



House of Commons
Health Committee

Audiology Services

Fifth Report of Session 2006–07

Report, together with formal minutes, oral and written evidence

*Ordered by The House of Commons
to be printed 2 May 2007*

HC 392

Published on 16 May 2007
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Current membership

Rt Hon Kevin Barron MP (*Labour, Rother Valley*) (Chairman)
Mr David Amess MP (*Conservative, Southend West*)
Charlotte Atkins MP (*Labour, Staffordshire Moorlands*)
Mr Ronnie Campbell MP (*Labour, Blyth Valley*)
Jim Dowd MP (*Labour, Lewisham West*)
Sandra Gidley MP (*Liberal Democrat, Romsey*)
Mr Stewart Jackson MP (*Conservative, Peterborough*)
Dr Doug Naysmith MP (*Labour, Bristol North West*)
Mike Penning MP (*Conservative, Hemel Hempstead*)
Dr Howard Stoate MP (*Labour, Dartford*)
Dr Richard Taylor MP (*Independent, Wyre Forest*)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/healthcom

Committee staff

The current staff of the Committee are Dr David Harrison (Clerk), Christine Kirkpatrick (Committee Specialist), Ralph Coulbeck (Committee Specialist), Duma Langton (Committee Assistant), Julie Storey (Secretary) and Jim Hudson (Senior Office Clerk).

Contacts

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 6182. The Committee's email address is healthcom@parliament.uk.

Contents

Report	<i>Page</i>
Summary	3
1 Introduction	5
2 History	7
Hearing problems	7
Audiology services	8
Provision of services	8
Staff	9
Modernising Hearing Aid Services	9
Successes	10
Failings	10
Waiting times	12
Data collection	12
Scale	13
Conclusions and recommendations	14
3 Government plans	15
Private sector involvement	15
The new framework	15
Criticism of the framework	16
Exclusion from the 18-week target	17
Conclusions and recommendations	18
4 Addressing the challenges	20
Establishing demand	20
New strategies to increase capacity	21
NHS Capacity	21
Private providers	23
Conclusions and recommendations	28
Need for better forecasting	28
Additional capacity	28
Improvement in NHS services	28
The use of the private sector	29
Conclusions and recommendations	31
Formal minutes	33
List of witnesses	34
List of written evidence	34

List of unprinted written evidence	36
Reports from the Health Committee	37

Summary

One in seven people in England suffer from hearing loss of some kind. People with poor hearing are more likely to be socially isolated and to have reduced quality of life. Fortunately, many people can receive an effective treatment. Digital hearing aids are far superior to older models. They give a higher quality of sound and are more comfortable to wear. They can also be used by people who were unable to use analogue aids.

In 2000, the Government introduced the Modernising Hearing Aid Services (MHAS) programme to improve audiology services, mainly through the provision of digital aids. The MHAS programme provided many people with digital hearing aids. However, there was a rise in demand not just from new patients, but also from those wishing to upgrade their analogue aids. Surprisingly the rise in demand was not predicted and led to very long waiting lists and times, exceeding two years in some places. Some PCTs have given audiology services a low priority.

In view of this situation, we decided to hold an inquiry. Following this announcement, the Government published a new framework on audiology, entitled *Improving Access to Audiology Services in England*. Our examination of the framework confirmed our view not only that audiology is not a priority for some PCTs but also that it is still not a sufficiently high priority for the Government. The framework added little that was new; instead it reiterated previous announcements.

A particular concern is that the new framework keeps audiology outside the 18-week referral to treatment target that applies to consultant-led services. This must change soon. Exclusion of audiology from the 18-week target compounds the problem of long waiting times. It has also led GPs to refer patients unnecessarily to consultant-led ear, nose and throat (ENT) departments so that they can be seen more quickly. This increases costs and waiting times for ENT outpatient appointments. While it would be difficult to add audiology immediately to the list of services required to meet the 18-week target by December 2008, we recommend that it be included in this target at an early date.

There is a need to increase capacity, but precisely how much extra capacity will be needed in the future is unclear. Some described future demand as a 'bulge' that could be overcome using short-term measures. Others told us that demand would continue to grow. Effective forecasting is needed. We recommend that the Department undertake a thorough examination of the medium- and long-term demand for digital hearing aids. For this to take place, the Department must collect comprehensive information on all audiology patients, including how long they have to wait between GP referral and receipt of a hearing aid.

Regardless of whether the current high level of demand is a temporary phenomenon or a long-term trend, it is clear that extra capacity is needed now. While there is much good practice in some NHS audiology departments, there is enormous variation between areas. There is much that could be done to make services more efficient. We recommend that audiology departments review the way in which services are provided, examining in particular the skill mix and levels of training needed. These reviews should include the

possibility of operating flexible opening hours, following up patients by telephone, using the Choose and Book system, and pooling capacity to ensure more patients are seen. In addition, it is necessary to consider whether the NHS is making the best use of new audiology graduates.

The Department has decided to involve the private sector through the negotiation of new contracts and as part of phase 2 of the Independent Sector Treatment Sector programme. It is crucial that value for money assessment of these contracts is carried out. This will be difficult without a tariff associated with audiology services and so we recommend that the Department produce a national tariff for audiology.

Many groups, including new entrants to the market such as opticians, are keen to supply and fit hearing aids. We were not presented with any evidence which convinced us that that such new entrants should be excluded from providing audiology services. However, our inquiry into *NHS Charges* found that NHS patients were sometimes encouraged by optical outlets to buy expensive spectacle frames and lenses. Vulnerable people who are hard of hearing must not be encouraged by private providers to 'trade up' to buy more expensive hearing devices than necessary.

Private sector services must be monitored and the quality of care must be assessed on the same basis as the quality of care is assessed in the NHS. The Department should also ensure that NHS capacity and expertise are not depleted due to private sector involvement.

The Department must balance the need to ensure value for money and quality of care with the need to encourage the private sector to invest in facilities and maintain high standards. We therefore recommend that contracts be relatively short-term in the first instance but extendable subject to companies achieving and maintaining high standards of care.

We are reassured that the Department is prepared to be flexible about the extent of private sector involvement, depending on evidence received from local NHS organisations. However, we are concerned that the evidence underlying the original commitments was inadequate. There was little analysis of the areas most in need of private provision. We recommend that the Department specify criteria for private sector involvement in the future, for example, failure to meet the 18-week target once it is in place. The Department must make evidence-based decisions and ensure value for money.

1 Introduction

The difference in hearing was remarkable, there was just no comparison, they brought me back into the land of the living.

Margaret Howard, digital hearing aid recipient

1. Hearing loss affects around one in seven people in England. People with poor hearing are more likely to be isolated socially and to suffer reduced quality of life. Fortunately, the problem is more easily addressed today than ever before because of the advent of digital hearing aids, which represent an enormous improvement on older analogue aids. While they are currently more expensive and take longer to fit, digital devices are more comfortable, more attractive and easier to operate than the older equipment.

2. However, high demand for hearing aids has led to long waiting times. Although precise information on numbers of patients waiting is not available,¹ waiting times for audiology services appear to exceed those of most other services. In some parts of the country patients wait more than two years to receive a hearing aid. Government waiting time targets exclude many audiology patients.

3. The Government has taken a number of steps to increase capacity, including negotiating contracts to purchase treatment for NHS patients from the private sector. The first patients will be treated under these contracts this year. However, it is unclear whether the measures announced to date will be adequate to reduce the waiting times to an acceptable level.

4. In view of concerns about the length of waiting times, and the actions of the Government, we decided to undertake a brief inquiry into audiology. Accordingly, we agreed to look at the Government's proposals and whether they are likely to be effective. We also decided to consider what else should be done.

5. Our Terms of Reference were as follows:

- *Whether accurate data on waiting times for audiology services are available;*
- *Why audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed;*
- *Whether the NHS has the capacity to treat the numbers of patients waiting;*
- *Whether enough new audiologists are being trained; and*
- *How great a role the private sector should play in providing audiology services.*

6. The issues raised are of concern to many different groups. We received 46 submissions from NHS staff, patients, recent audiology graduates, the independent sector, regulatory bodies and other professional groups. We held a single evidence session in March 2007, and took evidence from an NHS audiologist, a private provider and the Royal National

¹ The Department only has information on patients waiting for a hearing assessment. However, the RNID told us that over 4 million people could benefit from using a hearing aid.

Institute for Deaf People (RNID) in addition to the Parliamentary Under-Secretary of State for Health and Departmental officials.

7. As this has been a short inquiry we have focussed on the key issue, namely the long waiting times for audiology services. We are aware that this Committee has rarely made waiting times the focus of its inquiries. In most situations, quality is as great an issue. In this case, however, we received little evidence of poor quality of care in audiology services. Given the levels of concern, we decided to focus on the provision of digital hearing aids and associated waiting times alone. Long audiology waiting times are of particular importance because new digital hearing aids are so effective and so quickly improve people's quality of life.

8. Following the announcement of our inquiry the Government finally published its long-awaited framework for audiology services. Although it was not included in our original terms of reference, we questioned the Minister about the framework and consider it in this report.

2 History

9. In this chapter we look at recent developments in audiology. We examine hearing problems, the provision of audiology services, the measures taken to improve them and the extent of waiting times and reasons for them.

Hearing problems

10. Over 7 million people in England have hearing loss of some sort. Causes include deafness from birth, trauma, infection and degenerative hearing loss. Aural disorders account for 24% of all adult disabilities in the UK.² 55% of people over 60 are deaf or hard of hearing, and the figure increases to 80% by 80 years.³ As the population as a whole ages, the numbers of individuals affected by total or partial hearing loss will grow.

11. Poor hearing affects people's quality of life. The World Health Organization described deafness as a non-communicable disease that is "a cause of enormous human suffering and a threat to the economics of many countries...[that] constitutes a major contributor to the burden of avoidable risk and disease".⁴ The charity Help the Aged pointed out that loss of hearing may mean that people lose their social networks. The charity Sense stated that, "deaf, deafened and hard of hearing people are vulnerable to isolation and depression".⁵

12. Only a fraction of those affected by hearing loss (about 750,000) seek help from their GP each year.⁶ Many choose to ignore their hearing problems: only approximately 2 million use a hearing aid but over 4 million more could benefit from one.⁷ We were also told that it was common for patients not to use analogue hearing aids once they were fitted.⁸

13. Digital aids are far superior to the older models. They give a higher quality of sound and are more comfortable to wear. They exist in many different forms; they may be worn behind or inside the ear, and can be fitted to one or both ears. They can also be used by people who are unable to use analogue aids. One recipient of a hearing aid, Margaret Howard, told us that a digital aid gave her:

...not perfect hearing, but much, much better than I had ever experienced with analogue aids. Every person with a hearing loss should be able to be supplied with a digital hearing aid.⁹

Because of their effectiveness, digital hearing aids are more popular with patients and demand has increased.

2 Ev 98

3 Ev 98

4 WHO May 2004, http://www.who.int/ncd/mip2000/documents/key_areas_en.pdf

5 Ev 106

6 Ev 58

7 RNID, UK figures

8 RNID Modernising Hearing Aid Services leaflet and Ev 91

9 Ev 88

Audiology services

Provision of services

14. Audiology services are mainly provided by the NHS but the private sector also carries out assessment of patients with hearing loss and supplies digital hearing aids.

15. There are 158 audiology departments in England that assess and fit patients with hearing aids. Most audiology departments are based on acute hospital sites, although a few services operate within primary care. Within audiology departments there is a mixture of staff, including fully qualified audiologists and assistant audiologists, who often assess patients. Most adult audiology departments are run by a service manager rather than a consultant.

16. Other, consultant-led, services also provide specialist audiological care. For example, maternity units often screen newborn babies for hearing problems; Ear Nose and Throat (ENT) departments concern themselves with more complex cases of hearing loss and patients who need medical treatment or surgical intervention.

17. Most people with hearing problems attend an audiology department to have degenerative hearing loss restored through the fitting of a hearing aid. Most patients are referred directly to the local service by their GP, although some come via an ENT department. Following fitting of the hearing aid, patients receive follow-up care, which may take place in person or by telephone. Hearing aids must also be maintained, which requires the supply of batteries, repair and replacement. NHS audiology departments offer all these services. Around 500,000 adult 'patient pathways' (from GP referral to receipt of a hearing aid) are completed by the NHS in England each year.¹⁰

18. Approximately 25% of those who need a hearing aid use a private provider.¹¹ There are around 1,400 high-street practitioners which provide and fit hearing aids including several big companies, such as Boots, Scrivens, Specsavers and Healthcall. The price patients are charged for initial assessment, supplying and fitting a digital hearing aid and follow-up care varies from around £500 to £2,000 (average £1,200).¹² Following our evidence session, the Minister informed us that the cost of providing such a service to the NHS would be far less.¹³

19. There is no national tariff associated with audiology services and audiology is therefore not included in the Practice-Based Commissioning or Payment by Results initiatives.¹⁴

10 Ev 1

11 Ev 113

12 Ev 65, Ev 113, Ev 87

13 The cost of a 'pathway' delivered as part of the Public Private Partnership (see paragraphs 29–32) was between £217 and £380. Ev 125

14 Ev 80

Staff

20. Fully-qualified audiologists entering the NHS for the first time train for four years, having undertaken a BSc in Audiology at one of nine universities in the UK.¹⁵ The first set of graduates completed their training in 2006. From 2007, about 190 students will complete the course each year.¹⁶ Audiologists can complete further specialist training, or undertake an MSc, after this point.

21. Below this level are Assistant Audiologists. Training for these individuals varies according to the trust or Primary Care Trust (PCT) in which they work. There is no formal qualification required, and most training will be in-house. A further level of Associate Audiologist, above that of assistant, is envisaged. Staff at this grade will have trained for two years, to complete a Foundation Degree (see below). Standards for NHS audiology staff are determined by professional bodies and local trusts.¹⁷

22. Staff working for private companies are not trained to the same level as fully qualified NHS audiologists. Most complete a six-month intensive course and then take examinations before starting work within a private dispensary, where they are closely supervised for the first six months.¹⁸ Once the examinations, which consist of a theoretical and a practical element, have been passed and the post-examination training period completed, they become a Registered Hearing Aid Dispenser.

