided by the local NHS trust's audiology department

> *"They turn round and say, 'I want a hearing test, can I go to [independent provider a]?' or 'can I go to [hospital a] or [hospital b]?' or wherever and I just say, 'right, we'll do the referral, they'll send you the choice and you choose your one.' I'm not going to turn round and say, 'do this specific referral to*

[independent provider a] or [hospital b]." (AQP; Assumes choice; Very enthusiastic)

Case 2: unless patients expressed a clear preference for a different provider, the respondent was keen to direct his patients to the in-house clinic run by an independent provider on the grounds that it was very convenient for them and it was in his financial interest to ensure the clinic was successful. The clinic had been established before AQP was introduced.

> *"So in fairness to [independent provider a] I would include that option but I'll be absolutely honest because it's [an AQP provider] people hiring a room from us then I've got a vested interest to make sure that service survives. If I refer everybody to [independent provider a] and [independent provider b], these people might not get enough referrals and they might have to move out of our building so there's a financial interest for me to promote one particular provider." (AQP; Choice with direction; Uncertain)*

One practice had been approached by an independent provider (a large company) to set up a clinic in the practice but the parties had been unable to agree on terms. Another practice had been thinking of setting up a clinic because of long waiting times but then AHS under AQP had been introduced which had resulted in improvements in delivery by the NHS providers and there was no longer the need.

4.3 Triggers and Barriers

The research identified a number of factors that could make a GP more or less likely to refer patients to particular providers. These are summed up below for NHS and independent providers. It was noticeable that more triggers were recorded for NHS providers and more barriers for independent providers which suggests a predisposition among many GPs to favour NHS over independent providers.

4.3.1 NHS providers

Triggers

- Habit/familiarity – *'I go with what I know'.*
- Relationship with/trust in local NHS provider

> *"I'm not saying that [independent provider a] would be last, but as I'm attached to the hospital, I would put the hospital first and if he says '[independent provider a]', I'm quite happy to do that." (AQP; Default provider; Unaware of impact)*

- Loyalty to NHS/wish to protect services/assumed patient wants to support NHS

"I like to support the local hospital, you know it is at risk of closure and we want to keep as many services there as possible. Patients in general have a reasonable experience there and get reasonable hearing aids and can get up there quite easily. I think they have a drop-in service and they can get batteries and things from there." (AQP; Default provider; Unaware of impact)

- Part of an integrated service for example, the local NHS trust's audiology department can refer a patient directly on to ENT if necessary (e.g. if they have asymmetric hearing loss)
- Perceived expertise, for example, knowing that there is consultant back-up if required

"I suppose the ENT services linked to audiology we just sort of trust the consultants which we know and are familiar with." (non-AQP; Choice with direction; Mainly negative)

- Accessibility especially where the service is available via community clinics
- Ease of referral, for example where the GP has a *pro forma* referral letter s/he completes
- Perceived to offer unbiased advice and information, for example, in relation to hearing aids, as there is no commercial imperative

"I just feel like the NHS you're going to get completely unbiased advice compared to non-NHS ones." (AQP; Choice with direction; Very enthusiastic)

- Where waiting times were thought to be shorter/similar/not too much longer than independent providers (see 5.3.1 for further details about waiting times).

Barriers

- May offer less convenient access (location, opening hours, parking)
- Waiting times were sometimes known or assumed to be longer compared to independent providers.

4.3.2 Independent providers

Triggers

The main triggers were:

- More convenient access (location, opening hours, parking)

- Shorter waiting times
- Patient request.

A few GPs mentioned ease of referral (for example, where a provider had supplied the practice with an electronic template or the practice system only offers a particular provider).

> *"Do you know what I think, it's based on what is available to us as the doctors on the computer system. So we have in our practice something called the Intranet and the only form that is on that, the only referral form is [independent provider a's], so that is probably why we just use [independent provider a] thinking about it. That is what we automatically default to." (AQP; Default provider; Very enthusiastic)*

One respondent said that the local NHS provider had pared back the service.

> *"The trust has pared down the service they used to offer and there is no doubt about that. So in a way they are not encouraging referrals. [ ] But I think the trusts are quite happy not to have so many patients with hearing tests to do, to be honest." (AQP; Default provider; Fairly enthusiastic)*

Barriers

- A commonly cited barrier was a lack of awareness of the independent providers that respondents could refer to and/or that independent providers were not top of mind. In some interviews, respondents only recalled that they could refer patients to independent providers some way into the discussion

> *"The thought of actually referring them to [independent provider e] or referring them to [independent provider a], it doesn't even figure on the radar to be honest with you. It's just lack of awareness basically." (AQP; Default provider; Fairly enthusiastic)*

- Lack of knowledge of the service that was being offered and/or a lack of confidence in its equivalence to the service available from the NHS was a further barrier

> *"It may come up as an option when you're on Choose and Book but just because I don't know anything about the service I don't choose it." (AQP; Default provider; Uncertain)*

- Where GPs had been provided with *pro forma* referral forms (typically by individual service providers), these appeared to set out the criteria that should be used. Despite this, or possibly where no such criteria had been provided, a number of respondents commented that [independent provider a] will send

patients back to their GP if the provider thinks the patient does not meet the criteria for age related hearing loss. This was perceived by some respondents to be a waste of their time and, where they had to make another referral either to the local NHS trust's audiology department or ENT, a concern that the CCG would be charged for two referrals.

- The fact that independent providers were not integrated with NHS services was also a commonly mentioned barrier; for example, respondents spoke about patients being referred back to them if the hearing test suggested the patient had a more complex hearing condition. This meant that they had to have another consultation with the patient simply to refer them to the local NHS trust's audiology department or ENT whereas if they had referred the patient to the audiology department to begin with, they would have been referred directly on to ENT. There were also concerns about the fact that independent providers were unable to deal with more complex conditions or any complications that might arise
- Negative experiences of independent providers either reported by patients, where a respondent had some involvement with their CCG and had heard of problems, or had experienced problems themselves.

Many of respondents' concerns, which made them hesitant about making referrals to independent providers, reflected their more general concerns about AQP; these are discussed in more detail in sections 6.3 and 6.4.

One of the factors identified above was the ease of making a referral.

> *"Well you want to make it as easy as possible. So what you would do is you would draft a general sort of template, like a letter where you know it would be like a referral letter, along with a patient letter. So you'd have a separate patient letter and a separate referral letter and at the end of the patient letter, you'd have like a list of providers where the patient could attend. And you'd probably email that out to all the GPs and tell them to incorporate it onto their hard drive, because we have a certain section of the drive where we have all these letters and then just make everyone aware, raise awareness and say 'this is a service that is provided and there's certain locations'." (AQP; Default provider; Fairly enthusiastic)*

This was best illustrated by a GP who worked in two practices and was referring patients differently because of the relative ease of the referral process at each practice (see Case Study 1).

Case Study 1: How ease of referral can be a trigger

Medium sized practice in a metropolitan location; newly qualified GP

The GP divides his time between two practices and refers patients in different ways.

Practice 1

He uses an electronic referral form which contains patient details, a list of more complex conditions and an instruction to refer to ENT if any of these apply, a checklist for whether the patient needs transport, an interpreter etc. and the GP/Practice details and signature – he says that it is easy, a quick tick box exercise. It does not include details of AHS providers and this is not discussed with the patient. If the patient wants to be referred to [independent provider a], he has to write a letter explaining why he is referring the patient and detailing the patient history. He says the admin team process the referral using C&B but acknowledged that the majority of patients are referred to the local NHS audiology department as this is the simplest pathway from his point of view.

Practice 2

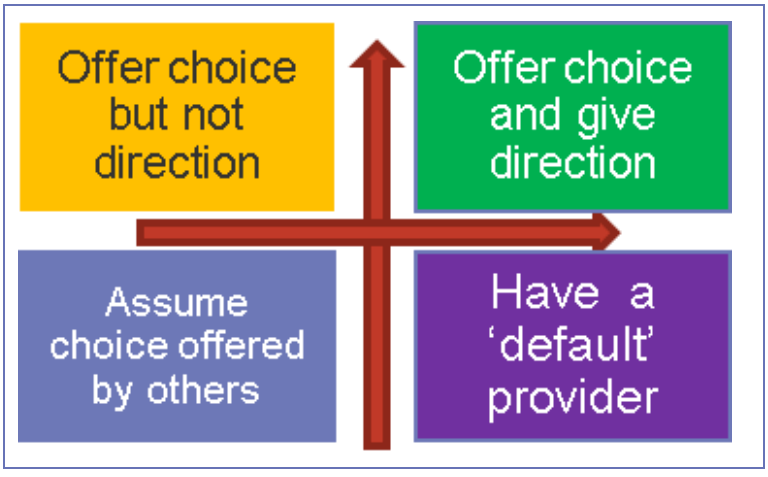
There is a link to a [independent provider a's] form on the patients' notes; when he clicks on it, the form is pre-populated and all he has to do is sign it. There is a nearby branch of [independent provider a] and most of his referrals are to here.

> *"Here in this practice we still do a lot of the audiology through the NHS whereas in the other practice I work in it's not done through the NHS. They've actually got a link for a [independent provider a's] form on their notes so I think it's just more convenient in that practice to click that button and you get the form printed out, sign it with the patient's name, details, medical history… so basically as soon as you click the [independent provider a's] form it brings up all the patients details onto the form so you don't need to handwrite anything, just a signature at the bottom and off they go with the form to [independent provider a]." (AQP; Default provider; Unaware of impact)*

4.4 Levels of Choice and Direction by GPs

GPs were offering patients various levels of choice of provider and in different ways. Looking across these patterns of behaviour, they fell into four main types depending on the extent to which GPs were offering patients a choice of provider and the degree of direction they were giving. The four types are

Figure 1: Levels of Choice and Direction by GPs



illustrated in Figure 1 in where the vertical red arrow represents degree of choice offered and the horizontal red arrow represents the degree of direction given.

4.4.1 Offer choice but not direction

Three respondents (all in AQP areas) were offering their patients a choice of provider either by using C&B during the consultation or by following a formal protocol. The choice they offered included a mix of NHS and independent providers. If a patient asked for guidance, the GPs would repeat the available options without offering any guidance. An example is provided below (see Case Study 2).

Case Study 2: GP offers choice but no direction

Small rural practice
Referrals are made via a RMC. The GP has a formal protocol which he follows which includes finding out if the patient has a preference in terms of the provider. If he does not record a preference, patients are referred to whichever provider has the shortest waiting time and if the patient's main priority is to be seen quickly, he leaves this unticked. *"I would say why I'm referring first and then say, 'there's two services doing this at the moment'. If they're a new referral, I'd say, 'you can be seen at the hospital, by the hearing aid audiologist or you can be seen at [independent provider a] by trained audiologists, where would you prefer to go?'" (AQP; Choice, no direction; Uncertain)*

4.4.2 Offer choice and give direction

Eight respondents were offering their patients both choice and, if asked, direction although the amount of choice and direction varied. Six of these were located within AQP areas and two were in non AQP locations.

Three of the GPs were discussing choice with their patients but if the patient did not express a preference or asked the GP for his/her advice, the GP would suggest whichever provider seemed most convenient (see Case Study 3).

Case Study 3: GP offers choice and gives direction

Practice in an economically deprived metropolitan area
This GP uses C&B while the patient is with him and gets a list of providers within five miles of the patient's home; many of these will be branches of [independent provider a]. He prints off a sheet with details of how to book. He 'has a conversation' about their choices and patients mostly choose one of the [independent provider a] branches for convenience. If asked for a recommendation, he

would suggest [independent provider a] for this reason because he knows that many of his patients will be using public transport and it is more difficult to go to the hospital.

> *"Now the majority will go locally bearing in mind most of these people will be elderly but I have to say, 'where would you like to go?' And really, the majority, for age reasons, locality, me knowing them, will go locally, the local footprint, and in my experience of the last year, probably 90% have chosen to go to [independent provider a] in [name of town]." (AQP; Choice with direction; Fairly enthusiastic)*

One further GP was doing the same thing except she had concerns about the behaviour of the independent providers (she was involved with her CCG) and refused to refer patients to one of these unless patients specifically requested it. She would therefore only inform patients of the local NHS providers (see Case Study 4).

Case Study 4: GP offers choice and gives direction

Smaller practice in a more economically affluent rural area

This GP uses C&B and gets a list of providers local to the patient. She then selects those NHS providers that are closest and discusses which the patient would prefer. She gives the patient the details of this provider to make an appointment themselves. She does not offer any independent providers on principle because she dislikes their marketing to people and prompting them to ask their GP for a referral to the provider. She also has concerns about the quality of service they offer (see 4.6)

> *"You'll see a list of providers, which will include both the local hospital, the local community hospital and then the 'any qualified providers', for example [independent provider a] and [independent provider b], and largely you would pick out those nearest to the patient in terms of their post code. [ ] And they do leaflet drops to houses about three times a year saying 'if you can't hear Holby City go and see your GP now'. Well, hello, I've got enough to do without you, [independent provider a], telling patients to come and see me – for me to refer you back to [independent provider a]." (AQP; Choice with direction; Mainly negative)*

The other four GPs in this category were discussing choice with their patients but they had their own definite preferences which they were making clear to their patients (see Case Study 5 for an example).

Case Study 5: GP offers choice and gives direction

A large suburban practice

The GP uses C&B to select the two or three providers that are closest to the patient's home. He prints this off and gives it to the patient.

> *"I just tell them that here's a choice of three local providers – you can go to one whichever you wish and leave it for them just to discuss with the Choose and*

Book helpline." (AQP; Choice with direction; Mainly negative)

However, if the patient asks for his advice, he directs them to the local community hospital as he is reluctant to refer them to an independent provider.

> *"Well, I've got now some reluctance to refer people to [independent provider a] through personal experience and through them rejecting occasional referrals so would preferably refer people to the NHS services." (AQP; Choice with direction; Mainly negative)*

4.4.3 Assumes choice is offered by others

Four GPs in the sample (all based within AQP areas) did not discuss or offer choice during the patient consultation but they expected or assumed this would be done by either their admin team or the RMC. While they think that patients are given a choice, they were not sure the extent to which this was actually happening.

The main reason they gave for not discussing choice was a lack of time during the patient consultation; there were also concerns about not having up to date information and, in at least one case, a concern about repercussions if they provided incorrect information (see Case Study 6).

Case Study 6: GP assumes choice is offered by others

Large practice in mixed urban area with increasing number of elderly patients

The GP writes a referral letter and her secretary then writes to the patient about their options under C&B; the respondent is uncertain what options are available through C&B.

She informs the patient in the consultation that they will receive a letter within two weeks and they should contact the practice if not. She tries not to mention choice of provider because she does not wish to enter into a dialogue about this. This is on grounds of her lack of knowledge about which providers are available and what they offer, and because the consultation time is too short to have such a discussion.

> ***"Do you tell them they will have a choice and that they will find out what their choice is?...***
>
> *…Um, I fudge that bit and I say that they will have some paperwork through within two weeks which is the deadline of patients being notified and if they don't hear within that time they are to ring back and talk to our practice secretary. So if I mention choice they might start asking me where or what would I recommend and, you know, what's the parking like and I don't want to get into that conversation. So it does get parked with the admin side, yes." (AQP; Assumes choice; Uncertain)*

4.4.4 Has a default provider

15 respondents, half the sample of GPs, had a preferred 'default' provider and unless patients asked specifically to be referred somewhere else, they were referred to this provider. Ten were in AQP areas and 5 were in non AQP areas.

Various reasons were given for selecting one provider over another; the most common was the assumption that the 'default' is the most convenient for the patient.

Examples are provided in Case Studies 7-9.

Case Study 7: GP has a default provider

Practice in an economically deprived metropolitan area; GP in current post less than a year

The GP follows a formal protocol from the local trust's audiology clinic to which he believes his secretary faxes a referral letter; he believes the trust and its community clinics are the local providers and most convenient for patients and for him. He trusts that they offer a comprehensive service.

He said he was unaware of independent providers under AQP but then recalled two patients requesting a referral to [independent provider a]. When speaking to the practice secretary at the end of the interview, she commented that lots of their patients were being referred to [independent provider a], possibly more than to the trust.

> *"To be honest with you, no, I haven't mentioned to anyone, anything about the [independent provider a]. If they ask for it I will do it, but otherwise I'll do the normal audiology clinic. To be honest here, I don't have much time to think about that because there is a normal process already in place. If I tell my secretary, she knows all about it and she can do the referral, so this is maybe a matter of convenience basically." (AQP; Default provider; Unaware of impact)*

Case Study 8: GP has a default provider

Inner city practice in an economically deprived location

The GP refers patients to [independent provider c] on the basis of its long-established relationship with ENT at the hospital so patients can be referred on to there if necessary. He has a standard *pro forma* letter for making the referral, it is cost effective (he assumes) and he has had positive patient feedback.

He does not offer choice unless the patient presents having had a free hearing test at a high street provider; in which case, he will refer them to their chosen provider.