23. Recently, a Foundation Degree has been developed by the independent sector regulator (the Hearing Aid Council) alongside the British Academy of Audiology (BAA), British Society of Hearing Aid Audiologists and the Association of Independent Hearing Health Professionals. It is intended to be the threshold entry qualification for all hearing aid audiologists in the future, including Associate Audiologists working within the NHS and those in the independent sector.¹⁹ The first intake of undergraduates will take place in 2007.

Modernising Hearing Aid Services

24. Before 2000, NHS patients had no choice but to receive an analogue-type aid. In 2000, the *Modernising Hearing Aid Services* (MHAS) programme was introduced to improve audiology services, in particular by supplying patients with newer, more effective types of hearing aid. Other changes to NHS audiology services aimed to increase capacity: audiologists were permitted to work overtime to offer 'out of hours' services and so see more patients.²⁰

15 Prior to the BSc training consisted of a 2 year B-Tec/NVQ level 3 course in Physiological Measurement and the Professional BAA Part I Theory and Part 2 Practical Training Courses. The theory exams were completed after an intensive three month training course. The student then returned to their practical training centre and carried out at least two years in-service training, which was followed up by the BAA Part II Practical Assessments. Alternatively, a second route into Audiology was for Audiological Scientists. This consisted of a MSc in Audiology and was followed up by the equivalent Practical exam.

16 Ev 120

17 Professional bodies include the British Society of Audiology and the Health Professions Council. The Registration Council for Clinical Physiologists registers audiologists and the BAA regulates the profession.

18 Ev 86

19 Ev 77

20 The Hearing Direct telephone follow-up scheme was also introduced.

25. The programme was run by the RNID on behalf of the Department of Health and involved a Public Private Partnership (PPP). It started at 20 pilot sites²¹ and was extended to cover the whole country in 2003 at a total cost of £125 million, which was largely spent by 2005. Funding was ring-fenced for the duration of the programme. The MHAS programme was considered a success by many; however, some failings were also pointed out. Both are discussed below.

Successes

26. NHS audiology services improved significantly following the MHAS programme. By spring 2005, all NHS trusts were equipped to fit digital hearing aids. According to the RNID, over 1 million people have received digital hearing aids from the NHS since 2000.²² A study by the Medical Research Council in 2005, designed to examine the effectiveness of the new hearing aids and the service offered to patients, was summarised thus:

People fitted with high quality digital hearing aids in the modernised service reported 41% greater overall benefit compared to those with analogue aids. They were using their aids more of the time, finding them more helpful, and were more satisfied with the result.²³

27. Many witnesses praised the MHAS programme. Adam Beckman, Audiology Services Manager at Plymouth Hospitals Trust, made a point echoed by several other submissions:

The huge investment that has been made to improve the quality of hearing aid services for patients is wholeheartedly welcomed. The improvements in outcomes and quality of life are extraordinary.²⁴

Ruth Thomsen, audiology services manager from Charing Cross Hospital, also stressed the positive effects of the programme:

We have been completely modernised. The investment coming via the RNID from the Government has been phenomenal. We have been well educated, well trained and at last we have been able to take the ball and run with it.²⁵

Failings

28. Witnesses also informed us of two main problems with the MHAS programme. The first related to aspects of the PPP, the second to the initial assessment of demand for digital hearing aids.

21 Hospital trusts in the pilot included Addenbrookes, James Paget, Royal Free, Sherwood Forest, Bradford, Leeds, Trafford, Royal United Bath, East Berkshire, Royal Berkshire and Battle, Winchester and Eastleigh, Queens Medical Centre Nottingham, Sheffield Children's, University Hospital Birmingham, Royal Shrewsbury, City Hospitals Sunderland, Morecambe Bay, United Bristol, Royal Cornwall and Kings Mill.

22 Ev 102

23 http://www.rnid.org.uk/VirtualContent/85414/MHAS_PPP__HD_leaflet_PDF_final_version_May_2005.pdf

24 Ev 46

25 Q 8

The Public Private Partnership

29. As part of the MHAS programme, the NHS Purchasing and Supply Agency and the RNID negotiated a contract to procure digital hearing aids from two private provider companies, David Ormerod and Ultravox. These organisations not only provided the hearing aids, but worked with the NHS to carry out assessment and fitting of the devices.

30. The PPP was an integral part of the MHAS programme; it is unlikely that MHAS would have been as effective overall without the involvement of the private providers. However, some witnesses called into question aspects of the PPP. The Hearing Aid Council (HAC) claimed that the treatment of NHS patients under the PPP was not adequately regulated.²⁶ Others argued that the PPP had unforeseen financial implications for NHS audiology departments. For instance, at Charing Cross Hospital, the private company engaged used NHS facilities, including the use of a room for testing patients and a receptionist to meet patients and handle telephone bookings and any problems that arose. The hospital was not recompensed for these services. Appearing before the Committee, Ultravox and Departmental officials argued that patients treated under the PPP should not have been seen in an NHS hospital.²⁷

31. Other witnesses argued that the cost of treating patients in the private sector as part of the PPP was higher than in the NHS. The BAA stated that PPP activity was twice as expensive as the equivalent NHS treatment. The Academy conceded that the scheme had been successful in part, but added:

...there have been examples of the private sector partners not fulfilling their obligations, being paid for work not done and up to 50% of these patients requiring access to the NHS Audiology Service for further rehabilitation.²⁸

32. The private providers disputed these claims, stating that the PPP delivered a good service, on time and in fact saved the NHS money.²⁹ In this short inquiry, we have had no opportunity to assess relative costs so cannot comment on this matter in detail. Other aspects of the use of private providers are discussed below.

Assessment of demand

33. Witnesses also claimed that levels of demand for digital hearing aids were not adequately assessed before the start of the MHAS programme.³⁰ We were told that, in addition to new patients, there was unexpected demand from patients with long-standing hearing problems. Several submissions pointed out that current NHS services in their areas could have coped with new referrals, but the number of patients who wished to 'upgrade' their hearing aids had overwhelmed services. Claire Carwardine, an audiologist from Worcestershire, stated:

26 Ev 77. These patients were not covered by the regulations that govern other NHS care. See para 81 for more details.

27 Qq 49, 161–163

28 Ev 55

29 Qq 50–51

30 Ev 48

If we look at new referrals alone, the current NHS service could cope adequately, but it is the patients that have been seen previously that all need changing over from analogue to digital, that have created these waits.³¹

Moreover, patients who had not previously come forward for a hearing aid started to do so as they became aware of the benefits of the new hearing aids.³²

34. Not only has there been a large increase in the number of patients, but the technology itself involves more work for audiology departments. Fitting a digital aid is a lengthier process than fitting an old-fashioned aid. According to Amplifon UK, an audiologist must spend three times as long fitting a digital hearing aid than an analogue type.³³

35. The Minister agreed that the number of patients seeking NHS audiology services had been larger than expected. He told us:

When we committed ourselves to the introduction of digital hearing aids and did the modernisation project in partnership with the RNID, in my view, there was no serious analysis or assessment of the consequences of that for demand....there was simply no anticipation of the strain that that would put on the system and the expectations that that would give to people.³⁴

36. All these factors meant that NHS audiology services, some of which already had significant waiting lists, received more referrals than they could cope with. Waiting times grew as a result.

Waiting times

Data collection

37. While it is clear that there are long waiting times, there is a distinct lack of reliable published data on the wait between GP referral to an audiology service and receipt of a digital hearing aid. Many witnesses claimed that information is not collected consistently across the country.³⁵ Some audiology departments hold detailed data on the patients they treat; others do not. Data may also be available in different forms. This means it is difficult to assess changes over time and compare services in different areas. Moreover, the data is not collected centrally. Dr Low from the RNID told us:

We think there are probably half a million people waiting for a hearing aid in the NHS right now. The reason we do not know, of course, is that neither the Department of Health nor the NHS collects waiting-time figures. There has been an initiative recently to collect the time between GP referral and having a hearing test

31 Ev 63

32 Ev 101

33 Ev 39

34 Q 117

35 Ev 47, 102

but of course the longer wait is from the hearing test to having the hearing aid fitted.³⁶

38. From January 2006, there is information available on the wait between GP referral and receipt of a diagnostic test but not a hearing aid. More detailed 'referral to treatment' information on those audiology patients referred to ENT services may also be collected from 2007. The Minister admitted, however, that robust data on waiting times from referral through to fitting of the hearing aid for all audiology patients were lacking. He added:

I personally think, although I am not committing to it, that what we should aim to be doing is having comprehensive data for all people. Because of the state we are at with audiology, which we are aware of...which is that we are not in as good a shape as we need to be in all parts of the country, I think there is a strong case for collecting data on all of the people who access audiology...³⁷

Scale

39. According to the Department, in November 2006 there were 166,740 patients waiting for an audiology diagnostic assessment. Of these, 108,628 had been waiting over 13 weeks and 80,941 over 26 weeks. Taken by Strategic Health Authority (SHA), the longest average wait is in the South East Coast area (45 weeks) and the shortest is in the East of England (10 weeks, see Table 1 below).

	Expected average wait (weeks)	Patients waiting over 13 weeks	Total waiting	Percentage waiting over 13 weeks
North East	32	9,256	13,201	70%
North West	13	13,157	21,277	62%
Yorkshire and the Humber	15	11,892	15,461	77%
East Midlands	22	9,361	13,889	67%
West Midlands	20	18,234	28,026	65%
East of England	10	4,846	8,620	56%
London	20	9,465	13,829	68%
South East Coast	45	12,742	16,101	79%
South Central	12	5,594	11,110	50%
South West	16	18,927	28,518	66%

Table 1. Waiting times for audiology assessments by SHA in November 2006, published in December 2006 (*Department of Health: Improving access to audiology services in England*)

36 Q 2

37 Q 188

40. Grant Shapps MP, who obtained information on audiology waiting times through a Freedom of Information request, informed us that the average wait “for fitting of hearing aids” was 41 weeks for first-time patients and 64 weeks for patients awaiting reassessment. There is great variation across the country. Some individual trusts, such as North Manchester, have no waiting list at all, while others such as Bromley, Plymouth and Mid-Staffordshire, have waits of between 104 and 112 weeks.³⁸

Conclusions and recommendations

41. **Audiology services improved greatly as a result of the introduction of digital hearing aids and the MHAS programme. However, this led to a surge in demand, not only from new patients but also from those who wished to switch from analogue aids. This increased waiting times which the NHS surprisingly did not anticipate.**

42. Data about audiology services is not adequately collected. The Department is starting to address this issue, but has concentrated on time to diagnostic test rather than time to receipt of a hearing aid. **Details about the extent of waiting times are unclear because of inadequate data recording and collection. We recommend that comprehensive data be collected and published on all patients waiting for audiology services from GP referral to treatment. The information we have received indicates that some individual trusts have no waiting list while others have waits of over two years.**

3 Government plans

43. To address the long waiting times for audiology services, in 2006 Lord Warner announced that the Department planned to purchase private sector activity. Following our decision to hold an inquiry, the Government published a new framework for audiology. In this chapter we examine these plans to improve the situation.

Private sector involvement

44. In July 2006, Lord Warner announced the procurement of 300,000 audiology “service pathways” by the Department from the independent sector each year, for the next five years.³⁹ Contracts have yet to be negotiated but the Department aims for the first patients to be treated under this programme from the second half of 2007.⁴⁰

45. In addition, more audiology treatments will be provided by the private sector as part of phase 2 of the Independent Sector Treatment Centre (ISTC) programme. The Department has procured 42,000 “patient pathways” per annum for the assessment and fitting of hearing aids from the private sector on behalf of seven SHAs: South West, South Central, West Midlands, North East, Yorkshire and the Humber, North West and South East Coast. This was due to start in April 2007,⁴¹ but no patients have been assessed under the programme to date.

46. The Department stated that use of the private sector will provide additional short- and medium-term capacity and represents value for money for the NHS:

the involvement of the independent sector will drive a more commercial approach to the provision of audiology services. This could potentially increase efficiency and levels of innovation.⁴²

NHS audiology departments will not be able to bid for the work available.

The new framework

47. The Minister admitted to us that “audiology has not been given the priority it deserves” in the past.⁴³ He argued that this situation was now changing, however, with plans to address the problems of long waiting times and limited NHS capacity not only through increasing use of the private sector, but through encouraging best practice in NHS departments and ensuring that existing targets were met. These plans were recently brought together in a new framework, entitled *Improving Access to Audiology Services in England*, published on March 6th 2007. The framework contained some new information and measures, but much of it was already in the public domain.

39 Ev 38, 83

40 Ev 83; Qq 172–174

41 Department of Health, *Improving Access to Audiology Services in England*, March 2007

42 Ev 1

43 Q 117

48. The following new announcements were made:

- the Department was “committed to considering the introduction of national audiology tariffs” in 2007.
- new “model care pathways” for NHS audiology would be published this year. This would include the adult hearing loss pathway, which is likely to encourage one-stop assessment and fitting of hearing aids⁴⁴, telephone follow-up and prioritisation of patients needing to upgrade their analogue aids.⁴⁵ This was due to appear in March 2007, although it has not yet been published.
- the Department would start to publish referral to treatment (RTT; ie. GP referral to receipt of a hearing aid) data on audiology patients treated through ENT but not those who attend an audiology clinic directly. It added that:

It would make sense to record RTT times for all audiology patients. We will consider whether a national data collection of all audiology RTT is necessary.⁴⁶

49. Otherwise, the framework reiterated existing policy, including:

- the use of the private sector to provide 300,000 pathways per year.
- assessment of patients through the ISTC programme.
- the six-week maximum waiting times for diagnostic tests, including audiology, that will apply from March 2008.
- exclusion of audiology from the 18-week waiting time target (see below).

50. Much of the report centred on the need for improvements to NHS services through better use of initiatives that cut across all specialties, such as the Choose and Book system. The report stated that audiology services would be transformed through:

Local health systems applying to the design and delivery of their audiology services the health reform mechanisms of better commissioning and pathway redesign, choice and competition, information and incentives.⁴⁷

Criticism of the framework

51. Many witnesses thought that the new audiology framework added very little and mainly served to bring together strategies already made public over the last couple of years. Dr Low from the RNID called it a “sop”.⁴⁸ Ruth Thomsen commented on the quality of the report:

44 This would be achieved using ‘open fit’ technology, which avoids the lengthy process of having an individual ear mould made.