> *"We have a great organisation locally and because they have the support of the ENT specialists, it works very well. Obviously high street providers, they can offer the audiology element, which is fantastic, but it's only designed for a specific diagnosis, so anything outside the norm, they can't handle it essentially." (AQP; Default provider; Fairly enthusiastic)*

Case Study 9: GP has a default provider

A medium size practice in an urban area with a high proportion of working class and elderly patients
The GP always selects from C&B the provider that is nearest to the patient, typically this is a branch of [independent provider a] He does not offer choice which means the process takes less of his time. *"I'll have a look at hearing loss and see what services come up, or you can just search on audiology clinics and it will give you a list of available services and what I've noticed the top one that comes out for us and which is I think, commissioned through our Clinical Commissioning Group in [town] is [independent provider a], they do offer the audiology service, they're the most local to us. In general, I automatically will book them in for an audiology assessment at [independent provider a] via Choose and Book. [ ] It comes at the top of the picking list and it's the most local service and it seems to be quite [ ] a good way for patients to access that service. They get a say in the day and the time they go and I know that it's very quick." (AQP; Default provider; Uncertain)*

4.5 Patients' Awareness of Choice of Provider

GPs' views were mixed on whether patients were aware of, and interested in exercising, choice with respect to health service providers. Within AQP areas, about half the sample commented that patients were becoming more aware of the option to be referred to independent providers (possibly as a result of them actively promoting their services), especially where the patients were also accustomed to the Choose and Book system.

> *"I've done it from the beginning to be honest so I just sit there and just say, 'where do you want to go to?' And because of historic reasons, you know a lot of patients want to go to the hospital to the audiology clinic. You know, they've been there before or they're aware they have to go to a specific place but increasingly more now are asking, can they go to the AQPs?…*
>
> ***…And any providers in particular they're asking for?...***
>
> *…Well [independent provider a] primarily. I think [independent provider a] did a leaflet drop in the area and that prompted, this is about 6 or 7 months ago and that's prompted a lot of patients to come in requesting to go to [independent provider a]. Traditionally they would have rather gone to [hospital a] which is like a local hospital or [hospital b] which is the main one." (AQP; Choice with direction; Very enthusiastic)*

In contrast, in areas where AHS were not available under AQP, all seven GPs thought that their patients were not aware of/interested in exercising any choice and tended not to differentiate within the NHS.

"Personally no, I think they just want to go to the local provider itself and they'd expect each and every NHS provider to be the same and have the same quality of care and that's what you'd ideally hope and I think most patients want to support their local hospital because they know that if they don't and they go elsewhere that their local hospital will close down." (non-AQP; Choice with direction; Mainly negative)

"They know it's on that mysterious thing called the NHS, they may not know if it's the [name of hospital] or some sort of health centre somewhere. They would assume there is some sort of free hearing test available, yeah. And they are always happy, I mean our surgery is only one mile from the hospital so they are very happy to go there." (non-AQP; Default provider; Uncertain)

The general conclusion seemed to be that younger and more 'professional' patients were more aware of and interested in choice (not just in relation to AHS but more generally) while older patients were less interested; by definition, patients presenting with age related hearing loss tend to fall into the latter group.

"I think a lot of this choice phenomenon has been driven by younger patients and not the older patients." (AQP; Default provider; Uncertain)

"I don't think with elderly people they're particularly interested in choice, rather than getting something local and getting it done. That's the problem isn't it? This whole idea of patient choice, it's what the politicians think people want or want people to want but they don't actually want a choice of provider, they just want a good one on the doorstop." (non-AQP; Default provider; Uncertain)

The finding that some GPs felt that choice was important while others did not probably also reflect differences in each practice's patient profiles. For example, GPs in more affluent areas sometimes reported that a high proportion of their elderly patients were experienced users of the internet and, as a result, were more aware of the options open to them.

"They're very physically active anything up to their mid 80's and mentally with it so they're all IT savvy, so they all know they've got choices and I think Choose and Book has been around for almost 10 years now. They're quite used to it now. So they quite like having the choice." (AQP; Assumes choice; Very enthusiastic)

Nevertheless, the commonly held view was that patients were not interested in having a choice *per se* but wanted to be seen promptly at a convenient location and that providing these criteria were met, patients would be happy wherever they were referred. Moreover, many felt that patients were often happy to be guided by their GP.

"Like I say, if they're coming in and they're old school where they just want a doctor to tell them what to do then I'm not going to give them the option because that's not what they want but if they're wanting an option or I know it's not going to be convenient for them to go on loads of buses or this, that and the other on

the travel then I'll give them the option but assess it on a case by case." (AQP; Default provider; Unaware of impact)

"I would have thought from the cohort of patients you're talking about, you know the elderly population, I think they don't seem to be as bothered about the actual choice of hospital, choice of provider. I mean I think they've always just used the local service, the local hospital and you know, as long as it's local, that seems to be their main agenda really or their main preference to have a local service." (AQP; Default provider; Uncertain)

"Patients want the nearest hospital to them and a hospital with parking. End of story. All they're interested in is, 'can I park, can I get out of my car and walk five feet as opposed to 500 yards, do I have to pay for parking and is it convenient?'" (AQP; Choice with direction; Mainly negative)

However, there were situations when GPs' views on what they thought was best for their patients did not meet the criteria of a prompt appointment at a convenient location (see, for example, Case Studies 10 and 11).

Case Study 10: Patients not being referred to the closest providers

Practice in a rural location
The GP was aware that she could refer patients to [independent provider a] but was not aware of two other independent providers that had been commissioned. Currently she refers all patients to the nearest hospital which is 10 miles away as this is familiar to her although there are five branches of [independent provider b] and one branch of [independent provider a] closer to the practice. She only refers patients to [independent provider a] if they request it. She said she didn't know if patients could self-refer to [independent provider a] and she had no information about the service they provide. *"I tend to refer to the hospital because I know the department and I don't even know if patients could self refer to [independent provider a], I don't know if they need a GP letter[7]." (AQP; Default provider; Uncertain)*

Case Study 11: Patients not being referred to the closest providers

Inner city practice in a relatively economically affluent location
The GP was aware of two independent providers but was mainly referring to the local hospital, partly because of its location. In fact, [independent provider c] was the closest provider and there is a branch of [independent provider a] which is almost as close as the hospital. When asked, he mainly associated [independent provider c] with other services, such as MRI scans, and was unaware of the local clinic.

[7] Some independent providers offer free hearing tests; if this indicates that the patient would benefit from hearing aids, and if they wish to have them provided by the NHS, they will need to ask their GP for a referral letter.

"I know one is supposed to offer choice but the [independent provider c] could be anywhere in London which obviously I can say, 'I'm going to refer you to [independent provider c], but the trouble is for an MRI they're seen anywhere over [city] it could be [location] or somewhere like that. I don't know physically where they do their audiology." (AQP; Default provider; Unaware of impact)

He was wary of referring anyone to an independent provider as he is concerned that they might try to sell private and more costly hearing aids.

4.6 Perceived Impact of Independent Provider Marketing

In some locations, respondents were seeing relatively large numbers of patients who were requesting referrals to an independent provider. This was attributed to advertising, in-store promotional material as well as suggestions from staff when patients attended for eye tests.

"I think [independent provider a] has managed to advertise its services fairly well, either through the shop … I'm pretty sure last time, there was a big sign saying along the lines of 'NHS hearing tests available here', in big letters, something along those lines and patients like that so will often say, 'can I go there please?' Or often word of mouth gets round so if the neighbour's gone to [independent provider a] or vice versa, and had a good experience, they often say 'I want to go back there please'." (AQP; Choice, no direction; Uncertain)

"A lot have come because they've been to [independent provider a] for their eyes and they've been told, 'oh if you go to your GP you can come back for your hearing', so they'll say, 'I want to go to [independent provider a] for my hearing', and they've come to get the referral so they've already decided where they wanted to go." (AQP; Assumes choice; Mainly negative)

"A lot of patients who have been going to [independent provider a] for their eyes have said, 'can you give me a note to go to [independent provider a] for my hearing?' so obviously they've been geed up at the [independent provider a]. I don't know if they've mentioned it to them or they've noticed adverts in the shop." (AQP; Choice with direction; Very enthusiastic)

In some instances, patients presented with the results of their hearing test and requested a referral to have hearing aids fitted; in others, they had had a preliminary hearing test and wanted a referral for a full test or they simply wanted to be referred for a first hearing test. We did not record a single case of respondents not agreeing to refer such patients assuming, in the latter case, the patient was judged to have age related hearing loss.

One GP objected to [independent provider a] advertising 'free hearing aids' when while they might be free to the patient, they represent a cost to the NHS.

"[Independent provider a] are, I think, getting quite irritating – mailing people through the doorstep saying 'free hearing aid', and they've done that from the outset saying 'free hearing aid'. Well, it's not a free hearing aid, the NHS has to pay for it, so again that's a bit – I think it's below the belt really to say it's free because it's not free." (AQP; Choice with direction; Mainly negative)

4.7 Meeting the Needs of Elderly People who are Isolated

We briefly explored issues of accessing AHS by isolated, elderly patients. Most respondents recognised that they might have such people on their list and that their needs with respect to AHS may not be currently met.

A range of patient 'types' who might find it difficult to access AHS were identified by respondents including:

- those with restricted mobility/who were housebound
- those living alone or in residential homes
- those with cognitive impairments such as dementia – not just in relation to accessing AHS but also adapting to using an aid
- those without access to public/private transport
- those with no family/friends nearby
- BME patients with language and cultural issues.

The extent to which this was perceived to be an issue varied. Some GPs were mainly seeing younger and/or more affluent patients who, for example, either had private transport or could afford to pay for taxis, etc. It was pointed out that care home residents and patients with cognitive impairment would typically have a carer who could help them access AHS and where a patient is referred to an NHS provider, it is normally possible to arrange transport to/from home and an interpreter for those who need it. It was suggested that more problematic for care home residents were practical issues of losing their hearing aids or the aids not working due to needing new batteries; these problems might not be quickly resolved.

Some GPs felt that those who were more at risk of not accessing services were frailer residents of nursing homes or others in the community with restricted mobility who might not be identified as needing help with accessing (any) services. The most common suggestion for making access easier for such patients was for the service to go to the patient.

> *"I think there are a number of patients who are in poor health and got very poor mobility who would probably have to go without hearing aids simply because the ability to get to a centre is too much of a challenge and too physically stressful for them so they probably could be assessed at home and fitted with a hearing aid. I'm not aware of services that offer that." (AQP; Choice with direction; Mainly negative)*
>
> *"Audiology would be very good if it could, and I'm sure it's a possibility, if it could be done in the patient's home that would be absolutely brilliant…*
>
> *…**So as far as you're aware at the moment that is not?..***
>
> *As far as I'm aware it's not available but it is a need, you know which I think is there. Mobility issues, poor vision as well as poor hearing, you know people can get some taxi cars or we can get transport to various things but sometimes it's much easier if it were done in the patient's home." (AQP; Default provider; Unaware of impact)*

The provision of a domiciliary service was felt to be the best way of taking the service to the patient and, in some locations, one or more providers were offering this.

> *"I think when it comes to patients who are not that mobile or not able to attend the clinics then they should come and there is no service that they do the audiology test in the nursing home itself, which is not happening, so we need to take the patients to the clinic itself, which is always difficult on both parties basically. So if that service is provided in the place where the patient is there then that's welcome, basically that is a thing that can be welcome." (AQP; Default provider; Unaware of impact)*

One GP said that the local NHS trust's audiology department does sometimes arrange a home visit but there was no agreed protocol for this and on every occasion when he has requested it, he has had a different response. Some people will say they do not do home visits, others will say they do but describe different criteria that have to be met; this means he has to spend a lot of time on the phone trying to see if he can arrange such a visit. He felt the department should come up with a formal protocol which makes it clear when a home visit can be requested and how this can be done – if it was part of the referral form, this would make things much easier.

Other GPs in areas without a domiciliary service would welcome its introduction. It is worth noting that in AQP locations where independent providers had been commissioned and were providing such a service, respondents were unaware of this.

4.8 Desire for More Information about Choice

Some, but by no means all, respondents felt that it would be helpful if there was more information available about the choice of AHS providers. This could help both themselves and their patients make a more informed choice.

> *"It would be good for us to have a printout of the choices that patients can have, perhaps for it to be more readily available in the reception area or anything like that but I don't have anything in hand in my surgery normally.[ ] I think it's very important that the patients don't feel that they're forced into one route. You know, they have to have the options all laid down in front of them and for them to ideally come to a conclusion themselves, not to be coaxed into any kind of way, but I think it's just to exercise autonomy, that's the main issue really with being able to provide them the choices and for them to make up their own decisions." (AQP; Default provider; Very enthusiastic)*

> *"It would be helpful to have more information about what's available. Things are changing so quickly all the time that it's sometimes hard to keep up with everything so yeah, it would be useful to know what a patient's options are." (AQP; Assumes choice; Mainly negative)*

One respondent reported that there were meetings with the CCG every two or three months to discuss service providers and referral protocols but as far as he was aware, nothing had been mentioned about AHS. He felt that firmer guidance from the CCG would influence his decision making/behaviour.

> *"I think this would come from the higher level basically. So instead of we deciding everything, probably if it comes from the CCG level and they have an education session or something on audiology and then tell all the local GPs this is what the service is available and this is the same service what you are getting now. If you recommend it, if you promote, then things might change." (AQP; Default provider; Unaware of impact)*

Others felt that having information from the CCG about the relative cost of AHS from different providers could influence their behaviour.

> *"If it was a cheaper service, you know our Commissioning Group is always looking for cheaper or less expensive but good quality services in the community and if there's more of a community audiology service who would do it because it is expensive going to the hospital. So yeah, I'm sure there could be some savings there but it would have to be put to our CCG Board Members I think, a case for making a referral." (AQP; Default provider; Unaware of impact)*

> *"And if someone tells me that I have to because it's cheaper, which they haven't done yet. With our scans and x-rays we are encouraged to use [independent provider c] because it's cheaper and we haven't been told to do that with audiology yet." (non-AQP; Choice with direction; Default provider)*

Another suggestion for communicating such information was for CCGs to have a dedicated section of their website that summarised the local commissioning arrangements.

> *"Maybe have a portion of their [the CCG's] website dedicated to local commissioning arrangements. I think that would probably be the most effective way so that if I wanted to search about what's going on locally, then you know, it's not a million miles away and it's fairly centralised." (non-AQP; Default provider; Uncertain)*

However, some GPs who already felt overloaded with information coming into their inbox, would prefer information about providers to be directed at their secretary who were, they felt, better able to handle it and liaise with the patient.

> *"But the choices out there change all the time and they vary and I'm not the sort of person that can remember that level of detail, it's not in my interest because it changes all the time. So from my point of view it is more important that I'm remembering changes to prescribing guidelines rather than who I need to refer somebody to for a hearing test." (AQP; Assumes choice; Uncertain)*

> *"There's so many different providers, every time you try and stay on top of it there's another one sprouts up somewhere else (laughs) so you think, I'll refer on and then god help them (laughs)…*

> ***…So it's just actually impossible to keep up to date with what's available?...***

> *Yeah it really is impossible to keep up with it and patients turn round and say, 'well, there's this clinic that's just been opened, can you refer me to it?' And I think, 'no there isn't', and at the end of it you look into it and there is and you've got egg on your face." (AQP; Assumes choice; Very enthusiastic)*

Given that GPs were unsure that patients were interested in having a choice of provider, they were also uncertain that they would read information to help them make their decision if given it. They thought any information would need to be short especially if it was to be printed out by the GP during the consultation. However, for the many patients able to and interested in using the internet, this might be an appropriate way of providing any information.

> *"Giving out leaflets and things like that it would just be too cumbersome. From a practical viewpoint it would just be too cumbersome." (AQP; Assumes choice; Very enthusiastic)*

> *"Well in order for patients to make a choice they've got to know the distance that needs to be travelled, they've got to know the waiting time for each provider and they've got to know the quality of the service. So I'm not in a position to give them that information. I don't know if NHS Choices or a website could do that but quite a lot of my patients are computer savvy so they could perhaps look that information up." (AQP; Default provider; Unaware of impact)*

5 Quality of Service

5.1 Introduction

This section covers the key dimensions of quality that were explored with respondents, GPs' awareness of the quality of service from AHS providers, their concerns about quality of service especially from independent providers and what information might be helpful for them to better understand the service quality offered by providers.

5.2 Key Dimensions of Service Quality

The discussion focused mainly around three key areas of service: waiting times, quality of the hearing aids and the nature and quality of aftercare. Other aspects of service were sometimes identified as important including:

- For patients: the way they are treated by staff (reception, technicians, etc.) and the nature of the premises
- For GPs: the provision of an integrated service (e.g. being able to refer on directly to ENT rather than sending the patient back to their GP); the level of expertise/training of the staff delivering AHS, and facilitating GP referral, for example, the provision of templates/referral forms/checklists etc.

5.3 Awareness of Service Quality

Respondents' knowledge of the quality of service delivered by various providers was typically extremely limited. As with many therapy areas, what knowledge they had often came from patient feedback which tended to be very anecdotal. Their views could therefore be heavily influenced by the experiences of a handful of patients.

A number commented that by and large the feedback they had received was positive.