45 Department of Health, *Improving Access to Audiology Services in England*, March 2007

46 Ibid

47 Ibid

48 Q 2

I have to say the first three words really made by heart sink. This new condition that has been invented, “hardness of hearing”, did reflect “Oh, gosh, an audiologist has not read this” because it is not a condition. There is not a huge amount of new stuff in there, in terms of what we are doing at Charing Cross.⁴⁹

The framework was also late. The RNID was expecting it in May 2006.⁵⁰ It was eventually published almost one year later, coincidentally two days before the Committee took evidence on the subject.

52. There were concerns that the framework was over-optimistic.⁵¹ However, the Minister assured us that the framework would lead to a drastic reduction in waiting times over the next year:

The bottom line will be...have we made massive progress on waiting lists and waiting times?...I think we have given you, to be fair to us, some very clear benchmarks to judge the NHS’s performance by, certainly by the end of 2008...

What I commit to doing is, at a national level, with the RNID and other stakeholders, monitoring progress...I will be reporting back to you on the outcome and hopefully that outcome will be considerably less waiting times both for assessment but frankly, more importantly actually, ultimately for fitting.⁵²

Exclusion from the 18-week target

53. The framework confirmed that most adult audiology cases will remain outside the 18-week target.⁵³ Patients under the care of a consultant are included in the target, but audiology departments are not consultant-led, and therefore the target does not apply unless the patient has come via a department that is consultant-led, such as ENT (ENT referrals amount to about 20% of adult hearing loss cases. The Minister told us that 50% of cases were referrals from consultant-led departments but that would include other cases such as paediatric referrals⁵⁴). However, audiology is subject to the same target as other diagnostic tests, such as x-rays and endoscopies, which requires patients to be seen within 13 weeks by March 2007 and within six weeks by December 2008.

54. The framework pointed out that no organisation would be “credible in claiming success at 18 weeks” if audiology waits remained high. We were told of several negative consequences of the exclusion of audiology from the 18-week target. For instance, we heard that GPs often tried to avoid subjecting their patients to lengthy waits for a hearing aid by referring them inappropriately to ENT services.⁵⁵ The National Deaf Children’s Association stated:

49 Q 2

50 Q 2

51 Q 2, Ev 105

52 Q 181

53 The 18-week target is described in the Department of Health document *Tackling hospital waiting: the 18 week patient pathway*, published in May 2006

54 Department of Health, *Improving Access to Audiology Services in England*, March 2007, Qq 116,117

55 Department of Health, *Improving Access to Audiology Services in England*, March 2007

Indications are that many children are now on multiple waiting lists (for example ENT as well as audiology) as GPs attempt to get access to the service for their patients in the quickest possible way.⁵⁶

Such an approach, while understandable, is counter-productive overall. As Ruth Thomsen told us, such patients would “clog up” ENT outpatient services and the consultant would do nothing more than refer the patient on to the audiology department.⁵⁷

55. Other witnesses told us that exclusion of audiology from the 18-week target meant that audiology would be less of a priority for trusts, funding would remain low and waiting lists long as a result.⁵⁸ Meeting the six-week diagnostic milestone by March 2008 will therefore be difficult. John Day, Head of Audiology at the North East Wales NHS Trust, claimed:

In the absence of relevant waiting times targets for hearing aid fitting...it could be anticipated that it will prove challenging for Audiology services to secure resources in competition against those services that do have associated waiting time targets.⁵⁹

A group of London audiologists told us:

Including the fitting of hearing aids in the 18 week targets would give Audiology a higher profile within the Hospital Trusts and PCTs. This would ensure that appropriate funding reached the departments and wasn't diverted elsewhere.⁶⁰

56. We asked the Minister why the 18-week target had not been adopted for audiology. He responded that, regardless of the reason for the decision, it was now too late to include audiology within the 18-week target:

it would be much simpler to be able to say every single person is simply covered by the 18-week maximum but, because 50% of those who need audiology were excluded from the 18-week target initially, the Department's position, understandably, is if we start adding extra things into the 18-week target on a regular basis, it makes a mockery of the target. It creates instability and it sends out messages to managers and others who are expected to implement these changes which are inconsistent.⁶¹

Conclusions and recommendations

57. Some PCTs have failed to give audiology services the priority they deserve. The Minister admitted that audiology services had not been seen as a priority, but this still seems to be the case. The publication of the new audiology framework was delayed for almost one year. Its publication eventually coincided almost exactly with the Committee's inquiry. The framework adds little that is new. Already some of the

56 Ev 88

57 Q 7

58 Ev 101, Ev 71

59 Ev 71

60 Ev 74

61 Q 116

targets in the framework, such as publication of the adult hearing loss model care pathway by March 2007, have not been met.

58. We note the Minister's determination to meet the existing target of providing diagnostic tests for audiology within six weeks by March 2008. This will be difficult. The first stage of this target—for all patients to receive diagnostic tests within 13 weeks by March 2007—has already been missed. The Minister told us that “quite a number of people could have their hearing aid fitted literally on the same day as the assessment”, presumably through the use of ‘open-fit’ technology. Whether this can be adopted widely is being investigated and must be confirmed.

59. The exclusion of audiology services from the 18-week target means that patients with hearing problems are waiting for over two years to receive treatment in some areas. This is particularly unacceptable since the hearing aids are so effective. The exclusion has led GPs to have their patients seen quicker by referring them to ENT departments. It is ridiculous that this loophole exists since it can be so easily exploited and increases costs and waiting times for ENT outpatient appointments. Waiting times for all audiology patients will remain long if audiology remains outside the 18-week target. It would be difficult to do it immediately, but we recommend that the Department of Health include audiology services within the 18-week target at an early date. Meeting the 18-week target should be possible once the six-week target for diagnostic tests for audiology has been achieved.

4 Addressing the challenges

60. As we have seen, the Government's response to the difficulties facing audiology to date, following the MHAS programme, has been unsatisfactory so far. In this chapter we examine how the issues of long waiting times and capacity should be addressed. First we consider the need to establish the extent of demand for digital hearing aids and whether it will continue to grow. Secondly, we look at what the NHS should do to increase capacity and maintain the high quality of care that patients receive once they are eventually treated. Lastly, we examine how and when the private sector should contribute and the factors that should govern its involvement.

Establishing demand

61. It is not clear whether the increase in demand for digital hearing aids is a short-term problem that may be overcome using temporary measures, or a long-term trend that needs a different approach. We received evidence in support of both points of view.

62. The BAA referred to the growth in demand as a “bulge” arising both from existing patients who wished to upgrade their old analogue device and from patients who might not have come forward for a hearing aid before but have realised the benefits of digital aids.⁶² Others agreed. Mark Brindle, audiology service manager from Queen Elizabeth Hospital in Kings Lynn stated:

If all analogue hearing aids could be changed over to digital ones then the reassessment waiting times would shrink significantly.⁶³

63. Some audiologists claimed that the initial demand was already falling. A group of London audiologists told us:

A typical Audiology Department such as at Chase Farm Hospital had approximately 22,000 patients registered with it on the paper system at the time of [the MHAS programme]. There is therefore a very high demand for the first few years. This initial rush is now calming down. Each month there is now a manageable amount of referrals for upgrading to digital hearing aids.⁶⁴

64. In contrast, others claimed that the increases in demand seen over the past few years were the beginning of a long-term trend which required a long-term approach. The length of the waiting lists may currently discourage patients in need of a hearing aid from presenting to their GP⁶⁵ but Dr Low from the RNID claimed that demand would continue to grow as waiting times decreased:

...this is not just a bulge; we do not have a one-off problem that needs to be fixed. Demographics are changing so we know that the number of people presenting is

62 Ev 74

63 Ev 53

64 Ev 74

65 Ev 123

increasing but also there is this huge unmet need and, as the waiting times come down, we know more people will present...this is an ongoing problem.⁶⁶

65. There was some support for this view from within the NHS. One audiology manager stated that it might not be possible to maintain the service currently provided by the NHS in the future:

Consideration will be required to be given to the sustainability of providing an open-ended service to all people once they have been issued with an NHS hearing aid. With an ever-increasing elderly population it is almost certainly unaffordable to continue to provide the present level of hearing aid service.⁶⁷

66. As we have seen, the demand for digital hearing aids was not accurately predicted in the past. Poor forecasting is doubtless partly due to a lack of reliable information regarding the numbers of patients waiting for treatment in different parts of the country. Reliable data are needed in order to forecast future demand. Local commissioners need to know the underlying trends if they are to procure the right levels of services for their areas. Once robust information is available regarding the current demand for digital hearing aids, it will be possible to evaluate likely future trends. However, to forecast effectively, more information than simple numbers of patients waiting is needed. The interactions between factors such as the age of the local population, patterns of presentation, and the backlog of patients waiting to 'upgrade' to digital aids should be examined, alongside the relationship of these factors to existing and predicted local capacity.

New strategies to increase capacity

67. While the precise nature of future demand is uncertain, it seems clear that in the short to medium term demand will exceed existing capacity. Additional capacity can be provided both from the NHS and from the private sector.

NHS Capacity

Spreading best practice

68. Witnesses argued that there were significant opportunities for increasing capacity in NHS audiology departments. We were told of a number of measures taken by individual departments to reduce waiting times. For instance, Charing Cross audiology department uses the Choose and Book system, operates flexible working hours to maximise the use of clinical equipment and assessment rooms and has one-stop clinics using 'open fit' technology.⁶⁸ Several other groups, such as the Pennine Acute hospital trust, told us that, in the absence of long waiting lists of their own, they had helped neighbouring trusts reduce their waiting lists.⁶⁹ The head of an audiology department within the Pennine trust stated:

66 Q 105

67 Ev 53

68 Q 2; this avoids the lengthy process of having an individual ear mould made; therefore assessment and fitting of a hearing aid can take place on the same day.

69 Ev 36, Ev 64

The NHS has the capacity to treat high numbers of audiology waits providing that commissioners look further than their local PCT boundaries, and by talking directly to the Audiology experts locally. By employing and utilising surplus capacity/good will in adjacent areas the NHS could manage the majority of these waits...⁷⁰

69. Other witnesses informed us of additional practices used by some departments that could increase capacity in the NHS overall, including:

- Sending out appointment reminders to reduce the risk of patients not attending;
- Increasing links with GPs and health centres to deliver services in the community;
- Operating walk-in clinics for repairs and batteries.

The spread of good practices could make a considerable contribution to increasing capacity.

70. It should also be possible to reduce costs by the bulk purchase of hearing aids.

Increasing efficiency

71. There is also concern about waste in some NHS audiology departments. The new audiology framework referred to the “significant variations in models of service, activity levels, productivity and costs” in different areas.⁷¹ The disparity in waiting times across the country in part attests to this. Witnesses mentioned the problem of poor skill mix in particular.⁷² Some observed that highly trained staff commonly carried out tasks that could easily be taken on by assistant audiologists.⁷³

Newly qualified staff

72. The NHS was criticised for not making greater use of staff who have completed the new BSc in Audiology. Only approximately 60% of graduates who graduated in June 2006 have found employment in the NHS, despite being trained at NHS expense.⁷⁴ We were told that if these newly qualified audiologists did not find jobs in the NHS, they might have to take jobs in the private sector where career prospects are limited and few of their skills will be used. The British Society of Audiology commented:

The indications are that these graduates are of incredibly high quality and could play a huge part in taking audiology forward in terms of leadership, scholarship and clinical practice. Clearly, it would be a big mistake not to train sufficient graduates of this calibre and deploy them.⁷⁵

70 Ev 76

71 Department of Health, *Improving Access to Audiology Services*, March 2007

72 Ev 120, Ev 94

73 Ev 74

74 Ev 120

75 Ev 57

73. The reasons that new graduates have not found jobs in the NHS are well known, as we highlighted in our inquiry into *NHS Deficits*.⁷⁶ Claire Carwardine told us:

It does come down to a lack of funding and a lack of staff, due to frozen, or cut, posts.⁷⁷

74. There was concern that SHAs were willing to pay to involve the private sector while qualified audiologists in their areas remain unemployed. Lesley Roberts, who graduated last year from Manchester University, told us of her efforts to find a job.⁷⁸ North West SHA is one of those that has requested that the Department negotiate for independent sector contracts.

Private providers

75. Additional capacity can also be provided by the private sector. The Department has already entered into contracts to commission services from the private sector. There is a great deal of interest from many companies in providing these services to the NHS. Submissions stressed the potential benefits of private sector involvement to the patient. The British Society of Hearing Aid Audiologists, which represents high street dispensers of hearing aids, stated that competition from private companies would improve choice and quality and bring down costs.⁷⁹ Others contended that a ‘one size fits all’, hospital-based approach to audiology services “did not suit the majority of patients at all” and is:

failing to deliver the choice or speed of delivery to which the patient is both entitled and increasingly demanding.⁸⁰

76. Some witnesses were concerned about both the existing commitments and about whether and how the private sector should be involved in the future. They raised a number of issues which echoed many of the points covered in our ISTC inquiry, including:

- The basis on which the numbers of pathways needed was decided;
- Value for money assessment;
- Standards of care;
- New entrants;
- Cost to patients;
- Additionality; and
- Length of contracts.

76 First Report from the Health Committee, Session 2006–07, *NHS Deficits*, HC 73–1

77 Ev 64

78 Ev 96

79 Ev 59

80 Ev 113

Uncertainty about numbers of pathways needed

77. As we have seen, there are different opinions about the number of extra patients who need to be treated each year in order to reduce waiting times, and therefore the extra numbers of pathways that must be provided either by the NHS or by the private sector. The RNID told us that over 300,000 extra “pathways” were needed. Others claimed that the figure was smaller.⁸¹

78. The Department is also not sure how many pathways need to be procured from independent providers and, to date, no NHS patients have been assessed or provided with hearing aids by the private companies. The Minister told us that the Department was ready to negotiate but:

...the SHAs and the PCTs are saying to us, “Hold on a moment until we are absolutely certain about our in-house capacity and if we did things better and differently within our areas we may not need you to procure 300,000 pathways”.⁸²

He added, however, that the discussions were drawing to a close and that he expected to know how many pathways were required by each SHA within, “a couple of weeks—not months”.⁸³ We have not yet heard the results of this dialogue.