> *"Positive from both [hospital] and [independent provider a] really on the whole!...*
>
> ***…Yes and what kind of things are they judging it on?...***
>
> *They're judging it on again that bus route and they often come back and say how pleasant. In terms of adult hearing services, no one's come back and said anyone is rude or anything and how helpful and time, duration to appointment." (AQP; Choice, no direction; Uncertain)*

"I probably would say well a lot of patients who have been there are very happy so in a way where you live and where [independent provider a] is, it's probably a shorter journey." (AQP; Choice with direction; Fairly enthusiastic)

"Well, I mean I haven't visited the local service, I couldn't say hand on heart what exactly it looks like physically. But the reports I get back from my patients is that the service is well run, it's well equipped, they communicate well, it's clean and I think you know, it's not as bad as when it comes to waiting for an appointment compared to some of the other specialities." (non-AQP; Default provider; Uncertain)

Where respondents expressed concerns about the service from independent providers, these were either based on negative feedback from patients or GPs' own observations of the behaviour of the providers. Examples of these concerns are discussed below (see 5.4).

Unless they had heard anything to the contrary, respondents sometimes assumed that the quality of service would be the same across all providers and that patients were satisfied with what was on offer.

"The patients seem to be happy because I don't get many coming back saying they're not, so therefore I don't know." (AQP; Default provider; Unaware of impact)

"But the actual quality of the service I don't think ever comes into it, or very rarely comes into it and it's never come into it when it's come to audiology or hearing services." (AQP; Default provider; Uncertain)

"I think the quality is actually the same all the way through, yeah, I don't have any issues or concerns that anyone is providing a poor service." (AQP; Assumes choice; Very enthusiastic)

In some cases, it was assumed that service providers were being monitored to ensure minimum standards were being met; one respondent assumed providers of AHS would fall under the CQC inspection regime and this gave him reassurance that there was a degree of quality control.

"So basically a lot of these organisations that provide these types of services, you know there's a certain degree of quality assurance because they've had CQC inspections. So you know if they're a provider, right, that they are automatically going to be vetted to a certain level. So you know to some degree, I don't really have that many concerns about the provider side of things." (AQP; Default provider; Fairly enthusiastic)

"One would assume the service is very good from all the providers, that they've had to jump through certain hoops to say, 'we can do this within a certain period of time and it will cost the NHS such and such'. I don't know enough about the

services, I just know there is choice nowadays." (AQP; Choice with direction; Uncertain)

5.3.1 Waiting times

Respondents were often unclear about waiting times and when discussing these, more often than not they did not differentiate between waiting times for a hearing test and waiting times for the fitting of hearing aids (if this was not carried out as part of the first appointment). Indeed, some GPs commented that they had no idea of the process involved including whether hearing aids were fitted at the assessment or subsequently.

While opinions about waiting times were sometimes based on information from C&B or information on referral forms which provided an indicative waiting time (which may not be up to date) or patient feedback, they were sometimes based on the respondents' own impressions. Waiting times were often perceived to be shorter for independent providers.

> *"I'm not sure. I think possibly there could be a wait up to a month with the trusts and with the AQPs, obviously they are keen to get them in as soon as possible, so one to two weeks usually." (AQP; Default provider; Fairly enthusiastic)*

One GP spoke about receiving a regular email from a provider that compared their waiting times and the percentage of patients fitted with hearing aids at the first appointment with the national average. Another GP spoke about how they used to receive regular updates on waiting times across all hospital services but this had stopped.

While short waiting times might be important to patients, from the GP perspective, age related hearing loss does not require immediate attention and, as long as waiting times were not too long (a few weeks), this was not felt to be an issue.

> *"Well, that doesn't really matter actually to be honest with you because by the time they've come to me, they've probably been thinking about it for 6 to 9 to 12 months. You do a letter 1, 2, 3, 4, 5, 6 weeks, now at 70 or 60 or 80 it's not life threatening, so as long as they get seen within a reasonable period of time, bearing in mind they've had 12 months of hearing impairment. [ ] I'm more interested in the quality of the product than the speed of the appointment." (AQP; Choice with direction; Fairly enthusiastic)*

> *"I mean I suppose in this particular area of medicine you know, age related hearing loss is not life threatening either. And you know, in medicine we have to sort of make these tough decisions about what to prioritise and what to fast track and I don't think necessarily, I'm sure my patients will agree with me as well, that*

you know this type of problem is not necessarily one that needs to be fast tracked either." (non-AQP; Default provider; Uncertain)

"Do you have any idea of what basis people might make their choice?...

…I think normally it's convenience, parking that's always a big one (laughs)…

…Do waiting times come into it do you know?

Yeah if there's a significant difference then yeah people would consider the shorter waiting times but it's not normally an urgent problem because normally it's something that's been going on for some time so that probably wouldn't be their main factor in choosing." (AQP; Assumes choice; Mainly negative)

Where the difference in waiting times was significant (several weeks), it did have an influence on GP behaviour as illustrated in the examples below (see Case Studies 12 and 13).

Case Study 12: Impact of waiting times on GP behaviour

Suburban practice with a fairly upmarket and younger patient profile
When AQP for AHS was first introduced, the NHS waiting times were 7-8 months and [independent provider a] were offering appointments within 1-2 weeks. As a result, if patients asked for his recommendation, he was directing them to [independent provider a]. Since then, the local NHS trust's audiology department has 'raised its game' – it has invested additional funds, employed more audiologists and moved from a block contract to an attendance based contract. As a result, waiting times are now down to about 3-4 weeks. If patients asked for his advice now, waiting times are no longer a factor in his mind and as he has other concerns about [independent provider a], he suggests that they go to the local hospital.

Case Study 13: Impact of waiting times on GP behaviour

Inner city practice with a predominantly BME, younger patient profile
The GP is in a non-AQP area for AHS and thinks that the total time for hearing aids to be fitted can be 3-4 months. In response to patient concerns, he has carried out his own research and discovered that several private providers offer free hearing tests. As a result, he now suggests to some patients that they could have a free hearing test at one of these providers and, as long as they will release the test results, he can then refer them to an NHS provider for hearing aids which will reduce the overall time it takes compared to being referred to an NHS provider for a hearing test. However, he has real concerns about whether he should be doing this: • are the private providers offering a service that is in the best interests of the patients?

- if he is perceived to be favouring one private provider over another, might he be accused of 'bias'?
- if anything went wrong, where does he stand from a medico-legal perspective?

> *"I think the main concern is that you're not kind of covered by the NHS in that sense. The NHS hopefully has been vetted and all the providers within it have had an audit and kind of safety and CQC and all these other kind of providers looking after them. [ ] Have the local [independent provider e] offering this hearing service, have they got it authorised, is it regulated in any way?" (non-AQP; Choice with direction; Mainly negative)*

He would like clear guidelines to be provided by the CCG.

> *"It would be quite useful if there is someone else to provide that kind of overview of what the actual services are and a referral pathway, make it streamlined, you know. Are we allowed even as NHS providers to refer on to these private companies? I mean we're doing it but is there kind of rules and regulations around it, we don't know, no one's really told us." (non-AQP; Choice with direction; Mainly negative)*

5.3.2 Is AQP having an impact on waiting times?

Based on the interviews, we are unable to conclude what impact AQP is having on waiting times for AHS. As noted above, many respondents in both AQP and non-AQP areas were unclear about the waiting times and this makes it difficult to assess if waiting times were different in AQP and non-AQP areas.

A few examples were noted of waiting times coming down following the introduction of AQP, not just because independent providers offered shorter waiting times but because NHS providers also acted to cut waiting times (see, for example, Case Study 12, as well as the following quote).

> *"I was surprised how you had to wait longer to go to the private than the local NHS ones because their waiting times have come down considerably anyway. All you're waiting really is a week to two weeks max on the NHS. It's just been considerably better than it used to be." (AQP; Choice with direction; Very enthusiastic)*

And while at least one GP in a non-AQP area said that waiting times for NHS hearing tests were 4-6 weeks and for hearing aid fittings, 6-8 months, another GP in a non-AQP area reported that waiting times were 8-10 days for a test and under 4 weeks for a fitting and commented that these were 'some of the shortest waiting times for any type of referral'.

> *"I think the audiology service is exceptional. What the problem is is the actual hearing aid production line as it were because I think you initially get your test*

quite quickly and then the patient is frequently disappointed that they then have to wait a long time for the hearing aid." (non-AQP; Choice with direction; Mainly negative)

"So they all get seen within two weeks, so we have a very good hearing assessment. So that is quite straightforward…

…So if they then need hearing aids, how long would that take?...

…I think that takes a little bit longer but they get called back directly by the department at the hospital, so we don't have to make any further referrals, we just get a letter saying they are going to be supplied with hearing aids and I think they get assessed what type they'd like, you know digital types or whatever. There is perhaps just a short wait, I think it's less than four weeks to get the hearing aids fitted and supplied." (non-AQP; Default provider; Uncertain)

5.3.3 Quality of hearing aids

There was some confusion over the process of moving from the hearing test to having a hearing aids fitted with some GPs having little idea of what was involved. There was also some uncertainty over whether patients needed to pay for hearing aids with an independent provider or at least, pay more if they wanted 'better' hearing aids (see also 5.4).

One respondent in an AQP area assumed that [independent provider a] only provided free hearing tests and if patients needed hearing aids, they would need to be referred to an NHS provider. Another confessed to having little idea of the process.

"I think the hearing aids for all the NHS clinics are pretty good. My understanding, I'm not 100% sure, is that the hearing aids for [independent provider a] they charge private but they can refer them back to the NHS to get them. I'm not sure if that's definite but I think that's what I've heard on the grapevine." (AQP; Assumes choice; Very enthusiastic)

While patients may perceive/expect NHS hearing aids to be lower quality and less up to date, there was an expectation among many GPs that the same/similar aids would be offered free to patients by all AHS providers. Many admitted that they did not know anything about the hearing aids provided while a couple of GPs made the point that digital hearing aids were available from their local NHS trust.

"I do get the impression that some patients who have been under the hospital for a while think they've got some hearing aids and maybe [independent provider a] would give them better ones and ask to be referred there in the future, but as I understand it they are using the same, very similar, have access to similar hearing aids." (AQP; Choice, no direction; Uncertain)

> *"I have no idea about the quality of the hearing aids or things like that. I know very little about that, what they are, the difference between the two, all the brands and everything I don't really know." (AQP; Default provider; Very enthusiastic)*

> *"I believe the NHS ones, the local [trust area] in particular, they're one of the first into the digital hearing aids." (AQP; Choice with direction; Very enthusiastic)*

As noted earlier, where a patient had concerns about the quality of NHS hearing aids relative to ones they had to pay for, some GPs would seek to reassure them. This may have been based on their own perceptions as most were unclear about what was actually being provided and whether this varied by provider.

A GP in a non-AQP area commented that patients had come back to see him saying they did not want the device they had been given under the NHS and asking if they could have an electronic hearing aid/one that went inside the ear and could not be seen. He said he told the patients that they are not available currently on the NHS and would encourage them to look at purchasing these hearing aids privately if this was an issue for them.

> *"I'd just explain the policy of the NHS and the affordability of these hearing aids and then I do encourage them to look into the private providers, provide them with one or two local providers itself and tell them the costing isn't as bad as they probably think and when they do find out the costing and say you know, it's only a couple of hundred pounds, they're a bit more inclined to go and give that person a visit and have a chat with them and then decide onwards." (non-AQP; Choice with direction; Mainly negative)*

5.3.4 Quality of aftercare

Likewise, unless they had reason to think otherwise, there was an expectation among some GPs that aftercare would be much the same from one provider to the next. A few respondents spoke positively about the aftercare from NHS providers.

> *"I think they've recently changed the digital ones and the good thing about the local hospital service is that, if they have a problem then they can go back to that service. So it tends to be beneficial to have that kind of local sort of troubleshooting type of scenario rather than, you know you might get one quicker but then you're not going to get any support service following it." (non-AQP; Choice with direction; Mainly negative)*

> *"There is also a separate service, for example if they have problems with the hearing aids or if they've got batteries that need replacing, they just have a number to call direct, so they can go direct to the department to get that sorted." (non-AQP; Default provider; Uncertain)*

Although individual hearing aids may only have a life span of a few years, age related hearing loss is not curable and patients will need aftercare/support for the remainder of their life. A number of respondents expressed concerns that aftercare provided by independent providers was or could be quite limited compared to the NHS where aftercare was 'for life'.

While most respondents were unaware of any actual limitations on how long providers were expected to provide aftercare, this was not always the case:

- one GP perceived that aftercare from [independent provider a] was limited to just 6 months after which patients needed another referral
- although most respondents assumed NHS providers offered life time aftercare, a small number reported that since the introduction of AQP, patients needed a further referral.

> *"But now once a certain period of time has elapsed they have to come back to the GP for a further referral, a referral for a further assessment and a further fitting which is a little bit irritating as you can imagine of my time to just say, 'yeah right, you need to go back to the same provider to have another hearing aid assessment'." (AQP; Choice with direction; Uncertain)*

> *"But when that AQP came out and that's when the [name of hospital] said, 'after three years, our system says it's not just a one referral, one payment which is on-going,' they get another referral so payment starts all over again." (AQP; Assumes choice; Very enthusiastic)*

> *"There's another massive source of frustration that for years patients who had hearing aids done, if they had a problem, they could simply ring up the Community Hospital and say, ' my hearing aid's faulty', and they'd say, 'no problem, just come down and we'll sort it.' And then we suddenly found that these patients who had rang up or even literally turned up there had been told, 'no sorry, now because it's Any Qualified Provider, your GP's got to refer you' so we had a significant number of people coming in to be re-referred just because they'd got a problem which was really frustrating for us and made us angry because it's just wasting our time." (AQP; Choice with direction; Mainly negative)*

Respondents sometimes spoke about patients coming to them if they were experiencing problems with their hearing aids; in most instances, they were unable to help as they lacked the 'know how' and would suggest to the patient that they go back to the provider. A GP in an area where AHS was not available under AQP was especially critical and felt that there was a need for clear and simple instructions which should include:

- information about the initial settings when the aids were first fitted in case the patient had changed these and needed to re-set them
- guidelines about how long batteries should last and how to change them
- suggestions for how to prolong battery life, such as switching their hearing aids off at night when not in use.

> *"First of all, I think patients need more written information about how to use it. There may be a little booklet that comes from the manufacturer but that's often insufficient for some elderly people and there also needs to be an explanation of how the settings have been set so that any family member trying to sort it out can see what they need to do. I think also the business about the batteries is a tangled question. How often you would expect to change the batteries, how you change the battery, how you know if the battery is working or not working and to take the battery out or undo the battery casing at night so that it is off at night so that you don't run down the battery when it's not in your ear. That kind of thing. It's all practical stuff that I think is badly done." (non-AQP; Default provider; Uncertain)*

5.4 Concerns about Quality of Service

A number of GPs expressed concerns about other aspects of the service offered by independent providers based on feedback they had received or, in some cases, their own experiences. These tended to have an impact on their willingness to refer patients.

A number of concerns were raised about independent providers generating unnecessary/additional costs which, it was assumed, were being met by the CCG:

- a patient was referred to [independent provider a] who fitted hearing aids for one ear but sent the patient back to his GP (within three weeks) for a further referral before they would fit an aid in the other ear

> *"[Independent provider a] did a hearing test, did the hearing aids but only did one ear. They didn't write to me to let me know what's the problem with the other ear, do they need a hearing aid or not or anything. But instead they told the patient to go back to their GP and get referred back to them for a second time and I wrote a letter saying, 'sorry, I think that's inappropriate, can you please explain why you want a second referral when you've already taken the money from the NHS and this is an on-going matter and you have not finished the first problem?' So I've not heard back so I'm still waiting. But I'll be reluctant now to send them to that certain [independent provider a], only because of my previous experience." (AQP; Default provider; Unaware of impact)*

- a GP who previously worked in ENT and conducted initial hearing tests within his practice was concerned that [independent provider a] was sometimes fitting

hearing aids when he felt the level of hearing loss did not warrant it; he also said that he had had patients sent back to him because they had wax in their ears when he considered the amount was not a contributing factor to their hearing loss

- in one location, a GP reported that [independent provider a] had been fitting hearing aids without a GP referral and then telling the patient to obtain a referral retrospectively; this was taken up with the provider and, as far as she was aware, the practice had stopped
- this same GP was concerned that [independent provider a] was fitting two aids (and charging this to the CCG) when the patient only required one aid

> *"Their [the CCG's] costs for hearing aids have sky rocketed because these AQPs are frankly taking the piss and they are fitting two hearing aids when one is adequate. One on each ear when one on each ear is definitely not needed, these people are not profoundly deaf. They fit them with two hearing aids and charge the CCG double the cost. But the CCGs are largely inadequate at dealing with these AQPs because the comeback we always get is, 'oh, it's a national contract, we can't do anything about it'." (AQP; Choice with direction; Mainly negative)*

Concerns were also expressed about whether independent providers might be encouraging NHS referrals to 'trade up' and purchase non-NHS hearing aids and that the distinction between NHS and private hearing aids might become blurred.