79. We were told that the SHAs where the private sector would operate had not been selected by the Department on the basis of large waiting lists or any other factor; rather they “selected themselves”.⁸⁴ Examination of the waiting times by SHA indicates that some SHAs who want to use private sector providers have similar numbers of patients waiting to those which have opted out. For instance, South Central SHA has a lower percentage of patients waiting over 13 weeks for assessment (50%) than all three SHAs that do not wish to have private sector audiology services in their areas (East of England 56%, East Midlands 67%, London 68%, see Table 1).

Value for money assessment

80. Witnesses raised a series of issues relating to value-for-money. In particular, they were concerned that:

- assessments would not be carried out prior to commissioning activity from the private sector. Amicus also argued that, even if this assessment were done, auditors would have limited access to financial information:

The procurement of both private sector audiology initiatives will fall under commercial confidentiality restrictions...this limits democratic accountability, preventing a value for money comparison with NHS services to take place.⁸⁵

81 Ev 73, Ev 54

82 Q 146

83 Q 146

84 Q 158

85 Ev 38

- the absence of a national tariff for audiology services meant that value for money assessment is difficult for both the NHS and for private companies that wish to bid for the contracts. The UK Federation of Professionals in Hearing and Balance told us that NHS departments would be better able to run their services if there was a tariff in place:

There seems to be a lack of detailed information at a local level to enable intelligent service delivery and commissioning. One way of addressing these issues is by audiology coming into tariff and being unbundled from ENT so that departments get paid for the services they provide.⁸⁶

The private provider Hidden Hearing pointed out how the lack of a national tariff is problematic for independent companies too. It suggested:

The development of a national tariff would provide an incentive for Primary Care Trusts and Practice-based Commissioners to commission audiology services from the Independent Sector to help tackle lengthy waiting times and meet the 13 week target.⁸⁷

- NHS organisations would not be able to bid for any of the available contracts. The Government has stated in the past that it wants the NHS to become more competitive. Witnesses contended that allowing NHS departments to compete for business, when they have the capacity, would help achieve this aim. Dr Andrew Philips, Head of Audiology from the Royal Berkshire Hospital, argued:

Value for money can only be achieved if both NHS and private sector organisations can bid for commissions on an equal basis.⁸⁸

Standards

81. The HAC regulates the assessment and fitting of hearing aids by the private sector. This responsibility will soon pass from the HAC to the Health Professions Council. The HAC told us that the current regulatory framework for hearing aid audiologists was “simply not fit for purpose”; that dispensers of hearing aids operating under the PPP were usually not regulated by any single body; and that premises were not covered by the Healthcare Commission’s Standards for Independent Healthcare Providers. This left the provision of hearing aids through PPPs “completely unregulated”.⁸⁹

82. Others, however, argued that although there was “potential for a regulatory gap” during the PPP, the regulation of privately-provided services was strong:

The HAC’s point regarding the limits of their jurisdiction is valid. However, under PPP each PCT established a precise professional service specification together with a formal process to ensure full patient protection. Hence, in practice, there was no void in regulation or ‘consumer’ protection. Further, patients, PCTs and RNID expressed

86 Ev 120

87 Ev 80

88 Ev 94

89 Ev 77

satisfaction with the standards delivered by the private sector and certainly no suggestion of consumer risk or harm.⁹⁰

The Minister also assured us:

We are certainly not, in my view, leaving the system so unregulated that we are putting patients at risk of a poor service.⁹¹

New entrants

83. Several companies that currently provide optical services are particularly keen to become involved in the supply of audiology services to the NHS. The Association of British Dispensing Opticians (ABDO), the Association of Optometrists (AOP) and the Federation of Ophthalmic and Dispensing Opticians (FODO) stated:

As in optics, the sector has shown itself very ready to respond in innovative ways to opportunities to improve services for patients.⁹²

84. The claim that opticians were well-placed to take on the role of supplying and fitting hearing aids was challenged, however. Mr Murphy from Ultravox stated:

Optical companies probably think it is close to spectacle provision. I do not think it is, but that is probably why they are making the submissions.⁹³

Ruth Thomsen told us that, “hearing aids are not like receiving glasses”.⁹⁴ The RNID agreed. It argued that measures should be taken to ensure that patients are not pressured into spending more than necessary:

Any expansion in the use of the private sector by the NHS must include comprehensive safeguards for service users, many of whom are vulnerable people. It is vital that patients are not persuaded to buy products they do not need. Unlike with spectacles for correcting common visual defects, it can be difficult for people with hearing loss to identify if they are gaining optimal benefit with hearing aids. Choices are not purely aesthetic and pricing of features is not transparent or standardised.⁹⁵

85. Ms Thomsen added that the location of opticians outlets might cause problems:

A very noisy shopping centre or high street can definitely compromise the quality of the testing and hearing aid verification which is at the heart of the process. Adequate sound proofing is costly and awkward to install correctly and would require massive capital investment.⁹⁶

90 Ev 124. Letter from Mark Georgevic, The Hearing Company; Peter Ince, Specsavers; Graham Lane, Hidden Hearing; Jeff Murphy, Ultravox; Peter Ormerod, David Ormerod Hearing Centres

91 Q 138

92 Ev 43

93 Q 104

94 Q 108

95 Ev 101

96 Ev 69

The view that adequate testing could not be performed in a high street setting was, however, strongly disputed by private providers.⁹⁷

86. There is also concern about the cost of hearing aids which might be supplied by new entrants. We are mindful that in our inquiry into *NHS Charges* we found that opticians often stock limited numbers of spectacles within the price range of those using NHS vouchers and customers are encouraged to purchase more expensive frames and lenses. This could happen with hearing aids. Specsavers told us:

Most independent sector companies would need to subsidise what is, in reality, the necessary low-cost provision required by the NHS through offering private sales to those customers who wanted to ‘trade up’ to a higher specification of product or who chose to pay for a cosmetically more attractive option.⁹⁸

Additionality

87. Witnesses were concerned that the increase in private sector involvement would effectively ‘out-source’ NHS services, leading to a diminution of expertise within the NHS and undermining NHS audiology services. Terry Allen, an audiologist at North Manchester Hospital, stated:

I am also extremely suspicious of attempts to somehow downgrade and cheapen audiology as a profession and/or as a service. Some of the modernisation thinking we hear about is shockingly regressive. Instead of promoting quality of care it seems to suggest the priority for change should be based on reducing costs...⁹⁹

However, Departmental officials assured us:

There will be a substantial increase in the output of both NHS and the independent sector. It is not a switch from NHS to independent sector; it is adding capacity in both sectors.¹⁰⁰

Length of contracts

88. Clare Carwardine told us that current waits were “an acute problem requiring an acute response”.¹⁰¹ The BAA also observed that the problem could be dealt with through short-term measures. It told us:

There is a possible role for the private sector to subcontract NHS work to meet short-term needs, as demonstrated by the PPP scheme...as a planned part of the NHS Commissioning Framework.¹⁰²

97 Ev 113

98 Ev 113

99 Ev 36

100 Q 177

101 Ev 63

102 Ev 74

89. On the other hand, the opticians' groups ABDO, AOP and FODO told us that short-term involvement of the private sector would not solve the problems:

It is vital that future partnership should be seen as a long term commitment to greater variety of supply and choice rather than a one off exercise for reducing waiting times. However, if taken forward only in this latter short term context, the problem will simply recur after a year or two...¹⁰³

90. Witnesses also pointed out that the length of contracts offered must be attractive to private companies, or they will not invest in services adequately. Mr Murphy from Ultravox told us:

Short-term large movements of the waiting list are financially sustainable if the contract is at the right price and it is at the right length of time where you could scale up and get a return on investment.¹⁰⁴

Conclusions and recommendations

Need for better forecasting

91. Both current and future demand for digital hearing aids is uncertain: many have described the current waiting lists as a short term 'bulge'; others have stated that the increased levels of demand are here to stay due to the ageing population and awareness of the benefits offered by digital aids. If local commissioners are to procure services effectively, they must have accurate information on demand both for the short- and long-term. **We recommend that the Department undertake a thorough examination of the medium- and long-term demand for digital hearing aids.**

Additional capacity

92. Whether the increase in demand is a bulge or more sustained, in the short to medium term there is a need for more capacity.

Improvement in NHS services

93. There is much good practice in NHS audiology services, yet we were appalled by the variability of the service. This is partly due to the lack of priority given to audiology by PCTs. There is also inefficiency; in particular, there needs to be more effective skill mix. We were told that more junior staff members could carry out many of the tests required, freeing up more experienced staff to concentrate on complex cases.¹⁰⁵ **We recommend that audiology departments review the way in which they provide services to patients, identifying the skill mix and the levels of training or experience necessary. Their reviews should also examine the possibility of operating flexible opening hours, telephone follow-up, home visits, the use of Choose and Book and cross-boundary**

¹⁰³ Ev 43

¹⁰⁴ Q 104

¹⁰⁵ Ev 53, and also suggested by Prof Sue Hill, Q 152

working to increase the numbers of patients seen. The cost of hearing aids could be reduced by bulk purchasing.

94. We received evidence about the extent of graduate unemployment. We recommend that the Department examine the situation of recent audiology graduates.

The use of the private sector

95. Several points covered in this inquiry about the use of the private sector were also raised in our inquiry into ISTCs. Again, there were concerns about value for money assessments and other evidence that has been or will be taken before contracts with the private sector are negotiated. Lessons should be learned from the ISTC programme. A tariff would allow better value for money assessment, would improve local commissioning and encourage trusts with limited waits to help neighbouring departments reduce their lists. **Value for money assessment must be carried out. This will be difficult without a tariff. We note that the Department will consider this in 2007. We recommend that the Department produce a national tariff for audiology at an early date.**

96. During this inquiry we heard claims that the quality of care provided by the private sector during the PPP was unsatisfactory, and that regulation was limited. We also note that these claims were strongly disputed. In a brief inquiry we are unable to assess these conflicting claims. Nevertheless, **we believe that private companies must be capable of providing a standard of care equal to that of the NHS. The contracts negotiated with the private sector must ensure that patients receive adequate care and follow-up. Services must be monitored and the quality of care must be assessed on the same basis as the quality of care is assessed in the NHS.**

97. We were not presented with any evidence which convinced us that that new entrants such as opticians should be excluded from providing audiology services. However, our inquiry into *NHS Charges* noted that finding spectacles with a value within that of vouchers supplied by the NHS could be difficult, and that customers were sometimes encouraged to buy expensive frames and lenses. We would not want a similar situation to arise with hearing aids. **We are concerned that older and sometimes vulnerable people might be encouraged to buy more expensive hearing devices than necessary. The Department must ensure that encouragement to patients to 'trade up' to a more expensive hearing aid is limited.**

98. A considerable number of witnesses were concerned that involvement of the private sector would mean that NHS services would be depleted and expertise would be lost. **The Department must ensure that the involvement of the private sector does not undermine the NHS's capacity to provide expert audiology services. It must assess the effects of private sector activity on NHS capacity and levels of expertise within audiology departments. We were encouraged that the Department appears to be listening to local commissioners about whether private sector involvement is needed.**

99. The effect of the involvement of the private sector on NHS audiology services is unknown; the Department should therefore proceed with caution with the negotiation of contracts. At the same time the private sector must be encouraged to invest in facilities and to maintain high standards. **We recommend that private sector contracts be relatively**

short-term in the first instance but extendable subject to companies achieving and maintaining high standards of treatment and care. Future contracts should depend upon demand remaining high, as the private sector maintains will be the case.

100. This has been a short inquiry and we have not been able to assess fully the claims and counter claims relating to the involvement of the private sector. We are reassured that the Department is prepared to be flexible on the numbers of “pathways” procured from the private sector, depending on evidence received from local NHS organisations. However, this suggests that the evidence underlying the original commitment to the combined 342,000 pathways was inadequate, and that this figure was essentially plucked out of the air. Likewise, the lack of analysis of the areas most in need of private sector involvement indicates a disappointing lack of evidence-based decision-making by the Department. **Decisions on the amount of activity required from the private sector have not been based on evidence, but appear to have been ‘plucked out of the air’.** The Department should specify criteria for private sector involvement, for example failure to meet the 18-week target once it is in place. The Department should make evidence-based decisions and ensure value for money.

Conclusions and recommendations

1. Audiology services improved greatly as a result of the introduction of digital hearing aids and the MHAS programme. However, this led to a surge in demand, not only from new patients but also from those who wished to switch from analogue aids. This increased waiting times which the NHS surprisingly did not anticipate. (Paragraph 41)
2. Details about the extent of waiting times are unclear because of inadequate data recording and collection. We recommend that comprehensive data be collected and published on all patients waiting for audiology services from GP referral to treatment. The information we have received indicates that some individual trusts have no waiting list while others have waits of over two years. (Paragraph 42)
3. Some PCTs have failed to give audiology services the priority they deserve. The Minister admitted that audiology services had not been seen as a priority, but this still seems to be the case. The publication of the new audiology framework was delayed for almost one year. Its publication eventually coincided almost exactly with the Committee's inquiry. The framework adds little that is new. Already some of the targets in the framework, such as publication of the adult hearing loss model care pathway by March 2007, have not been met. (Paragraph 57)
4. We note the Minister's determination to meet the existing target of providing diagnostic tests for audiology within six weeks by March 2008. This will be difficult. The first stage of this target—for all patients to receive diagnostic tests within 13 weeks by March 2007—has already been missed. The Minister told us that “quite a number of people could have their hearing aid fitted literally on the same day as the assessment”, presumably through the use of ‘open-fit’ technology. Whether this can be adopted widely is being investigated and must be confirmed. (Paragraph 58)
5. The exclusion of audiology services from the 18-week target means that patients with hearing problems are waiting for over two years to receive treatment in some areas. This is particularly unacceptable since the hearing aids are so effective. The exclusion has led GPs to have their patients seen quicker by referring them to ENT departments. It is ridiculous that this loophole exists since it can be so easily exploited and increases costs and waiting times for ENT outpatient appointments. Waiting times for all audiology patients will remain long if audiology remains outside the 18-week target. It would be difficult to do it immediately, but we recommend that the Department of Health include audiology services within the 18-week target at an early date. Meeting the 18-week target should be possible once the six week target for diagnostic tests for audiology has been achieved. (Paragraph 59)
6. We recommend that the Department undertake a thorough examination of the medium- and long-term demand for digital hearing aids. (Paragraph 91)
7. We recommend that audiology departments review the way in which they provide services to patients, identifying the skill mix and the levels of training or experience necessary. Their reviews should also examine the possibility of operating flexible

opening hours, telephone follow-up, home visits, the use of Choose and Book and cross-boundary working to increase the numbers of patients seen. The cost of hearing aids could be reduced by bulk purchasing. (Paragraph 93)

8. We received evidence about the extent of graduate unemployment. We recommend that the Department examine the situation of recent audiology graduates. (Paragraph 94)
9. Value for money assessment must be carried out. This will be difficult without a tariff. We note that the Department will consider this in 2007. We recommend that the Department produce a national tariff for audiology at an early date. (Paragraph 95)
10. The contracts negotiated with the private sector must ensure that patients receive adequate care and follow-up. Services must be monitored and the quality of care must be assessed on the same basis as the quality of care is assessed in the NHS. (Paragraph 96)
11. We are concerned that older and sometimes vulnerable people might be encouraged to buy more expensive hearing devices than necessary. The Department must ensure that encouragement to patients to 'trade up' to a more expensive hearing aid is limited. (Paragraph 97)
12. The Department must ensure that the involvement of the private sector does not undermine the NHS's capacity to provide expert audiology services. It must assess the effects of private sector activity on NHS capacity and levels of expertise within audiology departments. We were encouraged that the Department appears to be listening to local commissioners about whether private sector involvement is needed. (Paragraph 98)
13. We recommend that private sector contracts be relatively short-term in the first instance but extendable subject to companies achieving and maintaining high standards of treatment and care. Future contracts should depend upon demand remaining high, as the private sector maintains will be the case. (Paragraph 99)
14. Decisions on the amount of activity required from the private sector have not been based on evidence, but appear to have been 'plucked out of the air'. The Department should specify criteria for private sector involvement, for example failure to meet the 18-week target once it is in place. The Department should make evidence-based decisions and ensure value for money. (Paragraph 100)

Formal minutes

Wednesday 2 May 2007

Members present:

Mr Kevin Barron, in the Chair

Charlotte Atkins

Mr Ronnie Campbell

Sandra Gidley

Dr Doug Naysmith

Dr Howard Stoate

Dr Richard Taylor

Draft Report (Audiology Services), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 100 read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Fifth Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the Provisions of Standing Order No. 134.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

[Adjourned till Thursday 10 May at 9.30 am]

List of witnesses

Thursday 8 March 2007

Page

Dr John Low, Chief Executive, Royal National Institute for the Deaf,
Mrs Ruth Thomsen, Audiology Services, Charing Cross Hospital and
Jeffrey Murphy, Chief Executive, Ultravox Holdings Ltd Ev 1

Ivan Lewis, a Member of the House, Parliamentary Under-Secretary of State
 for Care Services, **Nick Chapman**, National Director, 18-week Target,
Professor Sue Hill, Chief Scientific Officer, Department of Health, and **Helen
 MacCarthy**, Director of Facilities Management and Utilities, NHS Purchasing
 and Supply Agency Ev 15

List of written evidence

1	Department of Health (AUDIO 01)	Ev 29
2	Terry Allen, North Manchester General Hospital (AUDIO 33)	Ev 36
3	Amicus (AUDIO 19)	Ev 38
4	Amplifon UK Limited (AUDIO 20)	Ev 39
5	Ultravox (A subsidiary of Amplifon) (AUDIO 20A)	Ev 42
6	Association of British Dispensing Opticians, the Association of Optometrists and the Federation of Ophthalmic and Dispensing Opticians (AUDIO 40)	Ev 43
7	Adam Beckman, Plymouth Hospitals NHS Trust (AUDIO 38)	Ev 47
8	John Beadle (AUDIO 06)	Ev 48
9	Mark Brindle, Queen Elizabeth Hospital King's Lynn NHS Trust (AUDIO 32)	Ev 53
10	British Academy of Audiology (BAA) (AUDIO 16)	Ev 54
11	British Society of Audiology (AUDIO 27)	Ev 57
12	British Society of Hearing Aid Audiologists (AUDIO 10)	Ev 59
13	Cardio Analytics Medical Services (AUDIO 11)	Ev 62
14	Byron Carnell (AUDIO 26)	Ev 62
15	Claire Carwardine (AUDIO 13)	Ev 63
16	Claire Carwardine (AUDIO 13A)	Ev 64
17	Charing Cross Hospital (AUDIO 21)	Ev 65
18	Ruth Thomsen (AUDIO 21A)	Ev 69
19	Ruth Thomsen (AUDIO 21B)	Ev 69
20	Jacque Connolly (AUDIO 29)	Ev 71
21	John Day, North West Wales NHS Trust (AUDIO 43)	Ev 71
22	Jane Deans, The Great Western Hospital, Swindon & Marlborough NHS Trust (AUDIO 14)	Ev 73
23	Keith Dunmore, Terry Nunn, Pete Roberts and Julie Wilkins (AUDIO 34)	Ev 74
24	Jan Harling, North Manchester General Hospital (AUDIO 04)	Ev 76
25	The Hearing Aid Council (AUDIO 42)	Ev 77

26	Help the Aged (AUDIO 42)	Ev 79
27	Mrs June Henriksen (AUDIO 02)	Ev 80
28	Hidden Hearing (AUDIO 25)	Ev 80
29	Hidden Hearing (AUDIO 25A)	Ev 86
30	Mrs Margaret L Howard (AUDIO 36)	Ev 87
31	The National Deaf Children's Society (AUDIO 18)	Ev 88
32	David Ormerod Hearing Centres (AUDIO 35)	Ev 91
33	David Ormerod Hearing Centres (AUDIO 35A)	Ev 92
34	Meenaxi Patel, Northwick Park Hospital (AUDIO 37)	Ev 94
35	Andrew Phillips, Royal Berkshire NHS Foundation Trust (AUDIO 15)	Ev 94
36	Paul Piper (AUDIO 03)	Ev 96
37	Mrs Lesley Roberts (AUDIO 05)	Ev 96
38	Royal College of Paediatrics and Child Health (AUDIO 39)	Ev 97
39	Royal College of Physicians (AUDIO 28)	Ev 97
40	Royal National Institute for Deaf People (AUDIO 23)	Ev 101
41	Royal National Institute for Deaf People (AUDIO 23A)	Ev 105
42	Sense (AUDIO 41)	Ev 106
43	Grant Shapps MP (AUDIO 30)	Ev 107
44	Liza Smeeton, Barnsley Hospital NHS Foundation Trust (AUDIO 09)	Ev 112
45	Mr Michael Snee (AUDIO 31)	Ev 112
46	Specsavers Hearcare Group Limited (AUDIO 17)	Ev 113
47	East Sussex Health Overview and Scrutiny Committee (AUDIO 08)	Ev 118
48	Dinah Taylor, King's College Hospital NHS Foundation Trust (AUDIO 22)	Ev 119
49	United Kingdom Federation of Professionals in Hearing and Balance (UKFPHB) (AUDIO 12)	Ev 120
50	Wirral Health Forum (AUDIO 44)	Ev 123
51	Kath Woolley, Bury Primary Care Trust (AUDIO 07)	Ev 123
52	The Hearing Company, Specsavers, Hidden Hearing, Ultravox and David Ormerod (AUDIO 47)	Ev 124
53	Supplementary letter from Ivan Lewis MP, Parliamentary Under-Secretary for Care Services (AUDIO 01A)	Ev 125

List of unprinted written evidence

Additional papers have been received from the following and have been reported to the House but to save printing costs they have not been printed and copies have been placed in the House of Commons Library where they may be inspected by Members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1. (Tel 020 7219 3074). Hours of inspection are from 9:30am to 5:00pm on Mondays to Fridays.

British Society of Hearing Aid Audiologists (AUDIO 10A)

Hear and There (AUDIO 45)

John Hunt (AUDIO 46)

Reports from the Health Committee

The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2006–07

First Report	NHS Deficits	HC 73 (Cm 7028)
Second Report	Work of the Committee 2005–06	HC 297
Third Report	Patient and Public Involvement in the NHS	HC 278
Fourth Report	Workforce Planning	HC 171

Session 2005–06

First Report	Smoking in Public Places	HC 436 (Cm 6769)
Second Report	Changes to Primary Care Trusts	HC 646 (Cm 6760)
Third Report	NHS Charges	HC 815 (Cm 6922)
Fourth Report	Independent Sector Treatment Centres	HC 934 (Cm 6930)

The following reports have been produced by the Committee in the 2001–05 Parliament.

Session 2004–05

First Report	The Work of the Health Committee	HC 284
Second Report	The Prevention of Thromboembolism in Hospitalised Patients	HC 99 (Cm 6635)
Third Report	HIV/AIDS and Sexual Health	HC 252 (Cm 6649)
Fourth Report	The Influence of the Pharmaceutical Industry	HC 42 (Cm 6655)
Fifth Report	The Use of New Medical Technologies within the NHS	HC 398 (Cm 6656)
Sixth Report	NHS Continuing Care	HC 399 (Cm 6650)

Session 2003–04

First Report	The Work of the Health Committee	HC 95
Second Report	Elder Abuse	HC 111 (Cm 6270)
Third Report	Obesity	HC 23 (Cm 6438)
Fourth Report	Palliative Care	HC 454 (Cm 6327)
Fifth Report	GP Out-of-Hours Services	HC 697 (Cm 6352)
Sixth Report	The Provision of Allergy Services	HC 696 (Cm 6433)

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395 (Cm 5876)
Third Report	Sexual Health	HC 69 (Cm 5959)
Fourth Report	Provision of Maternity Services	HC 464 (Cm 6140)
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571 (Cm 5896)
Sixth Report	The Victoria Climbié Inquiry Report	HC 570 (Cm 5992)
Seventh Report	Patient and Public Involvement in the NHS	HC 697 (Cm 6005)

Eight Report	Inequalities in Access to Maternity Services	HC 696 (Cm 6140)
Ninth Report	Choice in Maternity Services	HC 796 (Cm 6140)

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308 (Cm 5567)
Second Report	National Institute for Clinical Excellence	HC 515 (Cm 5611)
Third Report	Delayed Discharges	HC 617 (Cm 5645)

Oral evidence

Taken before the Health Committee

on Thursday 8 March 2007

Members present:

Mr Kevin Barron, in the Chair

Mr David Amess
Mr Ronnie Campbell
Sandra Gidley
Mr Stewart Jackson

Dr Doug Naysmith
Mike Penning
Dr Howard Stoate
Dr Richard Taylor

Witnesses: **Dr John Low**, Chief Executive, Royal National Institute for the Deaf, **Mrs Ruth Thomsen**, Audiology Services, Charing Cross Hospital, and **Mr Jeffrey Murphy**, Chief Executive, Ultravox Holdings Ltd, gave evidence.

Q1 Chairman: Good morning. May I welcome you to this inquiry into audiology services in England. Could I ask you to introduce yourselves for the record, please.

Mrs Thomsen: I am Ruth Thomsen. I am an audiologist at Charing Cross Hospital in London.

Dr Low: I am John Low. I am the Chief Executive of RNID, the national charity representing deaf and hard of hearing people.

Mr Murphy: I am Jeff Murphy, I am the Chief Executive of Ultravox Holdings Ltd.

Q2 Chairman: Welcome and thank you very much for coming along. Sheer coincidence gave us the publication earlier this week of the *Improving Access to Audiology Services in England* by the Department. I wonder if I could ask you all as a general question (a) if you would like to comment on it and (b) if you have learned anything new since its publication.

Mrs Thomsen: It obviously was very timely and did not give us a lot of time to glean information from the report. I have to say the first three words really made by heart sink. This new condition that has been invented, “hardness of hearing”, did reflect “Oh, gosh, an audiologist has not read this” because it is not a condition. There is not a huge amount of new stuff in there, in terms of what we are doing at Charing Cross. We share information with other audiology departments and we have worked hard to implement ways in which we can reduce our waiting lists. If we look at the back of the document, where the key outputs are, I went through them and tried to decide which ones we are already doing, even though the timeline for these is further on in 2007 and 2008. At Charing Cross we are using Choose and Book already; we triage our patients; we monitor our patients using tools implemented by the Modernised Hearing Aid Service and we follow very carefully defined protocols, both those sent down from the Institute of Hearing Research and those we have designed for Choose and Book, which have to be very stringent and passed down to educate our GPs; we implement open fits; and we use flexible working. There are a few areas that we could welcome, I think, in terms of more information for

patients, like they suggest on the *Healthy Choices* website, and a more cohesive information gathering system that looks at how long it takes to get a hearing aid and not just the diagnostic area of audiology.

Dr Low: I think that strategically this action plan is a sop, following the exclusion of audiology services from the 18-week target last May, when that framework was published. Audiology should have been inside the 18-week target and it was deliberately excluded. At the time they promised an action plan and it has taken some months but finally it has arrived. I believe the estimates of the waits inside the NHS are probably at the bottom end of the range. The need for an additional 300,000 patient journeys would be the minimum figure we could calculate: we think there are probably half a million people waiting for a hearing aid in the NHS right now. The reason we do not know, of course, is that neither the Department of Health nor the NHS collects waiting-time figures. There has been an initiative recently to collect the time between GP referral and having a hearing test but of course the longer wait is from the hearing test to having the hearing aid fitted. We are having to use proxies: a mystery shopping exercise by the private sector trade body. One of the MPs, the Member for Welwyn Hatfield, did a freedom of information survey and he came up with other figures. We reckon that approximately 40 to 45 weeks is the average waiting time for someone getting a hearing aid for the first time and 65 weeks is typical for someone being reassessed across the NHS. Charing Cross is a fabulous hospital. It is among the elite. The only way this action plan will deliver is if everything in it is made to happen. The largest single effect in the proposals within the plan is the procurement of additional capacity from the private sector. If we are to reduce the waiting times by December 2008, as proposed in this plan, we will require hundreds of thousands of additional patient journeys from somewhere. They are saying 300,000 in the plan; I would suggest the figure is perhaps bigger than that. Without a substantial procurement from the independent sector, I cannot see how the NHS can deliver. There are efficiency gains, there are

8 March 2007 Dr John Low, Mrs Ruth Thomsen and Mr Jeffrey Murphy

some technology improvements, certainly, but we know that, even if you take all the changes that can be squeezed, they will deliver only a small proportion of what is required. The key message is that we must do what Lord Warner announced in the House of Lords in July last year, which is to purchase 300,000 patient journeys per year ongoing for the independent sector.