> *"We don't know exactly how they're testing, what sort of equipment they're using, what sort of standard is it. The hearing aids they're going to offer, are they going to be pushing for the private ones which are going to cost them a fortune or are they giving them the choice openly and honestly about, 'here's the free ones, here's the expensive ones?' But we know with private companies they've got to make money as well." (AQP; Default provider; Unaware of impact)*

> *"I understand that you can go to [independent provider a] and have the NHS hearing aid, the standard one, and if you want to top up, as I believe it's called, you can say, 'well, that one is a bit better and it cost me £100 or £200' and obviously one would like to think they don't promote the dear ones for commercial reasons but if the NHS one is adequate that is where it stops." (AQP; Choice with direction; Fairly enthusiastic)*

> *"I have had patients complain of the cost of it, they have been quoted certain prices and I don't understand what is free and whether to get a better quality one they have to spend a lot more. So I've had one or two patients saying they have had their assessment and then they've been told that it would cost quite a bit of money. I don't understand how, they seem to provide a private service as well as the NHS one." (AQP; Default provider; Fairly enthusiastic)*

Another commonly held concern was that independent providers were not integrated with the rest of the NHS such that if the initial diagnosis proved incorrect or complications subsequently arose, patients were referred back to their GP for referral on to either the local NHS trust's audiology department or ENT. Not only did this take up more GP time, it was assumed that the independent provider was still charging the CCG for the referral, resulting in the CCG paying twice.

> *"Well, as I said I've got now some reluctance to refer people to [independent provider a] through personal experience and through them rejecting occasional referrals so would preferably refer people to the NHS services." (AQP; Choice with direction; Mainly negative)*

> *"In the hospital they often say, 'well, the asymmetric ones I've referred on to our colleagues at ENT', which I'm happy with there but I have had one I can think of off the top of my head where they came back from some [independent provider a] the other day saying, 'asymmetric loss, could you refer to the ENT and then send them back to us when they've been seen?'" (AQP; Choice with direction; Very enthusiastic)*

Linked to this was a perception among some GPs in the sample that the independent providers lack the necessary expertise beyond conducting a hearing test and fitting hearing aids such that if a patient then developed complications, the NHS would end up 'picking up the cost' – in which case, it might have been more cost effective if the patient had been referred to an NHS provider in the first place.

> *"So because [independent provider b] and [independent provider a] are not part and parcel of a comprehensive audiology service, it looks good at first sight. 'Oh, you can get a hearing aid, oh you can have a hearing test', but they don't provide a comprehensive service so the costs actually escalate because when they can't provide lip reading services, new batteries, that immediacy that the NHS can provide in our community hospital, the patient then has to make an appointment with us, to make an appointment at the hospital through Choose and Book. They have to wait and then there's the cost of a first outpatient appointment £220 in the NHS and then their follow-up. So from the outside, this all looks lovely and shiny. From the inside, the costs will, I can tell you for nothing, will have escalated hugely. It's a lack of understanding at a very high level actually of the implications of bringing in other providers into a service that is largely free at the point of delivery." (AQP; Choice with direction; Mainly negative)*

> *"If there are complex cases, people will tend to refer to [NHS clinic] – I had a patient who was getting allergies to an ear mould and again [independent provider a] said, 'oh we can't deal with that' and 'they need to go to [name] to get that sorted out.' So, it again sort of makes you think, oh why don't we just refer them there in the first place?" (AQP; Choice with direction; Mainly negative)*

One GP had had a personal experience when his very elderly father needed hearing aids. A partner in the practice had referred the father to [independent provider a] via

C&B because his restricted mobility made this more convenient. When the patient arrived for his appointment, the staff had not picked up his details from C&B so the referral had to be remade. [Independent provider a] then called and cancelled the second appointment. On the third appointment, staff carried out a sight test; when the father said he had come for a hearing test, he was told that there wasn't a hearing aid technician on duty so they could not conduct the test.

Although there was an expectation that patients could be referred to a different provider if they were not satisfied with the service they received, there was a concern that this would result in the CCG paying for the additional referral.

5.5 Engaging GPs with Service Quality

5.5.1 Interest in information about service quality

One of the consequences of taking part in the interview was an appreciation on the part of many respondents that their knowledge of the nature and quality of AHS was limited.

> *"I don't know the difference and again that may well be a flaw in going to somewhere like [independent provider a] rather than the local hospital but I don't know what the contract is that we have with [independent provider a] I don't know what we sort of pay them for or whatever, yeah that's something which I don't know about, the aftercare." (AQP; Default provider; Uncertain)*

A small number were not interested in finding out more; this was because they felt they did not have time to engage with patients in discussing AHS or because they would prefer to believe that somebody is monitoring all the providers and ensuring they are offering a good service so that they do not have to think about it.

> *"As long as the people auditing these peoples' professional standards say, 'look, this is reasonable', you have to delegate down. So once it's left my building, or our building, I am only concerned the patient gets a good service, but I'm not wanting to be involved because I work four days a week. I do 40 hours a week at the practice, I do what I can in the building and an expert is some manager who is in charge of opticians or hearing in [town], that is their job. It's not that I'm not interested but I don't want to be bombarded with information that is of no use to me." (AQP; Choice with direction; Fairly enthusiastic)*

> *"It would be important but I guess the commissioners of the service would be expecting to monitor quality and outcomes, so there must be a mechanism in place for that." (AQP; Default provider; Fairly enthusiastic)*

Others were interested in principle but concerned about the demands on their time/the need to keep on top of lots of different therapy areas among which AHS is a relatively low priority.

> *"I'm picking things up at the very earliest stages, so it hasn't necessarily massively impacted their lives. So the quality of the service that is provided probably just, in my mind, it's not as crucial as something that has reached a certain severity, does that make sense?" (AQP; Assumes choice; Uncertain)*

However, a number were interested in knowing more on the grounds of wanting the best for their patients and therefore needing to identify if one or more providers was better than others.

> *"I want the best for my patients really and if one service proves to be better than the other, I'll certainly be choosing it…*
>
> ***…What could make it better?...***
>
> *…Maybe in terms of quality of hearing aid, in terms of picking up of abnormalities and appropriate referral on to the hospital doctors. Again, waiting times come into it, lots of things really but you know it's quality of care and yes, I've always got my ears pricked up to it." (AQP; Choice, no direction; Uncertain)*
>
> *"I suppose if there was a big difference in the quality of the hearing aid they were receiving through [independent provider a] and another provider, I'd like to refer them to the one that was the best, with the best product." (AQP; Default provider; Uncertain)*
>
> *"If there was one service that for whatever reason was miles better than the others, so they were the best, you know that their hearing aids don't stop working after two weeks, you know, you get good patient feedback, it's that simple. If somebody is providing a service that is much better than any others." (AQP; Assumes choice; Uncertain)*

5.5.2 Type of information

The information that respondents felt they needed mainly related to the three main dimensions of service: waiting times, quality of the aids and aftercare.

> *"I think the waiting time, the qualifications of the people doing the testing, the types of aids they're able to offer…*
>
> ***…What about in terms of aftercare?...***
>
> *…Yes whether they did provide a follow-up, who would see them if the hearing aid wasn't working." (AQP; Default provider; Uncertain)*
>
> *"I would say waiting times, I think that's the main thing especially that's what patients want to know, waiting times, assessment waiting times, with having their hearing aids fitted. I guess an overall rating, patient rating as well might be useful*

from the anonymous feedbacks, might be helpful." (AQP; Default provider; Very enthusiastic)

"Aftercare is definitely one that potentially would be beneficial to be maybe a bit more specific. Quality of hearing aids would be good to know and also speed of getting that hearing aid…

…Then would that be something that you would discuss with patients if you had that information, do you think?...

…Yeah it would be part of the sort of decision making sort of tools of which to make that decision." (non-AQP; Choice with direction; Mainly negative)

5.5.3 Information channels

When discussing how they might best encounter information about service quality there was some interest in:

- a succinct summary setting out all local providers of AHS with a side-by-side comparison on key aspects of service/FAQs. A few GPs would like this to include patient ratings of satisfaction with services.

  "Just a one page sheet of paper with your local providers in the area and the wait times updated every three months or so, what the kind of service is that they're going to offer at the particular place. Otherwise it becomes really complex and difficult to explain to a patient which one to choose and they will turn back to you and say, 'which one should I go to?', but actually it's supposed to be patient choice but what it ends up being is just doctor choice and what's easiest for us to kind of get the result we want." (non-AQP; Choice with direction; Mainly negative)

- information that could be shared with patients/to which patients could be directed; one GP suggested that it would be helpful to be able to refer patients to a website on which they could also post comments about their experience of the service. He was less sure however that elderly patients would be able or willing to do this. Another thought it could be provided electronically via Choose and Book.

  "So it could be linked to the Choose & Book system so that when someone is being referred, there are some patient leaflets that could be printed off and sent to them in the post with details about how to make the booking. We could have those documents on our computer so that we could print them off in the surgery if we wanted to and point them out to people. We would do that for cancer referrals, there are leaflets that we give people." (non-AQP; Default provider; Uncertain)

- a few GPs suggested that being informed face to face about the changes and availability of a wider range of providers might be more memorable, possibly in sessions organised by the CCG.

> *"So there's about 80 emails and everything is telling me, some of them are just like rubbishy emails and some of them are like telling me about things that have changed, services have been moved, services have been changed. So often the way we find out or something that sticks in the mind is when we get told about stuff directly face to face. So I guess if they arranged for someone to come around to speak to us about it that might be a start." (AQP; Default provider; Fairly enthusiastic)*

> *"I think just to sort of send a letter about it, it just gets put in a pile and not really acted upon. I think you'd almost have to have a face to face discussion or presentation from someone." (AQP; Default provider; Uncertain)*

- feedback from patients and from fellow GPs about the service would also influence respondents' behaviour.

> *"Either the feedback from the patients, or feedback from the colleagues those are the two things that will be important for me to take it forward, if you know what I mean. So that is the basic bottom line, if the patients from my practice comes and says, 'this service is fantastic', so if ten of them come and say it's nice, then we can take it on board. And especially with the colleagues, in a meeting if they say that this is the service we are having in the CCG, which works fantastic and then we'll take it on board." (AQP; Default provider; Unaware of impact)*

> *"I would just say some good positive results, people coming back happy with the service, happy with the follow-up service, good quality hearing aids and continuity of staff. [ ] So if you get a good service and it seems to be quality service, you know it will depend on whether I refer people. Also the length of time for them to have to wait, ease of getting there, all those sorts of things." (AQP; Default provider; Unaware of impact)*

To be credible, it was felt that information would need to come either from the CCG or an independent source (such as a hearing loss charity) but some were unsure that this would be a priority for their CCG.

> *"Obviously somebody that's not biased with it but I wouldn't know how to say who would be the most appropriate though, somebody who's not biased and hasn't got any conflicting interests would be." (AQP; Default provider; Very enthusiastic)*

> *"As long as it wasn't biased and I guess the information I most look at and respond to is from people like the CCG so I'll be directed by if they start saying 'actually [independent provider a] are doing audiology tests a bit cheaper than the hospital'. Then they'll often persuade me which way to go or advise which way they think we should go." (AQP; Choice, no direction; Uncertain)*

> *"Whether the CCG would feel responsible to provide any information like that I don't know. So I'm not sure whether who that would come down to really…*

…Would you prefer it to come from the CCG?...

Well yes, because you'd hope that would be unbiased and that you'd get all the information that way rather than obviously if you were just getting information from one competitor you would be able to ask exactly what that meant, you wouldn't be suspicious." (AQP; Assumes choice; Mainly negative)

6 Any Qualified Provider

6.1 Introduction

We report in this section on respondents' awareness and understanding of AQP, the uncertainties they expressed about it, their attitudes towards it, and their views on the suitability of AHS for AQP.

6.2 Awareness and Understanding of AQP

> *"Well it's just a tendering process that providers can go through and if they meet certain specifications that the contract has in place then providing those are met then any provider can be an Any Qualified Provider as the name suggests. So they can provide the service that the specification has been sent out to them for. They can tender their services basically." (AQP; Default provider; Fairly enthusiastic)*

> *"Most services could be put out to tender and the not necessarily the cheapest but the most appropriate company could, you know, take the business." (AQP; Default provider; Uncertain)*

> *"You have to allow free competition in offering a service. Any agency that might offer it as a private provider will have an equal opportunity to bid for the service as the NHS provider does and that applies when the service has a particular cost above a certain level so that when the cost of the service is low, you don't always necessarily have to put it out to tender to Any Qualified Provider. When it's an expensive service above a certain level you have to do that." (non-AQP; Default provider; Uncertain)*

Most respondents had heard of and had a view on what AQP is, based on some direct experience (AHS or some other health referral area). In a couple of cases AQP was referred to as 'Any Suitable Provider' or 'Alternative Qualified Provider'.

About half the GPs located in areas where AHS were provided under AQP were aware that this was the case. About a quarter of them were aware of AQP but did not realise that AHS were now being provided under it – despite the fact that some of them had made referrals to independent providers. The remainder were both unfamiliar with AQP and AHS being delivered under it.

Across the sample, about one in five had a poor understanding of AQP or were unaware of it (despite, in one case, 'AQP' appearing on the top of the AHS referral form). Just one of these GPs was in a location where AHS were not delivered under AQP; other non-AQP GPs knew of AQP through other health referral areas.

The other healthcare areas in which AQP was known to operate were as shown below. Most were only mentioned once:

- Physiotherapy (most often mentioned)
- Counselling
- Pain relief
- Podiatry
- Endoscopy
- Hip replacements
- Ophthalmology
- Warfarin/anticoagulation services
- Dermatology
- Ultrasound scans.

6.3 Uncertainties about AQP

A number of uncertainties were expressed about how AQP operated including:

- a few respondents seemed unaware that independent providers need to meet certain standards and/or 'be authorised'
- others were concerned about what these standards are and who is checking they are met

> *"The providers are not playing on the same level of playing field as the NHS so in time that will lead to the destruction of perfectly good NHS services. So they need to have contracts that are able to be rigorously monitored by those that have given them the contract, so they don't step out of line and that is not happening." (AQP; Choice with direction; Mainly negative)*

- the basis of the contract, for example:
  - whether it is a block commissioned service

> *"I've never thought about it but my assumption would be the fact that I got this email notification of what [independent provider a] was doing. I would have thought that was - and again, I'm assuming and I don't know this - I've wondered whether it was a block commission service where [independent provider a] promised to provide all the hearing audiology services for a set fee but I don't know whether that is the case or not." (AQP; Default provider; Uncertain)*

  - whether providers apply to take over a service in an area as opposed to widening choice

> *"I was under the impression that would be someone bidding for a service to either take over a service in an area and to be the main provider and maybe have a 3 or 5 year contract." (AQP; Default provider; Unaware of impact)*

  - whether the lowest bid wins or 'the most appropriate' i.e. is it entirely driven by price?

A GP in an AQP area commented that if he saw independent providers on a list of possible providers, he would assume that they were offering private services only and that patients would be charged, unless he was told otherwise.

GPs were often unsure how they had been made aware of other independent providers they could refer to – there appeared to have been no clear or consistent form of communication. Examples of some of the different ways in which respondents said they had found out about AQP included the following:

- communication from the CCG (this might be in the form of an email, a newsletter, or a spread sheet)

  > *"It's usually our local commissioning organisations which is making us aware of those things. Now it may well be that they have told us but due to the impact of the sheer volume of information coming into the surgery it could be that's by-passed me, you know. So I wouldn't want to blame anybody for that. I think though that there's just not enough hours in the day that one can absorb all this information." (non-AQP; Default provider; Uncertain)*

  > *"I think the services for audiology here in [town] where I work, as well as [town] where I was before, were dictated really by what the CCG or where the CCG recommended you send them." (AQP; Default provider; Uncertain)*

  > *"I do recall being sent a spread sheet of all the AQPs for all the services [ ] and obviously some of the AQPs are miles away so it was irrelevant but I do remember seeing [independent provider a] on that and then soon after, a patient just turned round saying, '[independent provider a] said all you need is an NHS referral' and I thought 'are they pulling a fast one on me or what?' and I found out yes, they are [on the spread sheet]." (AQP; Assumes choice; Very enthusiastic)*

- communication from independent providers

  > *"I think [independent provider a] sent us through something and then [independent provider b] sent us a letter. So that's how we became aware of it." (AQP; Default provider; Fairly enthusiastic)*

- discussions at a meeting (in the practice, at the CCG)

  > *"Just really sort of talking in practice meetings and some of our doctors are working GP's with a special interest, Gynaecology or Dermatology, and I've just heard the word banded around but what I've just said to you I'm not 100% of what it means in fact." (AQP; Default provider; Unaware of impact)*

- one GP had been to a National Conference on Commissioning where [independent provider a] gave a talk and exhibited.

It seemed that often any communication had lacked clarity ('jargon', 'the word banded about') or had simply not been absorbed or fully understood.

Sometimes, GPs had become aware of AQP because they were confronted with independent providers as an option in their practice either because new providers appeared on Choose & Book or patients asked to be referred to a specific provider.

6.4 Attitudes towards AQP

GPs fell into one of five groups depending on their level of enthusiasm for the initiative. It should be noted that this is a qualitative typology based on overall views rather than responses to specific questions:

- **Mainly negative (n=6; 3 AQP/3 non AQP):** while not rejecting AQP these GPs expressed the most negative opinions based on either poor experiences of services being delivered under AQP and/or fears about the privatisation of the NHS
- **Uncertain (n=10; 7 AQP/3 non AQP):** this group of GPs could see positive short term impacts from the patient perspective (such as shorter waiting times) but longer term negative impacts on the NHS and therefore had concerns about the introduction of AQP
- **Unaware of impact (n=4; 4 AQP/0 non AQP):** these GPs were unable to comment on the impact of AQP but had some concerns
- **Fairly enthusiastic (n=6; 5 AQP/1 non AQP):** provided safeguards were in place to ensure services are of sufficient quality and there is a 'level playing field' between NHS and independent providers, these GPs were mainly positive about the introduction of AQP
- **Very enthusiastic (n= 4; 4 AQP/0 non AQP):** these GPs were very positive about AQP although one did not feel it was necessary for AHS.