Q3 Chairman: Jeffrey, do you have any views on this week's publication?

Mr Murphy: Yes. We welcome the report. I do not think you could disagree with the aspirations of the report. It will bring a more flexible and better service for the NHS. I think the report does identify some problems and I suggest it probably needs another layer to bottom out and explore some of the practicalities and ways of solving them. Modernisation is necessary. In our opinion technology does not usually solve logistic problems, so I think there will always be a capacity issue. We welcome the report's willingness to work with the private sector and we believe that we have the capacity to respond to the Government's requirements.

Chairman: We are going to move on to a few questions about waiting times.

Q4 Mr Amess: First of all, the three of you should sit back and enjoy this session. It is those who will be coming before us in the second session who want to be a little bit more anxious, but this is your opportunity to get it all off your chest and give you some therapy. As the Chairman has said, I am going to ask you some questions about waiting times, but, on a serious note, it is not very clever, is it, or very subtle that the Department bursts into life because we are having an inquiry this week? This is not a new subject and it is not very funny if you cannot hear properly and something can be done about it. I would imagine from your points of view that it is great that we are now having the inquiry and it is great that something is being done but it is taking the mickey really. It was announced on Tuesday and we are here Thursday, so that cannot really inspire you with enormous confidence, can it?

Dr Low: My response to that is that in May last year, when the 18-week framework was published for the whole of the NHS, there was a promised action plan in that document. We would have wished that it had been earlier than this and I am grateful for this Committee being an incentive to getting it published. If that is what it takes, I am grateful for small mercies.

Q5 Mr Amess: I congratulate one of my colleagues. It also is not very clever, is it, that my colleague Grant Shapps had to use the Freedom of Information Act to reveal that, for instance, in Bromley the process takes 112 weeks, in Plymouth 108 weeks, in mid-Staffordshire, 104 weeks, and for Western Area Hospital and East Hospitals it was 100 weeks. That is not very good, is it?

Dr Low: It is not good at all. If you cannot hear well, you are isolated from your family, you are not able to function well at work, we know your physical health deteriorates. Two years is unnecessary for a low-cost intervention. If the resources are made available within the system, these can be fitted within days. They do not have to take several years. People are struggling with either no hearing aid at all or an inappropriate hearing aid for far too long.

Q6 Mr Amess: The three of you understand the framework confirms that audiology will remain outside the 18-week target period. Do you think the target should apply? Can you tell the Committee why?

Dr Low: Yes, is the simple answer, because it is an important intervention. Not only is it important for the quality of life for huge numbers of people at very low cost to the NHS, but also the failure to do so has the effect of upward substitution of costs in the form of poor health, inability to live independently and ultimately pushing bigger costs onto the public purse rather than just dealing with this intervention at the right point in time.

Q7 Mr Amess: And your two colleagues agree.

Mrs Thomsen: Yes. There is a small loophole, I think, in the document, where it says that if you are referred to ENT then you come within the 18-week process for treatment by December 2008. If a GP refers a patient who needs a hearing aid and that is all they need, a hearing test and a hearing aid fitting, they will have the speedier service if they go through the middleman, the ENT surgeon, who can perform nothing but then refer them on to us for a hearing aid fitting, clogging up unnecessarily clinical time in ENT outpatients. A clever GP, I am sure, would be able to work out that he is going to get his patients through the system much more quickly if they refer to an ENT surgeon, leaving in the middleman, so to speak, and then they will come under the conditions of getting within the 18-week period. If you refer directly to an audiologist, where we are able to perform the hearing test and assessments, move the patients into ENT if they need to see them, and then fit a hearing aid, it is not a statutory condition that they are seen within the 18 weeks. They have written a loophole in here, which, if it gets abused, will see huge waits and bottlenecks elsewhere along the system.

Mr Murphy: My opinion is that the 18-week waiting list target is a must. We see 30,000 patients a year of an average age of 68 to 70, and for people of that age, with a life expectancy of whatever it is, to wait two years is not on, not acceptable and we should do something about it immediately.

Q8 Mr Amess: It is a standing joke that as Members of Parliament it would be often a relief if we could not hear what each other was saying, but for the rest of the public it is pretty distressing. Why do the three of you think audiology is such a low priority?

Mrs Thomsen: I think we were not a low priority when the RNID were rolling out MHAS. We were a Cinderella service and very low priority for a long

8 March 2007 Dr John Low, Mrs Ruth Thomsen and Mr Jeffrey Murphy

time when we were fitting analogue aids. I have been working in the NHS since 1984 and I was changing people over from body-worn hearing aids to behind-the-ear hearing aids and working that backlog out many years ago, so I have seen it come a few times. It was absolutely amazingly fantastic to have the recognition that was brought down from the RNID and the investment in our services. Five years ago we had one PC in our department. When the IT guys came up when we started to revolutionise, they really could not believe that these sorts of computers were still around. We have been completely modernised. The investment coming via the RNID from the Government has been phenomenal. We have been well educated, well trained and at last we have been able to take the ball and run with it. So we have not been neglected for a long time; it was when the ring-fenced money was removed and the backlog still had not been addressed that the waits started to grow. The money went elsewhere. The majority of the time, it is not life-threatening. The majority of patients I see are elderly. It is a patient group which often have other health problems which will take priority. If they were included in the 18-week wait, we certainly would have had better funding. All departments in the UK saw a drop in interest the minute the ring-fenced money went.

Q9 Mr Amess: You have been in it since 1984. You are very, very pleased with what is happening, but you now think the problem is down to what is happening generally in the National Health Service and money.

Mrs Thomsen: Prioritising.

Q10 Mr Amess: Do you both agree?

Dr Low: We used the Freedom of Information Act last year to find out what the budgets were. We asked commissioners: How much are you spending? The vast majority of them could not tell us how much they were spending on audiology because it was just lumped inside a big pot of other funding, that was going, if you were lucky, into ENT, but it might be going into a bigger pot still. There was no priority. The waiting times are still not collected between having a hearing test and getting a hearing aid, so it is not a priority. It is a very low level activity as far as the trust management is concerned and the commissioners. It is simply neglected. Through the modernisation process, the NHS is fitting high-quality hearing aids and fitting them to a very high standard. Patients are getting a good result, they are just waiting a very long time for them. The reason is that this is not given any priority or attention within the management of the NHS.

Q11 Dr Naysmith: Why was the ring-fencing removed?

Dr Low: We campaigned in 1999 and 2000 for modernisation. Through that process we were able to secure a lump of money. It was £125 million in total. That was spent between 2000 and 2005 to modernise the service. It was not an initiative

to tackle the inherent backlog. When the modernisation was finished, then the funding was put back for general allocations.

Q12 Dr Naysmith: That is where the upgrading of your equipment and so on came from.

Mrs Thomsen: Absolutely.

Q13 Dr Naysmith: But it was not meant for putting more patients through.

Dr Low: That is correct.

Q14 Chairman: Ruth, you mentioned that the majority of your patients are elderly but what about school-age patients. What is the position at your place? Do you have a national view of what is happening?

Mrs Thomsen: I cannot comment on the national view. I know you have had evidence from the NDCS. In Charing Cross we are lucky, we do adults and paediatrics. Children take priority everywhere, because they are in education, they need to learn. With the introduction of the neonatal screening programme, we are fitting hearing instruments on very tiny little babies. Their care is very intensive: you need to see them every few weeks, because they are growing and their ears are changing, to fit the shape of their ears. They always come first. As far as we are concerned at Charing Cross, no child should wait. They are fitted with top range hearing aids as well. We really achieve to give the child every opportunity. Certainly at Charing Cross it is not an issue with waiting with children.

Q15 Chairman: We hear these stories of waiting times up and down the country, some of them quite horrific. Are children likely to be caught into this situation where they are waiting months if not years?

Mrs Thomsen: I cannot comment on up and down the country but I certainly think there are dedicated paediatric audiology services up and down the country where the teams work incredibly hard. I have not heard of children having to wait for hearing aids. It would be a very sad day if that happened.

Dr Low: It is not perfect but it is very, very much better than the adult services. It does get priority. They have been modernised. They have the highest quality equipment and hearing aids and generally children are seen as a priority very quickly.

Q16 Sandra Gidley: I would like to disagree with you because I was lobbied last night by an MP whose child had had to wait three years for a hearing aid—and I can see nodding behind you—because there was simply no prioritisation in the trust where he lived.

Dr Low: I did say it was not perfect. That, mercifully, is the exception rather than the rule. There are areas where there are major concerns.

Q17 Sandra Gidley: How big an exception is it? Or do you not feel qualified to answer that?

Dr Low: I do not have figures in front of me but I would suggest that it is a small minority of places that have that kind of problem.

8 March 2007 Dr John Low, Mrs Ruth Thomsen and Mr Jeffrey Murphy

Q18 Chairman: It is not measured and we do not know, basically. I think that is what we would have to say.

Dr Low: Correct.

Q19 Dr Stoate: I am a GP and I know exactly how to abuse the system to get the best out of it, so it is not news to me that you refer straight to ENT consultants to short-circuit some of the excessive waits. Listening to you about how things are at Charing Cross Hospital, it all sounds pretty wonderful. You have had lots of new investment, new equipment, new computers, everything is modernised, you are doing one-stop shop in some cases, you are doing Choose and Book. Are you exceptional or is this happening elsewhere?

Mrs Thomsen: The Choose and Book came upon us. It was not something we implemented; we were told to implement it. I think we play an active role in linking in with other audiology departments up and down the country, looking at best practice, the sharing of information and with Internet and email, with the British Academy of Audiology working groups and regional groups. We share information. We are constantly looking and actively seeking how to bring down our waiting lists and treat the patients in the best way we can.

Q20 Dr Stoate: If you are doing so well, why is it there is a big problem? If all these departments up and down the country are being modernised and all having these wonderful one-stop shops—which I have to say I have never heard of—and Choose and Book. I cannot do that from my computer: despite the fact that I use Choose and Book whenever I possibly can, audiology is not listed. How come it is with you and it is not elsewhere?

Mrs Thomsen: We started with no waiting list when we were modernised. We were a hardworking department, a teaching department, and we were able to raise some revenue in order to keep our department up and running. We run a very tight ship. We are a department of 11 audiologists covering Westminster, Hammersmith & Fulham, Kensington & Chelsea, parts of Ealing. We cover a big chunk of West London. We were constantly looking at ways to improve the service. We are a very forward-looking team. We welcome the modernisation. I think every hearing aid centre in the UK has undergone modernisation, so we are not the only ones with nice new computers. I think everyone has that.

Q21 Dr Stoate: We have heard from some of the evidence we have received that the skill mix could be changed to improve the way things are working. It sounds to me as if you have already done that.

Mrs Thomsen: No. We are still looking at different ways of skill mixing. The introduction of the foundation degree, which will hopefully come on board in September 2007, will create a new role, which is an associate level audiologist, and uniform education, in terms of assistants, associates, qualified audiologists who will then go up the ladder and specialise.

Q22 Dr Stoate: You are saying the skill mix could go a lot further.

Mrs Thomsen: Absolutely. But it is going. It is just taking time.

Q23 Dr Stoate: Do you think skill mix would make a huge difference to the problem? Or do you think it will only make a partial difference to the problem?

Mrs Thomsen: The skill mix and a look at the establishment within an audiology department. A really good look at whether you have qualified audiologists doing stuff that associate level audiologists could do would help get these patients through, so that the people with the high knowledge are able to do the bits requiring the high knowledge. The problem with that is you do need to be able to do the basics as well. I think skill mix is important, but I think we need to look at the way we recruit. We have all these new BSc students about to exit this summer, from eight universities, I think, and we are not lined up for that in audiology. We are not lined up for lots of people to come on to the job market suddenly, all at once. It is really important that we look at the way we recruit and bring these people into the department and really make use of their skills as well.

Q24 Dr Stoate: You are saying that the skill mix will not take care of the entire capacity problem but it will make a big difference.

Mrs Thomsen: I think it will help a lot. I think the establishment of a foundation degree for hearing aid dispensers and people working in the private sector will give them a uniformity of qualifications.

Q25 Dr Stoate: We have heard of these graduates coming through the system and yet we are also hearing that many of them are struggling to find work. How do we get around that paradox?

Dr Low: It is simply an issue about capacity. Charing Cross is among the elite in the country. They have a good head of audiology who is proactive and pushes the department, seeks more funds, is active within the trust. They do not have any vacancies. They had posts cut but those posts have been restored. They are up to full strength and they are a well-resourced department doing a good job. In many parts of the county posts are frozen. The numbers on the establishment are not sufficient anyway. We have qualified people coming out, but from last year 40% still do not have a job. We have heard that the NHS is reducing the number of places on these courses they are commissioning, because the people coming out are not getting jobs, even though we need to boost the capacity in the NHS by 50% or 60% or 70%.

Q26 Dr Stoate: It is only about money really. You are saying that the capacity exists in terms of numbers of people coming through the system; it is just a matter of hospitals having the money to employ them.

Dr Low: It is not just that but that is a core issue.

8 March 2007 Dr John Low, Mrs Ruth Thomsen and Mr Jeffrey Murphy

Q27 Dr Stoate: That would pretty much deal with it.

Dr Low: I do not believe it would deal with it. If we need to increase the capacity by, say, 50%, that is a very large number. That may be an extra 800,000-900,000 audiologists. We are not going to get them in one year.

Q28 Dr Stoate: That could not happen. Even if hospitals employed everyone available, there still would not be enough capacity.

Dr Low: Correct.

Mr Murphy: Could I answer the question that was asked before on the 18 weeks. I think there are two issues. First, the 18 weeks is difficult to measure because it is not consultant led, so the audiology is not measured from the 18-week waiting list targets. Secondly, Ruth mentioned the Cinderella service. Audiology is delivered in acute hospitals and by very definition will not get the priorities. Until that changes, I think the 18-week waiting list is a mammoth target to try to achieve. On skill mix, I would call it a re-engineering of skills. If that happens in the independent sector, it would increase capacity significantly, and we have put forward proposals on that.