The majority of GPs acknowledged that AQP had the potential to deliver/was delivering benefits to patients especially shorter waiting times and greater convenience in terms of access and appointment time – as noted earlier, these were perceived by GPs to be the two most important things for patients.

"I think provided the service is of a certain quality and the outcomes are good for patients, the more convenient it is, the more local a service is, the better really. I'm in favour of it." (AQP; Default provider; Fairly enthusiastic)

"I think if the waiting list was shorter, access, some people don't want to go all the way out to the hospital, if there's [independent provider a] on the high street that might be more convenient with follow-up and with initial consultation." (AQP; Default provider; Uncertain)

"I think it's great…

…Why do you think that?...

…It gives patients such variety of services, convenience, reduce the waiting times. Yeah, I'm a great fan of it and in my previous practice there was even more AQP so I'm a great advocate of it." (AQP; Assumes choice; Very enthusiastic)

"For physio we were waiting for months, so it became quite critical really and that is why maybe it was easier for us to refer to other providers, new providers because, you know, we really had no choice." (AQP; Default provider; Fairly enthusiastic)

Some GPs also commented that AQP appeared to be driving improvements in the NHS; for example, in terms of shorter waiting times and more clinics in the community,

"I think that's made them up their game and provided a better service, quick access and more responsive to the patients so I think it has been great and that competition has been great in another way because it was a problem." (AQP; Choice with direction; Very enthusiastic)

"But if it means the hospital has got more space for more complex things, it's just really, it's almost an extension of hospital outpatients. Although some people might be negative about it, but in reality if we are moving things out of the hospital into the community and to all these little shops in the high street, well, that is like having hospital outpatients in the community. So it's actually very, very sensible. So I think my view is truly, truly green for go, get on with it and do it in more things." (AQP; Choice with direction; Fairly enthusiastic)

The point was made by one GP that with an increasing ageing population, there will be more people needing AHS and therefore the more providers, the better.

"I welcome it and I think that as you mentioned, there are more services out there and actually we should probably utilise as many as we can really because obviously as an ageing society I think we've got a growing number of people who are going to need access to the service." (AQP; Default provider; Very enthusiastic)

Another suggested that while he had a preferred provider to which he sent patients unless they requested an alternative, he envisaged that, over time, he might come to be more confident in the other independent providers.

> *"After a year or two of letters, and reminders, of patients' awareness, we will be referring equally to [independent provider a], [independent provider b] and [independent provider c]. It's a new service and we're still learning about them." (AQP; Default provider; Fairly enthusiastic)*

Conversely, one GP felt that while independent providers often seemed to be offering a good service currently, there was no guarantee that they would remain in the market in the longer term.

> *"I don't think it's been around long enough to know what they're going to be like in one year, three years, whether they'll still exist, whether they've been able to financially maintain that service. I mean that's always a possibility, if they haven't got enough people coming to the door then they might have to say, 'well, we can't justify a technician coming out to give that service'. So time will tell but no, it seems that the patients and us are all getting a good service at the moment." (AQP; Choice with direction; Uncertain)*

Moreover, in some other diagnostic/therapy areas, independent providers were felt to have been inadequate (e.g. physiotherapy, pain management, ultra-sound) due to less experienced staff, poorer equipment, discharging patients too quickly.

> *"It's provided quicker access. For instance, we have an AQP thing for ultrasound scans and that has resulted in faster access to ultrasound scans but – the but comes because although its faster, we are now getting reports back saying these ultrasound scans are not very good quality and they're coming up with lesions and things which, when they are done on NHS ultrasound scan machines or by more experienced radiographers, are found not to exist at all. And so there is an issue with quality. And the same sort of thing happened with pain management. We had a much more accessible pain management service, the main pain management clinics were like a year's wait, and that was great for a bit and then we find the quality of it is not good enough and doesn't match up. So it's that kind of 'pile 'em high and sell 'em cheap' – that's the feeling you get about it." (non-AQP; Default provider; Uncertain)*

> *"In my experience some private providers who have set up clinics in the locality and sort of brought in, when I say foreign consultants, I don't mean of a different nationality but just from outside the area, possibly haven't done so well because they're not so familiar with how our area runs. I think ideally a community clinic with links to the local hospitals tend to be trusted a bit more." (non-AQP; Choice with direction; Mainly negative)*

Conversely, there was an example (physiotherapy for back pain) where the criteria had to be narrowed because the service provided by an independent provider attracted too many referrals and became too costly.

The more negative respondents cited a range of concerns about AQP including:

- independent providers 'cherry-picking' the easy to provide services

"I think it's a bit of a kick in the teeth for maybe some of the traditional services from the hospitals who ultimately I guess from the hospital's point of view or from the traditional service, are trying to balance their books. I think they're going to be robbed of some of the straightforward, easy services that private providers can pick up and do on the cheap, make a good profit on and at the expense of that is, anything slightly more complicated ends up in the lap of secondary care hospital services and just makes it more difficult to balance their books." (AQP; Default provider; Uncertain)

"They have a huge amount of money for providing very little relatively and they don't mop up their mistakes. So if something goes wrong with their procedures, it will be the NHS that has to carry the can and that isn't providing a service as such. I mean they cherry pick the things that aren't going to have any complications so it means it looks very good statistically and it skews the data and it makes the NHS look like they are the bad guys and everyone else has to sort out cases that they are not familiar with." (AQP; Assumes choice; Uncertain)

"I'm probably slightly anti if anything because I view it as cherry picking off profitable areas and leaving the nitty gritty for the good old NHS to sort of fill the gap. I can see the advantage in getting waiting lists down for example, but I do think it is a question of cherry picking off the easy bits and leaving the sort of nebulous things, the complex. They never seem to tackle sort of chronic disease or anything like that. But I can see that it does improve perhaps prompt service for people." (non-AQP; Default provider; Uncertain)

- independent providers are able to advertise their services and drive referrals to themselves (unlike the NHS); this may result in creating unnecessary extra work for GPs

"I actually don't have any objections to more providers coming into the market place and delivering services that are equally good or if not better. I don't have any qualms with at all. What I do have qualms with is when another provider, an AQP provider is not playing on the level playing field that the NHS has to adhere to. They advertise, the NHS can't advertise, GPs can't advertise. They do leaflet drops in houses and what they do is they generate work that is unnecessary for GPs who physically cannot get through the day because we're so overrun." (AQP; Choice with direction; Mainly negative)

- the involvement of independent providers could result in more work for the GP if patients have to return for a further referral

"As long as there is a proper set-up and everything. I don't want the patients to come back from [independent provider a] saying, 'they can't do this, I have to go here', which is a double job for me, which I think can happen. It can happen, I'm not saying it will happen, so if I refer to the audiology clinic it's all done. Everything under one roof, it's all done. The same thing should be if they are providing service, it should be a proper service." (AQP; Default provider; Unaware of impact)

- once a contract has expired, the provider can walk away but damage may already have been done to the NHS service

- questioning of the standards being required of independent providers and the extent to which this was being monitored

> *"I think it's dwindled and got less robust, there's less kind of scrutiny for the independent providers simply because of the bureaucracy involved with each and every organisation having their own kind of criteria performance, management etc. There's no national standards with AQPs and the more we have, the more the NHS is going to disappear." (non-AQP; Choice with direction; Mainly negative)*

In addition to these concerns, AQP raised various questions across the sample, including among some of those who were more favourably disposed to the idea:

- how much are independent providers paid?
- is more money being spent on a lower priority service that could be better used elsewhere?
- are patients being fitted with hearing aids they don't need?
- is there a conflict of interest where a provider operates out of a practice and also sells private hearing aids?

All (including the most enthusiastic respondents) voiced uncertainty about the longer-term consequences for the NHS:

- could local NHS trust audiology departments disappear if they cannot compete on price or service?

> *"Soon enough the audiology department in the NHS will probably just disappear. Just because again, it comes down to convenience and what patients want and what's advertised to them and what seems good." (AQP; Default provider; Unaware of impact)*

> *"The impact will be that the local services like the hospital services or the community hospital service, may wither and die. Okay so when you have a private provider coming in and delivering services, they're on contract for one year, two years, three years, or whatever. The local community hospitals have to deliver hearing services ad infinitum. If a local hearing service provided a local community hospital, gets less trade through its door, then that service will be shut. The AQP – [independent provider a], [independent provider b] who've got a contract for a year or two years, then goes, 'oh, we don't like this, we're not going to bother doing this again', and suddenly we have no hearing aid services." (AQP; Choice with direction; Mainly negative)*

> *"The thing is, does one want a service to disappear? Obviously competition is a good thing if it does improve services. If one loses it completely then there's a*

problem. It becomes maybe a monopoly in an area and then the prices can start to go up." (AQP; Default provider; Unaware of impact)

- is routine audiology supporting more complex therapies/emergency treatment and therefore is it vital it should continue so that the service requiring greater expertise is not undermined?

> *"I get the impression talking to the hospital colleagues that actually, the hospital doesn't make money out of that [emergency treatment], it has a shortfall, so I think I'm very wary that the hospital needs to survive, we all want it, all the patients want it in case something really does go wrong." (AQP; Choice, no direction; Uncertain)*
>
> *"I think it might, one worries that one loses certain expertise from the Trusts who've been in it a long time, so for complicated cases that can't be sorted out, or for hearing problems with the aids, there's not maybe that expertise around in the AQPs where there is in the Trust, so one worries that with time one loses that expertise because the Trusts will no longer have that expertise there." (AQP; Default provider; Fairly enthusiastic)*
>
> *"Say, all audiology gets creamed away by [independent provider a] and they lose that income stream then something else will have to give. So that's the bigger picture and we all understand that." (AQP; Assumes choice; Very enthusiastic)*

Questions were also raised about the impact of having too many providers. How could GPs keep up to date, could the marketplace become very fragmented, both making it more difficult to track the patient pathway and define lines of responsibility.

> *"I think we can see it already that actually it's kind of making it very fragmented, wasting resources in both areas with referrals back and forth and no one taking real clinical responsibility for the patient." (non-AQP; Choice with direction; Mainly negative)*
>
> *"It's fragmenting things a bit really in terms of, we spend a lot of our time interfacing between different areas and the trouble is, the more you privatise off into separate little bits, who's going to communicate between those different areas? I spend half my time sort of chasing up results or making sure referrals have gone through and obviously everything is separate if things don't come under the umbrella of the NHS but they become more private." (non-AQP; Default provider; Uncertain)*
>
> *"I think a lot of it is fragmenting services. Services may be cheap and cost effective but it will very often not be joined to the rest of the NHS and when a difficulty arises, it can't be linked back into the main NHS and if their follow-up arrangements, aftercare responsibilities are not carefully detailed in the service agreement, they will not necessarily provide the patient with the best connected options after the provision of the main service." (non-AQP; Default provider; Uncertain)*

A few commented that it was a political issue and it was largely out of their hands.

6.5 The Suitability of Adult Hearing Services for AQP

Hearing services were sometimes seen as an area that is more suitable for AQP as it is a relatively straightforward service and AQP could provide some benefits to patients. However, the importance of ensuring that high and equal standards of service quality were provided was seen as a given.

> *"I think that this is an example of an area that it can actually have a lot of impact. We were talking about back pain which is something which is quite complex compared to hearing tests which is a lot simpler than that and I think that having the AQPs in our region for that [AHS] would help tremendously." (AQP; Default provider; Very enthusiastic)*

> *"I think it could be beneficial to people because they might be able to see the Any Qualified Provider nearer to their home because the current place you have to go is in the middle of the city and not very easy for elderly people, there's not very good parking around it for instance. And given what I've said about them not necessarily giving good follow up arrangements and explanations, you would have to have a service specification that made the commercial organisation have a responsibility to provide follow up and repeatedly over the years because that's what happens with these things. So you couldn't take on a commercial organisation that goes bust in two years time and people are left with all these hearing aids and they've got no means of redress or no means of sorting it out subsequently. So that would be a problem, the longevity of the provider because this is a long term problem, it's not something that is just a provision and then it's finished." (non-AQP; Default provider; Uncertain)*

A non-AQP GP, who said he was not generally in favour of AQP, could see that audiology (rather than ENT) was a good candidate for the system and his preferred NHS provider should not be affected by it.

> *"I would like our very good audiology service to continue, I think if there was an alternative provider, they obviously couldn't see everyone because they'd get overloaded so probably both services would carry on functioning. So I don't have any objection in principle really." (non-AQP; Default provider; Uncertain)*

Some GPs thought AQP could be an effective way to reduce waiting times, however, as noted earlier (see 5.3.1), waiting times for AHS were not always seen as critical for patients (unlike physiotherapy for example) and as a result, some GPs, including some who were in favour of AQP, did not see AQP as necessary for AHS.

A GP in a non-AQP area suggested that the system was not needed for the assessment part of audiology services but was needed for hearing aids provision because these waiting times were too long.

One GP proposed that people should be able to self-refer for hearing tests to avoid GP involvement but to a non-profit-making service.

> *"I think that patients should be able to self-refer for deafness. They could in fact ask some screening questions over the telephone and they could self-refer, they don't necessarily need to go through a GP process. It's not essentially a complex problem. The vast majority are going to have just age related deafness so I'm just a hurdle for the people to get over to get their hearing aid sorted out." (AQP; Choice with direction; Mainly negative)*

7 Conclusions

7.1 Introduction

We set out below our conclusions; these are grouped under the following headings:

- GP engagement with the patient journey
- are patients being offered a choice of AHS provider?
- how to increase the amount of choice offered to patients
- overcoming barriers to offering choice
- general principles of information provision.

7.2 GP Engagement with the Patient Journey for Adult Hearing Services

The feedback from GPs taking part in the research indicates that age-related hearing loss is a relatively easy condition to identify, subject to confirmation by a hearing test. Although most GPs were seeing new presentations on a regular basis, it is not life threatening, patients have often lived with the condition for some time and therefore, GPs felt that there is no great urgency in ensuring the patient gets seen.

In most cases, the GPs were only involved at the start of the patient journey; they make an initial diagnosis which will be subsequently confirmed by the AHS provider. Having made the referral, the GPs typically were having no further involvement. Exceptions may be where a hearing test suggested a different hearing condition and, if referred to an independent provider, the patient is referred back to GP, or the patient experienced problems with their hearing aids and re-presents to the GP.

Knowledge and experience of the patient journey once the initial referral had been made, was often limited. This, coupled with the fact that aged related hearing loss was considered a low priority relative to many other conditions that GPs were dealing with, meant that many of the GPs in the sample had little engagement beyond the initial referral.

7.3 Are Patients being Offered a Choice?

Respondents were aware of the policy of patient choice, not just in relation to AHS but in relation to many aspects of healthcare, and when asked a direct question, they often claimed to do so. However, when describing how they went about making a referral, it became clear that patients were not always being offered a choice, were offered a limited choice or were firmly steered towards a default provider. This is consistent with the results from the patient research. We set out below some of the learnings from the GP research in terms of how to increase the amount of choice being offered to patients. We then go on to consider how some of the barriers that prevent GPs from offering greater choice might be overcome.

7.4 How to Empower Patients to Make Choices

7.4.1 Channels

Patients can be offered choice in different ways: by the GP, by the admin staff in the practice, by the referral management centre. This has implications for how and to whom information about the provider options available is targeted.

The research has highlighted the potential role of **practice admin staff** and how it often seems to be the case that they know most about the choices/referral processes or are in the best position to know. A common concern among GPs was the lack of time they had to keep on top of lots of information. Admin staff may have more time/incentive to digest such information and this suggests they also need to be included in its distribution. They can also pass information onto GPs – rather than trying to keep GPs up to date using methods they may not read, practice managers could be alerted to key changes that they could then bring up at practice meetings.

Patients might be empowered directly. Patient requests to be referred to a particular provider was common amongst some GPs taking part in the research and the findings suggest that when a patient made such a request, their GP was unlikely to refuse to make the referral. Could the patient be given/sent a list of choices in the area with some key information about location, parking, waiting times, length of aftercare and the types of hearing aids provided (in general terms)? For example, this information could be made available when the patient is sent details of how to arrange an appointment via C&B by practice admin staff or by a RMC.

7.4.2 How much choice?

There is a danger that GPs and patients could be overwhelmed by information especially if they live in locations where there are a large number of possible providers of AHS. In some larger towns, for example, and taking into account the fact that some providers may operate out of multiple sites, the number of potential locations could be more than ten. This raises the question of how much choice is it reasonable to give a patient? If there was concise information about a limited number of options (say 3 or 4), it is more likely that GPs will be able to digest it and share it with patients. If this was information included as part of a referral template – possibly asking GPs to indicate which providers have been brought to the patient's attention, along with the criteria which are most important to the patient (such as waiting times, location, etc.) - the research suggests GPs might be likely to use it.