Q29 Dr Taylor: Knowing GPs and Howard referred to the consultant, is there not then a wait from the consultant to the fitting of the aid?

Mrs Thomsen: The 18-week wait was a statutory one: for complex cases, treatment by December 2008. This is from referral to ENT to treatment, and the treatment would be classed as a hearing aid fitting.

Q30 Dr Taylor: So that is an absolute way of getting around it.

Mrs Thomsen: Yes—but do not tell anybody.

Dr Stoate: Welcome to my world.

Q31 Chairman: You are saying that a hearing test is treatment.

Mrs Thomsen: No, the hearing aid fitting is the treatment. The hearing test is the diagnostic test. Generally, on their visit with ENT, the treatment is the fitting.

Q32 Dr Taylor: So if people are listening to this—and it is being broadcast—we are going to bring the whole ENT service to a halt by these referrals.

Dr Low: To be fair—not that I speak on behalf of Government—they recognised that. The whole point of this plan is that there was anxiety that the 18-week target, that whole scheme, is likely to fall into disrepute and fail because ENT will be swamped with patients and will fail to meet the target and people will say, “There is a target set and we did not even meet it.” There is an understanding that that is exactly what will happen if there is not a robust plan in place.

Q33 Dr Taylor: I am sure we will be tackling the Minister on the 18-week target in detail. Moving on, we have talked quite a bit about Modernising Hearing Aid Services already and I am absolutely

delighted to hear you, Ruth, say it has been fantastic. Is that so across the whole country? We have heard yours is an outstanding department. Has it helped the less outstanding departments, the run-of-the-mill ones?

Dr Low: Every single audiology department, every outreach clinic was modernised over the period from 2000–05. Every member of staff was trained, digital hearing aids became the standard and those have improved in quality over the time. The purchasing agency at the NHS has done a good job of putting a contract in place which is escalating the technology as it becomes available. So, yes, it is universal. The evidence that we had at the time we were involved with the Department of Health, showed that those departments that had long waits before the modernisation were the ones which had problems afterwards and the good ones before, like Charing Cross, were the ones which performed to the highest level afterwards.

Q34 Dr Taylor: It was phased in, was it not?

Dr Low: That is correct.

Q35 Dr Taylor: We were one of the lately affected areas and so I had lots of complaints then. To be fair, I have not had complaints about it really since. That was a success as far as it went. Obviously, as these digital hearing aids became more and more widely used and their effect and their benefits were appreciated, there was a tremendous surge in demand. Should that have been forecast and action taken to prepare for that demand?

Dr Low: We are very fortunate in this country because the MRC have some excellent epidemiologists in hearing and audiology. They have predicted that in the UK about two million people have a hearing aid and six to six and a half million would benefit immediately from having one. There are other people with hearing loss who might not fit into that.

Q36 Dr Taylor: Two million with and six and a half million who still need them?

Dr Low: No, in total. There are another four to four and a half million to go. If you are getting a poor quality hearing aid that is not working very well and everybody knows that, you are not going to bother going to your GP. If you have a friend who has a nice, modern, digital hearing aid and you are aware when you speak to them that they are communicating well, you will think, “Maybe it is time for me to go and do something about it.” So, yes, absolutely, there will be a surge in demand, and the epidemiology predicted it.

Q37 Dr Taylor: One thing I have always wanted to know and maybe Mr Murphy can answer, is however it was possible to reduce the price from £2,000 to about £70?

Mr Murphy: First of all, I do not know where the price of £2,000 came from. The average price for a hearing aid in the private sector is just over £1,000.

Q38 Dr Taylor: Some of my constituents at that time were quoted £1,700 or that sort of figure. At £70 each, is industry covering its costs or are these loss leaders?

Mr Murphy: The £70 is the price direct from the manufacturer. At one stage we are talking about a retail price and at another stage we are talking about a manufactured price.

Q39 Sandra Gidley: Why is there such a mark-up?

Mr Murphy: It is not a mark-up as such. The hearing aids that are £70, we pay in excess of £300 for. The mark-up is not £70 to £1,100. Most of the cost of dispensing the hearing aid is service. If we could buy hearing aids at £70 or whatever the price was, our prices would come down immediately on the high street.

Q40 Sandra Gidley: Are you saying that every time somebody has a hearing aid fitted privately they are getting £800 worth of service?

Mr Murphy: It depends. There are prices from £500 up to £1,500. The average price is £1,000.

Q41 Sandra Gidley: I think I know what I will do if I lose my seat at the next election!

Mr Murphy: The real comparison is the retail price with the wholesale price, so it is not £70 to £1,000; it is £70 to £280. The commercial price that retail companies are paying is well in excess of the NHS's price.

Dr Low: The NHS is the biggest single purchaser of hearing aids in the world and is therefore able to command extremely competitive prices.

Q42 Dr Taylor: Do these marvellous devices mean that people actually wear them? With the old ones, you had people continually fiddling to get rid of the noises and then they threw them out. Do they wear them?

Mrs Thomsen: The patients obviously used to fiddle a lot. The digital hearing aids have very clever technology. It is like a whole computer inside a small hearing aid. The majority of the digital aids available on the NHS have no volume control: they automatically adjust according to the environment. Some patients do need a volume control because their hearing fluctuates but the majority of the hearing aids have various programmes for certain listening environments and they adjust automatically. No matter what hearing aid you fit to a patient, you will not give them back the hearing they were born with. You have to look at the whole needs of the patient. You cannot just put something in an ear and say, "Okay, off you go." You need to look at their communication needs and support it with rehabilitation, explaining expectations, talking about adaptation time for getting used to the hearing aid. You also need to follow them up, to make sure it has been fine tuned appropriately. There is an infinite number of settings on these digital hearing aids and you need to have a good working knowledge of the software you use to programme them in order to utilise the best to match each patient's needs. One hearing loss can look

identical to another, but the patient's perceptions and needs can be very different and you need to tailor make for that. You need to look at supporting them in their environment as well, connecting with social services for things like doorbells, television aids and things like this, and also looking at the social aspects. Obviously a lot of people come because they have become very isolated and you need to try to encourage these patients back into the world, to get them back out there hearing and listening and having the confidence to start living their lives again.

Q43 Dr Taylor: So they do wear them all the time because they are so very good.

Mrs Thomsen: No. I sometimes say they are a bit like shoes: it is quite nice to take them off when you get home. If you have something in your ears all the time, it is quite nice sometimes just to take them out and give yourself a little rest. If a patient is sitting reading and they do not need to be listening for doorbells or telephones, then they have the advantage and they can have that lovely, quiet, peaceful time to read. Some people still feel the stigma. They are still embarrassed. There is still that area of "I don't want people to know." I have to say, however, that over the last five to seven years that is really, really reducing. That is not now, like it used to be, a huge hurdle to get over, with the help of the companies developing different colours, making them look more like mobile phones, and the fact that the word "digital" is in there seems to help a lot as well. When they see the knowledge and skills needed to fit it with the software, they realise and take it on board and do try. MHAS, when they rolled out the digital service, talked about this as well. It was not just about the product and what you were fitting; it was looking at the whole patient and making sure you met their communication needs.

Dr Low: Some of the modern hearing aids that the NHS are fitting have data loggers built in, so you can tell how much the person is using it and at what kind of setting.

Q44 Mr Penning: Big Brother.

Mrs Thomsen: It is, yes.

Q45 Dr Naysmith: I would like to ask Mr Murphy a few questions about the public/private partnership. I know his company is involved with it. Do you think it has been a success?

Mr Murphy: We think so. The positive from the whole thing is that it was a good motivation for our staff. I think we broke down some of the barriers between the independent sector and the public service. Our skill levels increased. We learned a lot from procedures that we had to perform. We processed through our branches nearly 40,000 patients, who got a flexible high street service. The report from the MRC, Professor Davies, was very positive. We were measured as having better outcomes than the NHS were supplying at that time and, also, we had a better service to the client on the high street, in convenient areas. We learned a number of lessons that we have now put into

8 March 2007 Dr John Low, Mrs Ruth Thomsen and Mr Jeffrey Murphy

commercial practice, so it was worthwhile from that point of view. We measure outcomes better and we had an experience with some geographical locations. There were some lessons to be learned. We made a major investment in software. The hospitals have two operational systems to deal with patients. That was a challenge for us. One of the software systems did not have an import/export system to remove patients' names and we had to invest a large amount of capital in that. We invested in branches and staff and, because of the size of the contract and the length of the contract, we probably never got that investment back. From our point of view, in all, 60,000 patients went through the service, we dispensed on time the correct instrument and had a very good outcome from it. I think it was a major success.

Q46 Dr Naysmith: Why is it that quite a lot of the evidence we got in was quite critical of the public/private partnership? Perhaps I could put to you some of the things that were said. "It cost more than National Health Services." "Half the patients treated by private providers ended up seeking further rehabilitation from the National Health Service." "Some people were paid for work that was not done." What do you say about these criticisms?

Mr Murphy: The only evidence I have seen is the report done by the MRC. There are anecdotal comments—and I have seen some of the evidence—that we did not experience. We had a very tough contract. There were compliance levels that were higher than some of the hospital levels and we complied with those compliance levels. We complied with the service times, we delivered our contract on time.

Q47 Dr Naysmith: Are you suggesting that it was some other company? Because it was not just one firm that was involved.

Mr Murphy: No, the other company that took part had a similar experience. There were some peripheral contracts around the PPP in which we did not participate, so it may be they are referring to that. Officially, from reports and feedback from the RNID who managed the project, from APASA who awarded the contract, from the MRC who did the research I have not had those comments in the PPP. As I say, there were other contracts that were done independently by hospitals and they may come from that.

Q48 Dr Naysmith: That will be published when our written evidence is published but it is already available now, I should think.

Mr Murphy: I have seen some of it.

Q49 Dr Naysmith: The Academy of Audiology was one of the bodies.

Mr Murphy: I have not seen their evidence. Charing Cross talked about PPPs being done in hospitals. In the contract, we could not go into the hospital. On the PPP the specific contract was outside of the hospital in the high street, we did not work in the hospital, we did not work with hospital staff, so

some of the evidence that I have seen does not refer to the PPP. I think it refers to the contracts that were outside—and there were a number of them—where hospitals contracted separately with independent audiologists. That might be the reports from there. Certainly the evidence in the PPP does not show that. I can only comment on the PPP because we did not participate outside.

Q50 Dr Naysmith: The costs of the PPP activity exceeded the marginal costs of treating the patients in the NHS by at least a factor of two. You can draw the conclusion that the programme should be considered as a temporary stop-gap and then return to the NHS. Is that an unfair statement?

Mr Murphy: I think it is unfair. The evidence does not show that. John may make a comment.

Q51 Dr Naysmith: I am going to ask Dr Low in a minute.

Mr Murphy: I cannot comment. All I have seen is that there was a document that showed the estimated cost of providing the service in ENT. It had three procedures and hearing aids which came to a sum that was greater than the cost of the PPP. I do not believe the PPP was at any other cost than a cost-saving to the hospital.

Q52 Dr Naysmith: Dr Low, would you like to comment on these matters?

Dr Low: Yes. There has long been animosity between audiologists in the NHS and people who fit hearing aids privately.

Q53 Dr Naysmith: I will ask the NHS audiologist in a minute!

Dr Low: Yes, I am sure. As you will have seen from the evidence from the Hearing Aid Council, the current regulation of the profession of audiologists is "not fit for purpose". That is their expression and I am not sure I would go quite so far. It is an entirely different training route for the two. When this contract with the independent sector was put in place, the regulator of the independent sector would not regulate their activities while providing NHS services. Therefore, the clinical governance, the responsibility, had to be taken by the head of audiology in each hospital. Some of them did it very well; some of them did it less well. It is very difficult for an NHS head of audiology to manage a private sector contract. It is very important that these large-scale contracts have the appropriate clinical governance and have the appropriate quality systems. But there is no doubt that the MRC's measurements showed that the private sector was capable of fitting routine cases—not the specialist difficult cases but routine cases—to a standard which at least matched that of the NHS. The cost of those contracts is very similar to the proposed tariffs inside the NHS for a similar activity and the volumes were relatively low. I believe that if the volumes were higher, an even better commercial arrangement would be entered into. I do not think there is a huge difference between the private sector and the NHS delivering in an acute care setting.

Q54 Dr Naysmith: Ruth, do you have any experience of managing a private contract?

Mrs Thomsen: Yes. We had PPP come into Charing Cross. Like John said, we are very good at looking for money, finding it and implementing it, and they offered us some services through PPP. We had reservations but we had a waiting list and we had patients who wanted a hearing aid fitting as soon as possible. We chose a company where we felt confident because the trainer within that company was NHS trained. It was a stick-to-your-own feeling. Our PPP was fine. We had issues about data collection. We still have issues about data collection. We have not had the facts and figures through from the company yet.

Q55 Dr Naysmith: Do you mean there were not proper records kept.

Mrs Thomsen: No. They kept them but to make it compatible with our service, we just have not had them yet. They have been sent; they were incompatible. It is a logistical issue. Historically, I think there has been a problem of them and us between the dispensers and the NHS audiologists. I have worked on both sides of the fence—not in dispensing instruments but in manufacturing, so I have produced instruments for the private market as well. I think the private market has a role to play. We welcomed PPP when it came because it really filled a stop-gap of doing those waiting lists. My main concern with the Hearing Aid Council and the fact that that is changing over—and I welcome that and I welcome that they are looking at proper state registration for hearing aid dispensers. It is the maverick side of it I have real concerns with. That in terms of, probably every week, maybe every fortnight, because I see patients every day, I listen to another sob story of some kind.

Q56 Dr Naysmith: What can we do about it?

Mrs Thomsen: The Hearing Aid Council and dispensers are getting their shop in order. They are looking at a foundation degree, they are looking at a uniform qualification, where people can then become state registered and the boundaries will break down between the NHS and the dispenser. There will be a proper qualification in place that will be recognised, and we can work with that and go forward, but that will not be in place until later. They are looking for bids for foundation degrees now, so the foundation degrees will not start until September 2007. The foundation degree is a two-year degree, an “earn and learn degree” as they call it, where they are part-time, so they will be working under someone else but they will not be qualified for two years. It says here that in 2008 they will be coming. It will be 2009 when they are fully qualified. They will be in the workplace, working under supervision. One of the main concerns I have is that the supervision is at the end of the phone sometimes. That is a real concern for me.