7.4.3 Promoting a level playing field

The research also suggests that GPs need to be better informed about how providers are selected and the terms and conditions under which they operate. This may help allay fears that there is a lack of a level playing field and assure them of the credibility of all providers commissioned to provide the service.

Any steps taken to support patient choice need to avoid unintended consequences. For example, any efforts to increase patient awareness of choice of AHS providers so that they can initiate a conversation about choice with their GP, should ensure patients are informed about the options available. Otherwise, the outcome might be that patients are directed to certain providers and not others, and so will not be able to make a fully informed choice.

Similarly, if one provider facilitates the referral process by providing GPs with an electronic referral template, the danger is that GPs will channel more referrals to this provider rather than offering patients a proper choice. Ensuring equal ease of referral can therefore be important across providers.

7.5 Overcoming Barriers to Offering Choice

The research has shown that there is no single factor that prevents or inhibits GPs from offering their patients choice but rather that a range of barriers exist. Many of these are not just applicable to AHS but potentially to all or most health services delivered under

AQP. In the following sections, we set out a range of barriers and then briefly describe how these might be addressed.

7.5.1 Perceived importance for patients

Perceptions that choice is not a priority for patients

This barrier might be addressed by:

- encouraging patients to enquire about choice on the basis that GPs refer, where they can, in line with preferences
- publicising the patient research findings conducted in parallel with the GP research that suggest most patients who were offered a choice found it valuable and most of those who were not offered any choice felt it would have been valuable.

Perceptions that an absence of complaint = satisfaction

Rather than GPs relying on anecdotal feedback which may not be very representative, their views could be informed by:

- providing independent feedback on the patient experience.

7.5.2 Lack of clear direction for GPs

Unclear what is the 'best' thing to do

Guidance/direction could be offered:

- a number of GPs commented that for some services they have been given guidance about referral pathways including, in some cases, being encouraged to refer patients to providers that are delivering a cheaper service but this has not happened for AHS
- provide GPs with information so they can understand what action is in the best interests of their patients, CCG budgets and NHS providers in their area; for example if there is a cost differential, what are the implications for referrals?

7.5.3 Process

Pressure of time in consultation

Anything that might increase the time taken for the consultation is likely to be resisted;

whereas anything that helps keep the consultation short is more likely to be embraced by GPs:

- CCGs could offer clearer guidance on the referral protocol to follow to ensure a more consistent approach
- if choice is to be offered to patients, discussed and a provider selected as part of the consultation, the GP needs quick access to succinct information that
  - lists all current providers that are convenient for the patient
  - provides comparative information on key indicators of quality for each provider (locally not nationally based)
  - as we understand it, C&B offers the first of these but not the second; moreover not all GPs are using C&B
- where C&B is not being used, a standardised electronic referral template could be provided which could include directions on offering choice
- If the GP does not wish to arrive at a preferred provider with the patient, is there a simpler way of at least indicating what is important to the patient in that choice so that practice admin/the RMC can use this information to offer the patient appropriate options?
- Practice admin staff might also be key targets for this information (see 7.4.1).

Perceptions that signposting to support services comes/should come later

It might be considered whether such signposting is indeed better done by NHS and independent providers after confirmation of a diagnosis of age-related hearing loss. If it is important that it is delivered earlier/by the GP:

- can this be done as a print-out that GPs can access along with patient choices or that practice admin/RMC can send to the patient?
- it is vital that any such information is kept up to date if GPs are not to lose confidence in it.

7.5.4 Providing information on quality of service

There is an unmet need (for some GPs) for information on quality of service. This could be in the form of FAQs and comparative data targeted at GPs but in a format that can be easily shared with patients. The research suggests it needs to be from an unbiased/independent source (such as the CCG or a hearing loss charity).

7.6 General principles of information provision

A very clear and oft repeated message from the GPs interviewed for this research is that they are constantly bombarded with information on all sorts of issues and it is extremely difficult to keep abreast of developments. Therapy areas that are perceived to be of a lower priority are sometimes overlooked. This means that any information that is sent to them about AHS needs to be both **succinct** and **targeted**. Amongst other things, this means that the information needs to be **relevant** to individual GP practices. There was certainly no appetite for being sent regular statistical updates of national statistics about the provision of AHS.

There is also a requirement for the information to be clear and free of jargon.

> *"You go to meetings and there's all these jargon phrases and I figured out what it meant by what was on the agenda. But no one really said to me, 'oh, there's a new system called Alternative Quality Providers', or whatever it was and it kind of just happened to me at a meeting by chance." (AQP; Choice with direction; Fairly enthusiastic)*

8 Appendices

8.1 Sample Quotas

The majority of the interviews (n=23) were carried out among GPs located in areas where AHS are provided under AQP; the remaining interviews (n=7) were with GPs in areas where AHS are not currently provided under AQP. In order to ensure as many different CCGs were covered by the sample, only one GP practice was recruited in a CCG.

The aim was to select the CCGs in such a way as to ensure the final sample was broadly representative. This was done using two databases provided by Monitor: a database at the level of individual CCGs and a database of all GP practices.

8.1.1 Practice level quotas[8]

The Monitor database grouped CCGs according to which NHS England region they were in; quotas were set to ensure the sample broadly reflected this but also to ensure that minimum cell sizes were achieved (see Table 4).

Table 4: Quotas based on Region

	Areas where AHS are provided under AQP				Areas where AHS are not provided under AQP			
Region	of all CCGs (%)	Quota (n)	Re-cruited (n)	Re-cruited (%)	of all CCGs (%)	Quota (n)	Re-cruited (n)	Re-cruited (%)
London	8%	1-3	3	13%	15%	1-2	2	33%
Midlands and East	33%	7-9	7	33%	34%	1-2	3	33%
North	39%	7-9	7	21%	31%	1-2	1	17%
South	20%	5-7	6	25%	20%	1-2	1	17%
Total	**100**		**23**	**100**	**100**		**7**	**100**

Respondents were asked to classify their practice catchment area into one of three categories: ‘largely/entirely urban’, ‘largely/entirely rural’ or ‘a mix of urban and rural’. Quotas were set to ensure that a number of practices with ‘largely/entirely rural’

[8] The intention had been to recruit 24 practices from AQP locations and six from non AQP locations and quotas were set to reflect this. After the fieldwork was completed, it became clear that a CCG that had been classified as an AQP area was, in fact, in a non AQP location and the sample profile was adjusted to reflect this. The tables show the actual numbers of practices and GPs recruited based on the revised classification whereas the quotas are based on the original aim of recruiting 24 from AQP locations and 6 from non AQP locations.

catchment areas were represented (see Table 5). The quota of at least one 'non AQP' practice to have a 'mainly/largely rural' catchment was dropped as recruitment proved to be difficult.

Table 5: Quotas based on Catchment Area

	Areas where AHS are provided under AQP		Areas where AHS are not provided under AQP	
Catchment area	Quota (n)	Recruited (n)	Quota (n)	Recruited (n)
Largely/entirely urban	max 16	13	max 4	4
Mix of urban/rural	7-9	7	1-2	3
Largely/entirely rural	max 4	3	min 1	-
Total		**23**		**7**

Within areas where AHS are provided under AQP, the number of different providers identified as offering the service (both NHS and independent) varied between 1 and 12; a third of CCGs had 1-3 providers, a quarter had 4 or 5 and the remaining 41% had between 6 and 12 different providers. Just over 20% of CCGs in areas where AHS are not provided under AQP had a contract with an independent provider (this would have pre-dated the introduction of AQP). They may or may not also have NHS service providers. Quotas were set to reflect the number of AHS providers in operation (AQP areas) and whether or not AHS were provided by an independent provider (non AQP areas) (see Table 6)

Table 6: Quotas based on Number/Type of Provider of AHS

	Areas where AHS are provided under AQP		Areas where AHS are not provided under AQP	
No. of providers of AHS	Quota (n)	Recruited (n)	Quota (n)	Recruited (n)
1-3 providers	7-9	8		
4-5 providers	7-9	8		
6+ providers	7-9	7		
Independent provider(s)?	Quota (n)	Recruited (n)	Quota (n)	Recruited (n)
Yes			1-2	2
No			4-5	5
Total		**23**		**7**

Age is the biggest single cause of hearing loss. Hearing loss that develops as a result of getting older is often known as age-related hearing loss or presbycusis. While there is no specific age threshold, a diagnosis of age related hearing loss typically is made

where a patient is aged 55 or older and other causes have been ruled out. The database of GP practices included a breakdown of each practice's patients by age using the following age bands:

- % of patients aged <45 years old
- % of patients aged 45 to 64 years old
- % of patients aged 65 to 74 years old
- % of patients aged 75 and above.

On average, 42% of a practice's patients were aged 45 years and above, including 8% who were aged 75 and above. Given that the research was focused on age related hearing loss, quotas were set to ensure that at least half the practices had more than 40% of patients aged over 44 and that at least one in six practices had an above average proportion of patients aged 75 and above (see Table 7).

Table 7: Quotas based on Patient Age Profiles

	Areas where AHS are provided under AQP		Areas where AHS are not provided under AQP	
	Quota (n)	Recruited (n)	Quota (n)	Recruited (n)
Less than 40% aged 45+	max 12	8	max 3	2
More than 40% aged 45+	min 12	15	min 3	5
Less than 10% aged 75+		16		3
more than 10% aged 75+	min 3	7	min 2	4
Total		**23**		**7**

Respondents were asked to estimate the proportion of their patients who were of Black and Minority Ethnic heritage. Data were not available about the ethnic profile of practice patients and a quota was set that broadly reflects the population profile of England and Wales where 14% of the population reported their ethnic group as White in the 2011 Census[9] (see Table 8).

[9] http://www.ons.gov.uk/ons/dcp171776_290558.pdf

Table 8: Quotas based on Patient Ethnicity

	Areas where AHS are provided under AQP		Areas where AHS are not provided under AQP	
	Quota (n)	Recruited (n)	Quota (n)	Recruited (n)
Very few		7		-
Up to 10%		9		4
More than 10%	at least 4	7	at least 2	3
Total		**23**		**7**

The number of partners within each practice was recorded and a limit was set for the number of GPs operating alone (see Table 9).

Table 9: Quotas based on the Number of Partners in the Practice

	Areas where AHS are provided under AQP		Areas where AHS are not provided under AQP	
	Quota (n)	Recruited (n)	Quota (n)	Recruited (n)
One	max. 4	1	max 2	-
Two to Four		5		2
Five or more		17		5
Total		**23**		**7**

Respondents were asked if a referral management centre or system was in place to help patients choose a provider and make their appointment for AHS once they have been referred by their GP. A limit of 5 in total was imposed (see Table 10).

Table 10: Quotas based on Referrals via a Referral Management Centre (RMC)

	Areas where AHS are provided under AQP		Areas where AHS are not provided under AQP	
Referrals made via RMC?	Quota (n)	Recruited (n)	Quota (n)	Recruited (n)
Yes	max 3	3	max 2	-
No		21		6
Total		**24**		**6**

8.1.2 GP level quotas

All respondents had referred at least one patient with age related hearing loss to AHS in the last 12 months. Quotas were set with respect to GPs in terms of:

- how long respondents had been practising as a GP with the aim of achieving a spread (see Table 11)
- their attitude towards AQP/patient choice with the aim of achieving a spread and not just recruiting those GPs who felt strongly for or against patient choice (see Table 12
- the number who were attached to a residential care home (to help explore views on access to AHS by elderly and isolated patients) (see Table 13).

Table 11: Quotas based on the number of years respondents had been practising as a GP

	Areas where AHS are provided under AQP		Areas where AHS are not provided under AQP	
No. of years as practising GP	Quota (n)	Recruited (n)	Quota (n)	Recruited (n)
less than 3 years	max 4	1	max 1	-
3 to 15 years	8-12	12	2-3	3
16 to 30 years	10-12	9	2-3	4
over 30 years	max 2	1	max 1	-
Total		**23**		**7**

Table 12: Quotas based on respondents' attitude towards AQP/patient choice

	Areas where AHS are provided under AQP		Areas where AHS are not provided under AQP	
Attitude towards AQP/patient choice	Quota (n)	Recruited (n)	Quota (n)	Recruited (n)
I am a strong supporter of offering patients greater choice in the provision of healthcare services	max 8	7	max 2	-
I broadly support the idea of offering patients greater choice		6		4
While I don't object to the principle of offering patients greater choice, I have concerns about how it is being delivered		10		3
On balance, I am opposed to the idea	max 8	-	max 2	-
Total		**23**		**7**

Table 13: Quotas based on the number of GPs attached to a residential care home

	Areas where AHS are provided under AQP		Areas where AHS are not provided under AQP	
Attached to a residential care home?	Quota (n)	Recruited (n)	Quota (n)	Recruited (n)
Yes	min 2	10	min 1	4
No		13		3
Total		**23**		**7**

8.2 Recruitment Screener

Introduction

Good morning/afternoon. My name is _____ and I'm calling on behalf of Acumen and Creative Research. We are conducting research on behalf of **Monitor** to get feedback on the provision of **adult hearing services** across England. By adult hearing services, we mean services for people with age-related hearing loss. It is sometimes referred to as 'direct access adult hearing services'.

As part of the research, we would like to talk to GPs about referring patients to adult hearing services.

[If appropriate, explain that you can email/fax a copy of a letter from Monitor which confirms we are conducting the research on their behalf].

The research involves taking part in (ask as appropriate):

- a face-to-face interview with one of our researchers on 29th or 30th September; this would last about 45 minutes and could be conducted either at the practice or another location of choice; we can offer a payment of £80 by way of a thank you for your time
- a telephone interview with one of our researchers at a time that is convenient between 6th and 17th October; we can offer a payment of £60 by way of a thank you for your time.

The research is being conducted on an anonymous basis. While we will report GPs' views back to Monitor, we will not tell them who took part in the research or who said what.

If respondent agrees to participate, continue. Otherwise, thank and close.

I just need to ask you a few questions about yourself and your practice as we need to ensure we speak to a cross-section of GPs.

NB Q1-7 must be recorded from the database

Q8-9 can be asked of the practice manager/other member of practice staff;

Q10-15 must be asked of the GP who will take part in the interview.

Q1 CCG and region: write in CCG name and code region

CCG:			
London	1	**AQP** 1-3	**non AQP** 1-2
M&E	2	7-9	1-2
North	3	7-9	1-2
South	4	5-7	1-2

Q2 Type of provision on adult hearing services

AQP area	1	24 respondents
Non-AQP area	2	6 respondents

Q3 If in an AQP area; number of providers of adult hearing services:

1-3 providers	1	7-9 respondents
4-5 providers	2	7-9 respondents
6-12 providers	3	7-9 respondents

Q4 If in a non AQP area; are there independent providers present?

Independent providers present	1	1-2 respondents
Independent providers not present	2	4-5 respondents

Q5 How many partners are there in the practice? *Record number and code below*

No. of partners:			
One	1	**AQP areas** Recruit a spread; no more than 4 single partner practices	**Non AQP areas** Recruit a spread; no more than 2 single partner practices
Two – four	2		
Five+	3		

Q6 Proportion of patients aged over 44

less than 40% are aged 45 and above	1	No more than 12 AQP/3 non AQP practices
40% or more are aged 45 and above	2	At least 12 AQP/3 non AQP practices

Q7 Proportion of patients aged 75 and above

less than 10%	1	
10% or more	2	At least 3 AQP/2 non AQP practices

Q8 Would you say the catchment area of your practice is largely urban, largely rural or a mix of urban and rural?

Largely/entirely urban	1	No more than 16 AQP/4 non AQP practices
Largely/entirely rural	2	At least 4 AQP/2 non AQP practices
A mix of urban and rural	3	

Q9 In terms of patients who are of Black and Minority Ethnic heritage, would you say your practice has?:

Very few patients who are of BME heritage	1	
Up to 10% of patients who are of BME heritage	2	
More than 10% of patients who are of BME heritage	3	At least 4 AQP/2 non AQP practices
Don't know	4	

Q10- Q15 must be asked of the GP who will take part in the interview

Q10 For how many years have you been in general practice?

Less than 3 years	1	**AQP areas**	**non AQP areas**
3 to 15 years	2	11-13 respondents to have been in practice for up to 15 years; no more than 4 to have been in practice for less than 3 years	3 respondents to have been in practice for up to 15 years; no more than 1 to have been in practice for less than 3 years
16 to 30 years	3	11-13 respondents to have been in practice for over 15 years; no more than 2 to have been in practice for over 30 years	3 respondents to have been in practice for over 15 years; no more than 1 to have been in practice for over 30 years
Over 30 years	4		

Q11 Approximately how many patients have you referred to adult hearing services in the past 12 months? By adult hearing services, we mean services for people with age-related hearing loss and excluding those with more serious conditions, such as tinnitus. I do not need to know the precise number, an estimate is fine. *Write in number and code below*.

No. of referrals:		
None	1	**CLOSE (NB another member of practice may qualify – you must ask this GP Q10-Q15)**
One to two	2	Recruit a spread
Three to five	3	
Six to ten	4	
Over ten	5	

Q12 Is there a referral management centre or system in place to help patients choose a provider and make their appointment for adult hearing services once they have been referred by their GP?

Yes	1	Maximum of 5 respondents (3 AQP/2 non AQP)
No	2	

Q13 Do you use Choose & Book when referring patients to adult hearing services?

Yes	1	as found
No	2	

Q14 Are you attached to a residential care home in addition to your main practice duties?

Yes	1	At least 3 respondents (2 AQP/1 non AQP) (NB if another member of the practice qualifies, it may be possible to arrange the interview with this GP- you must ask this GP Q10-Q15)
No	2	

Q15 You may be aware that the NHS has sought to promote patient choice through the use of Any Qualified Provider. We are aware that some GPs are in favour of these changes while some have reservations about the merits of patient choice and we want to make sure we include GPs with a range of attitudes on this issue. Which ONE of these statements comes closest to how you personally feel about offering patients greater choice?

I am a strong supporter of offering patients greater choice in the provision of healthcare services	1	No more than 8 AQP / 2 non AQP respondents
I broadly support the idea of offering patients greater choice	2	
While I don't object to the principle of offering patients greater choice, I have concerns about how it is being delivered	3	
On balance, I am opposed to the idea	4	No more than 8 AQP / 2 non AQP respondents

Q16 Record respondent's gender

male	1	Recruit a spread
female	2	

If respondent is willing to take part and is in quota, record the following details

Respondent's name	
Practice name and address	
Practice telephone no.	
Type of Interview	Face-to-face
	Telephone
Date of interview	
Time of interview	
If f2f location of interview if not at the practice	
If telephone number to call to carry out the interview	

Recruiter Guidelines

Purpose

The research is being conducted on behalf of Monitor – the regulator of healthcare services in England.

The purpose of the research is to get feedback about the provision of adult hearing services; these are community-based services for adults aged 55 and above with suspected or diagnosed age-related hearing loss. Services can only be accessed following a referral from a GP. In some areas, the service is known as 'direct access adult hearing services'.

In some areas of England (referred to as non-AQP areas), adult hearing services are typically provided by the NHS, typically by hospital Trusts. In other areas (referred to as AQP areas), adult hearing services are provided by a range of organisations, including independent providers, such as [independent provider].

We wish to talk to 30 GPs to learn about their views on, and experiences of, referring patients to adult hearing services.

Your Task

Your task is to recruit 30 GPs to take part in the research. 5-6 of the interviews are to be conducted face-to-face on 29th-30th September lasting 45 minutes while the remainder are to be conducted by telephone between 6th and 17th October and will last 30 minutes.

Incentives

£80 for those taking part in a face-to-face interview and £60 for a telephone interview.

Letter of Authority

You will have a letter of authority from Monitor which confirms this is a *bona fides* research project. You can refer to this when recruiting respondents. Please send/fax/email a copy of this letter to respondents when you confirm details of all interviews.

Eligibility

All GPs taking part must have referred at least one patient to adult hearing services in the past 12 months (codes 2-5 @ Q11).

Spread Sheet

There is a spread sheet which provides information on a range of CCGs including which CCGs are within AQP areas for adult hearing services, and for those CCGs in AQP areas, it also shows how many providers of adult hearing services there are. For those CCGs in non AQP areas, it indicates if there are any independent providers present. You should use this information to answer Q1-4.

There is also a spread sheet that provides a list of GP practices within each CCG and, for each practice, the number of GPs as well as the percentage of patients aged over 45 as well as the percentage aged over 75. You should use this information to answer Q5-7.

Q8 and Q9 are general questions about the practice and you can record the answers to these questions from either the respondent or another member of their practice. Q10-15 must be asked of the GP who will be taking part in the interview.

Quotas

- **CCG:** Only one GP to be recruited per CCG. Please record the name of the CCG at Q1
- **AQP vs. non AQP**: 24 interviews must be with GPs operating within AQP areas; 6 should be with GPs in non-AQP areas (Q2)
- **Number of providers**: within AQP areas, please recruit equal numbers of respondents from areas where there are:
  - 1-3 providers (code 1 @ Q3)
  - 4-5 providers (code 2 @ Q3)
  - 6+ providers (code 3 @ Q3)
- In non AQP areas, recruit 1-2 respondents where an independent provider is present (code 1 @ Q4)
- **Practice size:** recruit no more than 5 practices with a single partner – up to 4 in AQP areas and 1 in non AQP areas (codes 1 @ Q5); recruit a spread in terms of those with 2-4 and 5+ partners (codes 2-3 @ Q5)
- **Patient age:** use the spread sheet to answer Q6 and Q7.
  - at least 12 AQP and 3 non AQP practices should have 40 per cent or more of their patients aged 45 and above (code 2 @ Q6)
  - at least 4 AQP and 1 non AQP practice should have 10%+ of their patients aged 75+ (code 2 @ Q7)
- **Catchment area:** the provision and accessing of the service is likely to differ depending on whether the practice is in an urban or rural area; please ensure that
  - no more than 20 practices (16 AQP/4 non AQP report that they serve a largely/entirely urban area (code 1 @ Q8)
  - at least 5 practices (4 AQP and 1 non AQP) are serving a largely/entirely rural area (code 2 @ Q8)

    NB we have not defined what we mean by rural – we anticipate that respondents will have a good appreciation of this but if asked, rural catchment areas would comprise mainly villages and small towns in areas where there is a high proportion of agriculture/countryside.
- **Patient ethnicity:** we also want to ensure we recruit from practices which have different proportions of patients of Black and Minority Ethnic heritage; please recruit a mix of codes at Q9 and ensure that at least 5 practices (4 AQP/1 non AQP) have more than 10% of their

patients who are of BME heritage – we do not require a precise answer but the respondent's best estimate (code 3 @ Q9)

- **Length of service:** in terms of the respondent's length of service as a GP, please ensure that
  - between 14-16 respondents (11-13 AQP/3 non AQP) have been in service for up to 15 years; of these, no more than 5 (4 AQP/1 non AQP) to have been in service for 3 years or less (codes 1-2 @ Q10)
  - between 14-16 respondents have been in service for over 15 years; of these, no more than 3 (2 AQP/1 non AQP) to have been in service for 30+ years (codes 3-4 @ Q10)
- **Referrals:** please record how many referrals to adult hearing services the respondent has made in the last 12 months – an estimate is all we need. Write in the actual number and then code (codes 1-5 @ Q11). Aim for a spread. **NB** if respondent has not made any referrals in the last 12 months **you must not recruit them even if they have made referrals in the past. However, another member of the practice might qualify, in which case, ask Q10-15 of this GP)**
- **Referral Management system:** check to see if there is a referral management system in place that is responsible for helping patients make their appointment. No more than 5 respondents (3 AQP/2 non AQP) to be in areas with such a system (code 1 @ Q12)
- **Choose & Book:** ask respondent whether or not they use Choose & Book when referring patients to adult hearing services between 10 and 20 (8-16 AQP/2-4 non AQP) should do so (code 1 @ Q13
- **Residential care home:** we would like to include at least 3 respondents (2 AQP / 1 non AQP) who are attached to a residential care home in addition to their main GP duties. Please ask Q15 and aim to recruit at least 3 respondents who answer yes (code 1 @ Q15). **If another member of the practice meets this criterion, you could recruit them instead – but be sure to ask them Q10-15).**
- **Patient Choice:** we wish to ensure we speak to a range of GPs in terms of their views on patient choice; please ask Q15 and ensure that
  - no more than 10 respondents (8 AQP / 2 non AQP) choose code 1
  - no more than 10 respondents (8 AQP / 2 non AQP) choose code 4
- **Gender:** record respondent's gender at Q16; aim to recruit equal numbers of males and females.

Respondent details

Where respondents are eligible, in quota and willing to take part in the research, please complete the required respondent details.

For those respondents taking part in a telephone interview, you should offer them the option of the interview being carried out via a video link. In order for them to do this, they will need to have access to a PC or laptop with a webcam and speakers/sound and an internet connection. You should also record their email address. We will then send them an email with a link for them to click on at the time of the interview. If respondents do not have access to the necessary equipment, the interview will be conducted by telephone in the usual way.

Face-to-face interviews

5-6 interviews are to be carried out f2f in advance of the telephone interviews on either 29th or 30th September. Three researchers will conduct these interviews with each researcher doing 1-2 interviews. Please aim to set them up in pairs on the same day and at locations that are reasonably close together so that the researcher can travel between appointments but be sure

to allow sufficient time for this. Ideally, 1-2 of the locations will be in London, 1-2 will be in the Birmingham area and 1-2 could be in the North West.

Please aim for the following:

- 4 in AQP areas; 1-2 in non-AQP areas
- Of those in AQP areas:
  - at least 1 in an area where there are 1-3 providers
  - at least 1 in an area where there are 4-5 providers
  - at least 1 in an area where there are 6-12 providers
- 1-2 to be with practices serving a largely/entirely rural catchment area
- A spread in terms of respondents' length of service
- In terms of attitude to patient choice:
  - 1-2 who are strong supporters (code 1 @ Q15)
  - 1-2 who are opposed to the idea (code 4 @ Q15).

Data Security

Please ensure all documents that contain respondent details have **'Protect: Personal/Restricted'** in both the header and footer on every page and that the documents are password protected.

8.3 Topic Guides

8.3.1 Face to face interviews

Introductions

- Moderator introduces him/her self and explains the purpose of the research[10]
  - it has been commissioned by Monitor
  - a survey of patients who have been referred to adult hearing services over the last 18 months is being conducted to get feedback on the service
  - in parallel with this, we are conducting interviews with a cross-section of GPs to get their views
  - the research is being conducted on an anonymous basis; Monitor do not know who is taking part and the findings will be fed back on an anonymous basis
- Moderator explains about recording the interview and asks respondent to sign the permission to record form (face to face)/ asks respondent's permission to record the interview (telephone)
- Moderator invites respondent to introduce him/her self and their practice
  - how long they have been a practising GP; how long they have been in their current practice; what is the practice profile?
  - how they would sum up their practice in terms of the patient mix and the nature of their catchment area

Referral Protocols/Forms

- Moderator checks that respondent is familiar with the term 'adult hearing services'
  - is this the term s/he would use themselves? If not, what term/description would they use [respondent may use the more generic term 'audiology' or 'routine audiology'; in some areas it may be referred to as 'direct access adult hearing services']?
  - if they were explaining to a patient what is meant by 'adult hearing services', how would they describe it?
  - if necessary probe to establish if respondent is aware that adult hearing services are for people with age related hearing loss and not for more complex conditions such as tinnitus

NB: common causes of non-age-related hearing loss include medication side effects, viral infection, head injury, Ménière's disease & meningitis.
The following interventions/conditions are out of scope:
- Cochlear implant (assessments / fitting / follow-up)
- Minor operation / Surgical operation / Surgical intervention
- Sudden or rapid hearing loss
- Pain in the ear/inflammation in the ear
- Tinnitus / Vertigo / Balance problems

- Moderator explores respondent's experience of age related hearing loss
  - approximately how many patients/how often overall do such patients present? how often do they see new patient presentations?

NB: this includes patients presenting with a complaint of hearing loss as well as those presenting with another condition which the GP recognises as being due to hearing loss.

[10] Respondents should have been sent a copy of the Letter of Authority from Monitor. Moderators will take a copy to the f2f interviews in case the respondent has not seen it.

- from a clinical perspective, how easy/difficult is it to arrive at a diagnosis of age related hearing loss? Moderator to explore any issues related to this including what they do if they are unsure of the diagnosis
- once you are reasonably satisfied that the patient has age related hearing loss, is there a formal referral protocol (i.e. a written down protocol)?
- if referral protocol in place: is this based on CCG guidelines/practice's own protocol/something else?

- Moderator invites respondent to talk through the referral protocol; what typically would happen (NB moderator will not prompt at this point on issues of choice, AQP etc.)
  - what steps are involved in the referral process?
  - what would they say to the patient/how would they explain the process to them?
  - how does the referral process differ by different patient type/by type of presentation?
- Is the protocol effective – moderator to explore any issues identified by respondent?
  - are there situations where a patient might be resistant to the idea of wearing hearing aids even though they would benefit from doing so? If so, how would respondent proceed?
  - if the protocol requires that patients who are unwilling to wear hearing aids should not be referred, how does respondent feel about this?
  - is there a clinical rationale for not referring such patients?
  - if not, on what is the protocol based (e.g. CCG trying to manage demand)?

NB: referral forms in some areas require the GP to ask the patient whether he/she would be willing to wear hearing aids. If the patient says no, the GP will not refer the patient to adult hearing services. This can be a problem from the patient's perspective because the patient might not be psychologically ready to wear hearing aids (having only just found out that they have hearing loss sufficient for an intervention), but would nonetheless benefit from hearing aids.
We need to make sure we understand this.

- Moderator to explore if respondent directs/signposts patients to other services which can help support patients with their hearing loss (such as lip reading, self help groups, etc.).
  - <u>If yes:</u> under what circumstances – which types of patients/which types of services. How is this done e.g. information leaflets in reception? How does respondent find out about these services?
  - <u>If no:</u> why not? Do you see this as an example of making the delivery of care more integrated? What would make it easier for GPs to signpost services?

Range of Providers

- Is there a range of different providers of adult hearing services operating in the area? If so,
  - is respondent familiar with all the available providers? which providers can they name?
  - is respondent confident s/he knows which providers are operating in their area?
  - how is this information made available to the respondent (e.g. does the CCG provide up to date lists?)
  - <u>in AQP areas</u>: moderator to probe respondent's views on independent providers e.g. whether respondent feels NHS funded care should only be delivered by NHS organisations
  - <u>in AQP areas:</u> moderator to check if a provider offers a clinic in the GP's own surgery; <u>if yes:</u> how does that work?

NB: in some AQP areas there may be only 1 provider (only 1 provider has "qualified"). Although AQP was supposed to facilitate patient choice, it does not appear to have always done this. Moderators should use information about the availability of suppliers within the CCG area to help inform this discussion. NB this information may not be entirely accurate. The availability of choice is not restricted to AQP areas – in non AQP areas there may be more than a single NHS provider.

- If a referral management system for adult hearing services is in place (refer to Q12 of screener): moderator asks respondent to outline how this works and the extent of his/her involvement in helping patients choose which provider to use

Patient Choice

NB Some of the following points for discussion may be redundant where a referral management system is in operation.

NB Spread sheet indicates the total number of providers within each CCG area although not all of this may be located geographically close to the GP practice.

NB refer to respondent's answer to Q15 on the screener to establish their views on choice

- Where there is a choice (i.e. 2 or more providers of adult hearing services – applies to both AQP and non AQP areas): does respondent explain to patients that they have a choice?
  - if yes: how do they do this? what do they tell patients? Moderator asks to see any information respondent may share with patients such as leaflets
  - if no: why is this?
  - if respondent tells some but not all patients: why is this and which patients do they inform/not inform(e.g. an elderly patient who is easily confused)
  - are there any circumstances when respondent would not offer a patient any choice? If yes: moderator explores the circumstances
  - What would make it easier for respondent to offer patients a choice?
- In respondent's experience, are patients generally aware that they have a choice of provider?
  - is it important to them? do they want to exercise their choice?
  - moderator to explore more fully e.g. which types of patients are/are not aware, want to/do not want to exercise their choice?
  - do patients ever ask to go to a particular provider? How does the patient become aware of that provider - e.g., through friends and family, because of a leaflet or a poster in a shop window, etc.
  - moderator to explore if respondent knows whether patients are able to change providers (e.g. if unhappy with the service they receive). As far as respondent is able to say, do patients ever want to change providers (once they have been assessed/received their hearing aids)? For what reasons?
- Does respondent feel that they/patients have enough information to be able to exercise choice?
- Does respondent/respondent's practice use Choose and Book or any other electronic referral system when referring a patient to adult hearing services?

NB: Moderator to refer to Q13 of screener. Note that some GPs will not be using it directly – it will be the GP's receptionist who will book the patient's appointment using Choose and Book
Note that some local areas have adopted electronic referral systems other than Choose and Book (e.g., we understand that in the Wirral area they use a system called 'Rock' and in the Kent area they use a system called 'DXS'). Such systems may replace Choose and Book or may operate in parallel.

  - why do they use/not use C&B?
  - for those using it: how well does it work? is it useful when helping patients select a provider? Why is this?

Recommendations

- Moderator explores whether respondent ever recommends a provider to patients or directs patients towards certain suppliers? Always/sometimes/never?
  - if always/sometimes: under what circumstances would respondent make a recommendation?

    - never: what do they do if patient asks for a recommendation/is unable to make the choice themselves?
    - if provider offers a clinic in GP's own surgery: are all patients referred to this provider? Are patients informed about other providers?
- If respondent ever recommends a provider or directs patients towards certain providers (even if rarely done): what are the factors that determine which supplier(s) is/are recommended/suggested? As necessary, moderator to prompt for the role/importance of the following factors:
    - the financial position of their local trust

NB: a local hospital may be losing money and this may be putting pressure on the clinical and/or financial viability of the trust. To help prop up the hospital the CCG / local GPs may want to ensure that as many patients as possible are referred to that hospital (not all trusts are on fixed price contracts, and the revenue they receive is dependent on the numbers of patients they see). Alternatively, a GP may have concerns that the quality of the service provided by a trust may have suffered due to cost savings and would prefer to direct patients to an alternative supplier.

    - relationships with either the organisation or the staff working within the organisation – e.g. a preference for referring patients to a 'tried and tested' provider vs. referring to a relatively new and unknown provider
    - the CCG – do they offer any steer as to whether some suppliers are considered more preferable than others?
    - marketing information provided by providers – what form does this take? how useful is it?
    - the quality of the service on offer from different providers?
    - the waiting times at different providers?
- Is it generally the case that respondent always recommends the same supplier or does it vary? Why is this?
- Has respondent's recommendations changed over time i.e. are they now recommending different suppliers compared to 1-2 years ago? If so, why is this?
- What might motivate respondent to change who is recommended in the future?
- Conversely, does respondent ever discourage patients from using certain providers? When/why is this?

Quality of service

- To what extent is respondent aware of the quality of the service offered by different providers? Do some suppliers in the area have a reputation for better/poorer quality of service?
    - on what are respondent's opinions based e.g. feedback from patients, feedback from elsewhere
    - is respondent aware of the waiting times for different providers
    - what have they heard (e.g. how long are waiting times/how does this differ by provider)?
    - how have they heard about this?
    - Is this the waiting time for a first appointment/assessment or the predicted time that the patient will be able to get hearing aids (recognising that at some providers that there might be delays between an assessment and fitting)?
    - moderator to explore any issues that may arise relating to the quality of service e.g. examples of good/poor service
    - is the quality of service something the respondent shares with patients when helping them to choose a supplier?
    - would respondent welcome more information about the quality of the service offered by different suppliers? Why is this? Who might supply this information?

Any Qualified Provider

NB: issues relating to AQP may have already arisen in the interview in which case, you may not need

to probe on all the following issues but be sure you have a good understanding of respondent's views. If respondent is unfamiliar with AQP use show card

Any Qualified Provider (AQP) is a means of commissioning certain community-based NHS services in England with the intention of increasing patient choice. AQP was a policy developed by the Department of Health and put in place by PCTs from 2012. Clinical commissioning groups (CCGs) are now responsible for determining the services to be commissioned as AQP.

Providers can offer services if they meet specified requirements and patients choose from a list of providers who meet those requirements. Patients can choose a provider based on what is important to them, such as somewhere that is close to home or work, is easy for them to access, has shorter waiting times, or good customer service.

- AQP areas: Moderator checks if respondent is aware that adult hearing services in their area are now delivered through AQP:
  - how did they become aware of this (e.g. from the CCG, other GPs, patients, patient groups, information from providers themselves)
  - what are their views on this?
  - has it changed the way they refer patients to adult hearing services? Why is this?
  - as far as they can tell, has it had an impact on the quality of adult hearing services? For better/worse – in what way? e.g. has it facilitated the entry of innovative new services or services that are more patient centric? has the introduction of different providers resulted in existing suppliers 'upping their game'?
  - AQP has only been in operation for up to two years – what impact might it have on adult hearing services in the longer term?
  - **If feel AQP has not had much of an impact on service quality:** is there scope to improve services for patients? How might you encourage providers to deliver that quality improvement (other than through AQP)?
- Non AQP areas: Moderator checks that respondent is aware of the Any Qualified Provider initiative and their views on this
  - as far as they can tell, has it had an impact on the quality services? For better/worse – in what way?
  - what are their views based on e.g. other AQP services that are offered in their area (which ones); having worked previously in an AQP area, etc.
  - would they be in favour or against the idea of adult hearing services being offered by Any Qualified Provider? Why is this? What impact do they think it might have on the quality of adult hearing services?
  - For non-AQP areas where patients have a choice: How do arrangements compare to AQP – is there a difference? Has there always been choice of provider in the area? What impact has choice had on the quality of services/patients needs?

Isolated Elderly and other patients who can find it difficult to access services (if time permits)

Moderator explains that Monitor want to ensure that any issues relating to elderly and isolated patients are fully understood for example, elderly people who are living by themselves and who may have no family or close friends living nearby. If they also have hearing problems, this can make them even more isolated.

- Moderator explores:
  - what types of groups can find it difficult to access adult hearing services
  - the extent to which respondent comes across these types of patient
  - thoughts on how it can be made easier for such patients to access adult hearing services
  - in AQP areas: what impact, if any, AQP has had in this regard

- <u>in non AQP areas:</u> what impact, if any, AQP could have in this regard

NB: e.g. has/could AQP enabled the entry of niche providers offering domiciliary services for patients, provided greater scope for voluntary organisations to participate in the provision of services, etc?

<u>If respondent is attached to a residential care home</u>:

- Moderator explores if there are any particularly challenges/difficulties in terms of ensuring care home residents access adult hearing services – if so, what are these challenges and how does respondent try to over come them

NB: issues relating to patient choice should have been covered as part of the earlier discussion around adult hearing services. **<u>If time permits</u>**, probe more generally around the issue of choice. Similarly, if not clear from earlier discussion, probe further on views about Choose & Book

Summing up

- Moderator comments on respondent's answer to Q15 (I note you indicated that you are…) and invites respondent to sum up why s/he feels this way.
- Use Show card/read out: Moderator explains that a range of reasons have been put forward by GPs and others as to why GPs are not always taking steps to enable patient choice and invites respondent to comment on them – which if any do they agree with or apply to their own circumstances

it is not the GP's role to offer/enable patient choice

many/most patients are not interested in having a choice

GPs lack the necessary information to allow them to enable choice (e.g. they may not know which providers are operating in their area or the quality of the service being offered)

GPs don't have the time to spare during a patient appointment to discuss the pros and cons of the options available

GPs feel more confident using tried and trusted service providers

GPs are ideologically opposed to private sector participation in the NHS

GPs are restricted by the CCG in where they can send patients

Patients demand to be referred to a particular provider – they are not interested in finding out about what else might be available

Thank and close

8.3.2 Telephone interviews

Introductions

- Moderator introduces him/her self and explains the purpose of the research[11]
  - it has been commissioned by Monitor
  - a survey of patients who have been referred to adult hearing services over the last 18 months is being conducted to get feedback on the service
  - in parallel with this, we are conducting interviews with a cross-section of GPs to get their views
  - the research is being conducted on an anonymous basis; Monitor do not know who is taking part and the findings will be fed back on an anonymous basis
- Moderator explains about recording the interview and asks respondent permission to record the interview
- Moderator invites respondent to briefly introduce him/her self and their practice
  - how long they have been a practising GP; how long they have been in their current practice; what is the practice profile?
  - how they would sum up their practice in terms of the patient mix and the nature of their catchment area

Referral Protocols/Forms

- Moderator explains that we are going to be talking about age related hearing loss and not more complex causes of hearing loss

NB: common causes of non-age-related hearing loss include medication side effects, viral infection, head injury, Ménière's disease & meningitis.

The following interventions/conditions are out of scope:

- Cochlear implant (assessments / fitting / follow-up)
- Minor operation / Surgical operation / Surgical intervention
- Sudden or rapid hearing loss
- Pain in the ear/inflammation in the ear
- Tinnitus / Vertigo / Balance problems

- Moderator explores respondent's experience of age related hearing loss
  - approximately how many patients/how often overall do such patients present? how often do you see new patient presentations?
  - from a clinical perspective, **how easy/difficult is it to arrive at a diagnosis of age related hearing loss** (e.g. ruling out other possible causes such as wax, inflammation, etc)? Moderator to explore any issues related to this including what they do if they are unsure of the diagnosis
  - do you ever have patients presenting with a complaint which they think is something else (i.e. not hearing loss) which you recognise as being due to hearing loss? If yes: how

[11] Respondents should have been sent a copy of the Letter of Authority from Monitor. Moderators will take a copy to the f2f interviews in case the respondent has not seen it.

often, what symptoms is the patient reporting, what is their response to being told they are experiencing hearing loss?

- **Once you are reasonably satisfied that the patient has age related hearing loss, please talk me through the referral process** (**NB moderator will not prompt at this point on issues of choice, AQP etc.**)
  - is there a **formal referral protocol** (i.e. a written down protocol)? is it based on CCG guidelines/practice's own protocol/something else?
  - what would you say to the patient/**how would you explain the process** to them? Prompt as necessary
  - is there an **age threshold** i.e. do patients have to be above a certain age before you can refer them to adult hearing services?
    - if yes: what is the age threshold? what happens if the patient falls below this threshold?
  - if a **referral management system** for adult hearing services is in place, how does this work?
  - are appointments made using **Choose & Book**?
    - if yes: who actually makes the referral (e.g. respondent, admin staff, etc.); how well does it work? Why is this?
    - if no: why is this?

NB: Moderator to refer to Q13 of screener. Note that some GPs will not be using it directly – it will be the GP's receptionist who will book the patient's appointment using Choose and Book

Note that some local areas have adopted electronic referral systems other than Choose and Book (eg, we understand that in the Wirral area they use a system called 'Rock' and in the Kent area they use a system called 'DXS'). Such systems may replace Choose and Book or may operate in parallel.

  - are there situations where a patient might be **resistant to the idea of wearing hearing aids** even though they would benefit from doing so? If so, how do you proceed?
  - does the protocol require that patients who are unwilling to wear hearing aids should not be referred? how do you feel about this?
    - is there a clinical rationale for not referring such patients? if not, on what is the protocol based (e.g. CCG trying to manage demand)?

NB: referral forms in some areas require the GP to ask the patient whether he/she would be willing to wear hearing aids. If the patient says no, the GP will not refer the patient to adult hearing services.

This can be a problem from the patient's perspective because the patient might not be psychologically ready to wear hearing aids (having only just found out that they have hearing loss sufficient for an intervention), but would nonetheless benefit from hearing aids.

  - **is the protocol effective** – moderator to explore any issues identified by respondent. How could the protocol be made more effective?
- Do you **direct/signpost patients to other services** which can help support them with their hearing loss (such as lip reading, self help groups, etc).
  - If yes: under what circumstances – which types of patients/which types of services. How is this done e.g. information leaflets in reception? How do you find out about these services?
  - If no: why not? **What would make it easier/more likely for GPs to signpost services?**

Range of Providers

NB: in some AQP areas there may be only 1 provider (only 1 provider has "qualified"). Although AQP was supposed to facilitate patient choice, it does not appear to have always done this. Moderators should use information about the availability of suppliers within the CCG area to help inform this discussion. NB this information may not be entirely accurate. The availability of choice is not restricted to AQP areas – in non AQP areas there may be more than a single NHS provider.

- How many different providers of adult hearing services are you aware of that you could be referring patients to? **Which ones can you name?** How do you know this – e.g. does the CCG provide up to date lists?
- Moderator to **prompt** using list of suppliers known to be operating in the area (see note below)
  - which of these suppliers are you **aware of**?
  - which ones do you **refer patients to**?
  - if patients only being referred to some suppliers: **why is this?**
- Where respondent not aware of all providers: **what could be done to ensure you are aware of all the providers of adult hearing services to whom you can refer patients?** Probe for who should provide it, in what format etc.
- in AQP areas: moderator to check if a provider offers a clinic in the GP's own surgery; if yes: how does that work?

Patient Choice

NB Some of the following points for discussion may be redundant where a referral management system is in operation.

NB refer to respondent's answer to Q15 on the screener to establish their views on choice

NB the majority of questions in this section relate to respondents who are aware of 2 or more providers of adult hearing services to whom they could refer patients – applies to both AQP and non AQP areas and covers not just independent but also NHS service providers e.g. 2 Trusts.

- When you are making a referral, **do you explain to patients that they have a choice**?
  - if yes: **how do you do this/what do you tell patients?** Prompt – do you have any information about the range of suppliers, such as leaflets, that you give to patients?
  - are there any circumstances when you would not offer a patient any choice? If yes: moderator explores the circumstances
  - if no: **why is this**? Probe fully reasons why respondent is not encouraging patient choice
  - where a referral management system is in place: moderator to explore how patient choice is managed e.g. does GP discuss the options first with the patient
- In your experience, are patients generally **aware that they have a choice of provider**? Do patients ever ask to go to a particular provider?
  - as far as you can tell, where are patients getting their information from?
  - is it important to them? do they want to **exercise their choice**?
  - in your experience, which types of patients are/are not aware, want to/do not want to exercise their choice?
- **Do you ever direct patients towards certain suppliers**?
  - if yes: **when do you do this? which suppliers do you direct them to? why these suppliers and not others?** do you tend to always direct patients to the same providers?

Probe as appropriate for reasons behind which suppliers patients are directed towards e.g.

- the financial position of their local trust
- relationships with either the organisation or the staff working within the organisation – e.g. a preference for referring patients to a 'tried and tested' provider vs. referring to a relatively new and unknown provider
- the CCG – do they offer any steer as to whether some suppliers are considered more preferable than others?
- marketing information provided by providers – what form does this take? how useful is it?
- the quality of the service on offer from different providers?
- the waiting times at different providers?

  - if no: **what do you do if a patient asks for a recommendation/is unable to make the choice themselves**?
  - if provider offers a clinic in GP's own surgery: are all patients referred to this provider? Are patients informed about other providers?

- **Do you ever discourage patients from using certain providers**? When/which suppliers/why is this?
- **Do you feel that you/your patients have enough information to be able to exercise choice? What would make it easier for you to offer patients a choice?** Probe for who should provide them with information, format, frequency, etc.

NB if respondent is only aware of one service provider of adult hearing services to whom they could refer patients ask the following question

- Now you know that there are a number of providers of adult hearing services to whom you could be referring patients, do you think this will have an impact on how you make referrals in the future?
  - in what way? Probe for respondent's views on offering patients a choice in the future and any steps that could be taken to encourage this
  - **what would be the best way of ensuring that all GPs in this area are made aware of the range of service providers?**
- **What would make it easier for you to offer patients a choice?**

Quality of service

- To what extent are you **aware of the quality of the service offered by the different providers of adult hearing services**? Do some suppliers in the area have a reputation for better/poorer quality of service? Probe to establish what respondent's opinions are based on e.g. feedback from patients, feedback from elsewhere
- Are you aware of the **waiting times** for accessing the different providers
  - what have you heard (e.g. how long are waiting times/how does this differ by provider)? how have you heard about this?
  - is this the waiting time for a first appointment/assessment or the predicted time that the patient will be able to get hearing aids (recognising that at some providers that there might be delays between an assessment and fitting)?
- Are you aware of differences in the **quality of hearing aids** given to patients by providers?
- Are you aware of differences in the **quality of the aftercare service** offered by providers?
- Any **other aspects of quality** that you think is important to patients?

- Moderator to explore any issues that may arise relating to the quality of service e.g. examples of good/poor service
- **Is the quality of service something you share/discuss with patients when helping them to choose a supplier?**
- Would you welcome **more information about the quality of the service** offered by different suppliers? Why is this? Who might supply this information? What information in particular would be useful?
- **What information would give you more confidence to offer patients a choice of providers?**

Any Qualified Provider

NB: issues relating to AQP may have already arisen in the interview in which case, you may not need to probe on all the following issues but be sure you have a good understanding of respondent's views. If respondent is unfamiliar with AQP use show card

Any Qualified Provider (AQP) is a means of commissioning certain community-based NHS services in England with the intention of increasing patient choice. AQP was a policy developed by the Department of Health and put in place by PCTs from 2012. Clinical commissioning groups (CCGs) are now responsible for determining the services to be commissioned as AQP.

Providers can offer services if they meet specified requirements and patients choose from a list of providers who meet those requirements. Patients can choose a provider based on what is important to them, such as somewhere that is close to home or work, is easy for them to access, has shorter waiting times, or good customer service.

- All respondents: **are you familiar with what is known as Any Qualified Provider?**
  - if yes: can you briefly outline what you understand by Any Qualified provider?
  - if no or if understanding is limited, read out above description
- AQP areas: **are you aware that adult hearing services in your area are now delivered through AQP?**
  - **how did you become aware of this** (e.g. from the CCG, other GPs, patients, patient groups, information from providers themselves)
  - **what are your views on this** – positive, neutral, negative? why is this?
  - **has it changed the way you refer patients to adult hearing services**? Why is this?
  - as far as you can tell, has it had an **impact on the quality of adult hearing services**? For better/worse – in what way?
  - AQP has only been in operation for up to two years – what impact might it have on adult hearing services in the longer term?
  - **If feel AQP has not had much of an impact on service quality:** is there scope to improve services for patients? How might you encourage providers to deliver that quality improvement (other than through AQP)?
- Non AQP areas: **what are you views on Any Qualified Provider?** As far as you can tell, **has it had an impact on the quality of services**? For better/worse – in what way?
  - **what are your views based on** e.g. other AQP services that are offered in their area (which ones); having worked previously in an AQP area, etc.

- **would you be in favour or against the idea of adult hearing services being offered by Any Qualified Provider**? Why is this? What impact do you think it might have on the quality of adult hearing services?

Isolated Elderly and other patients who can find it difficult to access services (if time permits)

Moderator explains that Monitor want to ensure that any issues relating to elderly and isolated patients are fully understood, for example, elderly people who are living by themselves and who may have no family or close friends living nearby or who are residents of care homes. If they also have hearing problems, this can make them even more isolated.

- In your experience, which types of patients can find it difficult to access adult hearing services?
- Do you have any suggestions on how it can be made easier for such patients to access adult hearing services?
  - in AQP areas: what impact, if any, AQP has had in this regard
  - in non AQP areas: what impact, if any, AQP could have in this regard

NB: e.g. has/could AQP enabled the entry of niche providers offering domiciliary services for patients, provided greater scope for voluntary organisations to participate in the provision of services, etc?

Thank and close