Q57 Dr Naysmith: Do you want the last word, Mr Murphy?

Mr Murphy: Yes. I think what you are asking for can probably be done by contract. The compliance levels can be put in the contract, as it was with the PPP. I do not share Ruth’s opinion of what happened. We did not do a PPP at Charing Cross. I would be interested to find out who did it, but we did not have that experience. We believe that within the contract of the current PPP there is enough regulation and compliance levels and targets for the NHS to get the service up they are paying for. I think we have delivered it.

Q58 Chairman: With referrals to PPPs, you normally refer on to the independent sector. Is that normally done on the basis of the need of the patient? Obviously a medical intervention would be in the hospital. Are there different levels of referral? We had this debate last year, when we looked at the Independent Sector Treatment Centres, as to whether they get all the cherry picking.

Mrs Thomsen: There were very strict criteria. It was the basic, direct referrals or the patients who had been through the system already—because, as you can imagine, every patient who had a hearing aid needed changing over. A patient is a patient for life. We had their medical records, their details, and if we knew it was a basic hearing loss due to the ageing process then that would be generally quite straightforward patient so they could test, fit, follow-up. If we had good GP letters which gave us the proper details of the patient, we could see no other underlying causes and they had followed our protocols that had been sent out for referral, then we could triage those letters and obviously put some new patients their way as well. I would just like to say that I think it was unfair for PPPs in a way because they were in short bursts. I think the contracting is great, and if you have really stringent rules and regulations when you put into place these contracts, that is great, but if there are problems you need to give them time to be ironed out. The PPP came and went when the ring-fenced money went and the RNID stopped it. A lot of the anecdotal evidence I have gathered on PPP—which is not great because people will always moan rather than tell you the good stories—is stuff that could possibly have been sorted out, but then the PPP contract was finished, and you did not have time to put those checks and measures in place and address the quality issues that you did not get when you were running those contracts.

Q59 Chairman: The referral was your referral, as opposed to the choice of the provider.

Mr Murphy: Yes. The referral came from the hospitals. They decided who would be referred and they referred through to us. Also, when the ring-fencing went and the money was not available, the majority of hospitals continued to use our service and gave it additional contracts, so that, from the commercial point of view, proved that we were doing a good job. As I say, the majority of hospitals carried on and found the money from other sources,

8 March 2007 Dr John Low, Mrs Ruth Thomsen and Mr Jeffrey Murphy

so they were motivated to find the money from another source to carry out a contract that would reduce their waiting lists.

Q60 Dr Naysmith: The academy said something like 50% had to have further treatment after they had been to the private sector. That is a very strong criticism. Is there any truth in that?

Mrs Thomsen: We were very lucky with the girl we had at PPP. She was very professional, she was well trained. She was not educated in any way near the level of the audiologists working in our department. but she was in our department and we were able to liaise with her and iron out any problems immediately. A hearing aid patient is a patient for life, so the 50% that were seen again may have needed more fine-tuning.

Q61 Dr Naysmith: But the contract was just at an end, and they could not go back to the original one, or what?

Mrs Thomsen: If the PPP contract had finished, then obviously they will move back. If they are our patients, they will stay our patients. Hearing loss is progressive. Their hearing may have changed, they may have needed extra fine tuning or, for one reason or another, the person who was fitting them in PPP may not have had the skills and the knowledge in rehabilitation—which you get in the NHS, because you have been fitting digital hearing aids for a long time to people.

Q62 Dr Naysmith: That is really a matter for a contract in the future, to make sure that is picked up in the contract.

Mr Murphy: Ruth is saying that the person they had doing the PPP was working in the hospital. I think people are talking generically about a PPP. Under the actual PPP contract, we could not work in the hospital, so that dispensation was not part of the PPP. Generically there were other public/private partnerships. That number cannot be correct. Outside of the PPP—whatever you would call those contracts—maybe there were 50% referrals, I do not know, but Ruth did not experience a PPP. Generically, she did, but the PPP contract was not carried out in any hospitals, so those submissions are not about the PPP, in my opinion.

Q63 Mr Amess: Do not start falling out with each other.

Mr Murphy: We love each other.

Q64 Dr Naysmith: They are not falling out.

Mr Murphy: We will have a love-in later! This is fine. We are all friends.

Q65 Mr Penning: At this stage I need to declare an interest. I am part of the campaign for fairer pensions for our servicemen who have had hearing damage while in the Armed Forces and I compliment the RNID on what they have been doing there. Could I quickly go back to Mr Murphy, and these huge profits—whichever way you want to swing it—that are being made by companies selling

hearing aids in the private sector to my constituents and others. The profit margins are quite huge. I am a great believer in the market and competition driving down prices. It has worked in other areas, in opticians, why is this not being driven down in your area? Are my constituents and others being ripped off by these costs?

Mr Murphy: They are coming down.

Q66 Mr Penning: They have not come very far, have they?

Mr Murphy: Digital introduction has reduced prices by £200 or £300 per hearing aid over the last two or three years.

Q67 Dr Naysmith: And the costs, you have admitted, are coming down as well. Why is that not being passed on?

Mr Murphy: The costs have not come down the same. The NHS buy 400,000 hearing aids a year and they are paying £49.

Q68 Mr Penning: There is a marketplace out here.

Mr Murphy: Yes.

Q69 Mr Penning: There is competition in the marketplace.

Mr Murphy: Yes.

Q70 Mr Penning: You all basically charge the same.

Mr Murphy: That is the average selling price.

Q71 Mr Penning: Throughout the market, you charge the same. Why is the market not driving this price down? Why are you still being allowed to have 400% or 500% mark-up on a hearing aid which costs the NHS 70% and you say it costs a couple of hundred pounds to you?

Mr Murphy: It costs £200 or £300.

Q72 Mr Penning: You are earning thousands out of it, so why?

Mr Murphy: The market is, from the point of view of the size of the market, supplying the market and the cost of getting the hearing aid to the patient. For example, there are lots of products where the service is the most expensive part of the product.

Q73 Mr Penning: Every company which is selling this in the private sector has exactly the same costs and exactly the same overheads and no one is willing to undercut anybody else.

Mr Murphy: There is undercutting. There is marketing promotions, there are price—

Q74 Mr Penning: I am very suspicious. Could I take you on to private sector involvement. I was very conscious of a little whisper that went on between Dr Low and Ruth Thomsen to do with post cuts and position cuts and frozen posts. Could the NHS cope with the waiting lists without the private sector involvement? In the light of the fact that you are losing posts and then saying it is great having the private sector coming in, if you were not losing posts

8 March 2007 Dr John Low, Mrs Ruth Thomsen and Mr Jeffrey Murphy

would you be able to cope with waiting lists, with that investment coming in to you rather than going into the private sector?

Mrs Thomsen: I would love for the Government to have faith in its modernisation process and really carry on with the investment and put the correct number of audiologists to patients in the NHS. We have developed a fantastic BSc degree and we are looking at a foundation degree to have the appropriate skill mix. I think hospitals are generally well placed for patients. The transport systems all run in there. We operate in three or four centres in West London. We go out to the patients. We are in the community. We fit in local GP centres and we do home visits. The wait for our home visits is three to four weeks.

Q75 Mr Penning: You could increase your capacity of treating patients if your posts were not being cut, your posts were not being frozen, and the money came to you rather than going to the private sector.

Mrs Thomsen: I cannot see why it is so much better to go somewhere else when there has been no data to say that it can provide a cheaper solution or it can provide a more cost-effective solution. I think we have had four fallow years with the BSc degree and no audiologists coming through. We have had no earn and learn. Audiology has been on the list for people to come in from outside the UK to work and we have benefited greatly from that. We have had some very well educated audiologists from different parts of the world come to work with us and share knowledge. But I have worked in the Workforce Confederation in building up these degrees, in making sure that the training is appropriate, that there are clinical placements and that we have built a workforce for London in the Strategic Health Authorities I was working with, and there are no posts for these guys to go into.

Q76 Mr Penning: We have qualified, dedicated people being trained by the NHS at taxpayers' expense who cannot find a job. You are laying people off and then we are going to the private sector to employ people. In a nutshell, that is where we are, is it not?

Mrs Thomsen: Absolutely. And the degree is funded.

Q77 Mr Penning: We are losing capacity within the NHS.

Mrs Thomsen: We are putting people through four year degrees which are fully funded degrees—

Q78 Mr Penning: And then cutting the posts at the end of the day.

Mrs Thomsen: We have spent all this money in education and there is no jobs for them.

Q79 Mr Penning: That is fascinating.

Dr Low: I think it matters not where the patient is seen. I am interested in large numbers of people who are waiting to get a hearing aid to have a significant improvement in their quality of life, and I do not

mind whether it is done in the private sector or in the NHS. Honestly, I do not. It is not an issue for RNID as an organisation.

Q80 Mr Penning: I completely agree that what we need is patients treated. I am concerned about whether the capacity with the NHS is being cut to fund the private sector use within the NHS. We are all agreed on the principle. Especially as a Conservative, I very much just want patients treated and it is whether the taxpayers' money is being wasted at one end to facilitate a private sector involvement at the other.

Dr Low: If you will forgive me, I will make one comment before answering your question. That is that most people want to receive a hearing aid in a convenient location. They do not need or want to go to an acute care hospital to receive a hearing aid. They would not go to an acute care hospital to get a pair of glasses.

Q81 Mr Penning: That is an argument for having it moved into private care—on which I would probably agree with you.

Mr Murphy: To answer your question: the NHS does not have the capacity. There are half a million people waiting. It fits around half a million people a year. That is about a year's worth stacked up in the system and there is no way that the NHS is able to raise the capacity, increase the capacity by any means to eradicate that list, to bring it down within the 18 week target by the end of next year.

Q82 Mr Penning: Dr Low, we said earlier on that the capacity within the NHS was being cut. Posts are frozen. You said that in your evidence earlier on. We are not saying that they could do everything which is in their capacity within the 18-week list. Are you saying that you are happy for posts to be cut so that the NHS has involved more private sector. Are you saying that the capacity that is there you are happy to lose, so that more people come into the private sector.

Dr Low: That is not what I said. The action plan has a whole number of things that need to be done to achieve the target of bringing the waits down under 18 weeks. I said earlier in my evidence that each of those are important but the most important item of them all, because it has the biggest capability of bringing huge additional capacity, is to contract with the private sector where there is existing capacity and there is the potential to bring on stream more capacity more quickly than the NHS could do it. I do not think posts should be frozen in the NHS. Of course they should recruit the degree qualified people who are available and they should do everything in terms of skill mix, new technologies and so on to increase efficiency and capacity in the NHS, but even doing all of that will not be enough. More will be needed.

Q83 Mr Penning: You have indicated it would not be enough but we have capacity there. It is of concern that that is being lost. I can image where you are

8 March 2007 Dr John Low, Mrs Ruth Thomsen and Mr Jeffrey Murphy

going to come from, Mr Murphy, but I will ask the same question of you. Could the NHS cope without you?

Mr Murphy: They have up until three years ago. From our point of view, we are only here saying that if there is a capacity problem we can help, we have the resources. We have no comment really on what should be done on posts or what should be done in investing in the NHS's training. I would welcome it anyway. A healthy NHS service helps our business. We all want patients to be treated in a timely manner. On what the NHS should do about their capacity: yes, please, increase it. All we are saying is that, if there is a short-term need, we can invest in the capacity in a different way and we can deliver an effective, compliant, cost-effective service.

Q84 Mr Campbell: Specsavers have suggested that the system is failing. It is failing in delivery, in speed of delivery. They are a private outlet. What is your concern there? You are saying people would like to go everywhere but Specsavers are saying it is not working.

Dr Low: I am not sure I fully understand your question.

Q85 Mr Campbell: Specsavers is saying the current system is failing on speed and delivery. That is a private company saying it is failing. You said before that people are going to go anywhere but they are saying it is failing.

Dr Low: Yes, but they are saying the NHS is failing. They are not saying they are failing themselves.

Q86 Mr Campbell: The current system, anyway. I am not sure if it is saying themselves. People are very demanding now: they want speedy service. They should be saying that but they are saying that the current system in which they are involved is failing.

Dr Low: Specsavers are not involved in providing the NHS services at all. They have never been involved in any of the contracts, as I understand it. They have a huge appetite and a huge growth programme in terms of hearing aid services and I know that they would welcome the opportunity to fit NHS patients. I imagine you have to read their evidence with that perspective in mind.

Q87 Mr Campbell: Would an optical place, like Specsavers, be a proper place to have hearing aids fitted?

Dr Low: We have experience of private companies fitting NHS patients with NHS digital hearing aids and the feedback from the patients was very positive. They liked the experience of being able to go into a shop on the high street and get their hearing aids rather than having to go out to an acute care hospital where they have to wait as part of a kind of "sick patient syndrome" in the NHS. They like that. They like the access.

Q88 Mr Campbell: Would you agree with that?

Mrs Thomsen: We gave our patients the choice. We informed them that if they wanted to they could take part in the PPP and be seen by a private dispenser

working within our department. A lot chose not to do that, even though they knew it was within our department. I am sure those who chose to go to the high street were happy because that is what suited them. We try to meet the patients as close to their local environment as possible. I do think audiology should be out there in the community. You are not sick if you have a hearing loss but you do have fundamental communication needs. I do not always think the delivery of a hearing instrument is all there is to it. There are often other quite significant problems that need to be dealt with. The patient needs to be dealt with holistically and not sold a pair of glasses as they walk out.

Q89 Mr Campbell: Why should Specsavers be saying that they are failing to deliver? Why should they be saying this?

Mrs Thomsen: I do not quite understand who is failing. Are the NHS failing?

Q90 Mr Campbell: I presume that is what they are saying. I thought they were saying it was the whole system.

Mrs Thomsen: I have outlined my reasons in the NHS why there are long waits in the NHS. I think there is a lack of investment in audiologists in the department. The skill mix is not quite there. We have redeveloped the way we are educated and trained. Unfortunately that all happened as a result of the introduction of the Modernised Hearing Aid Services. I think there are areas covered by audiology departments which geographically are very large. Getting all those patients in is a big problem and there are some big waits and that is where PPP have been able to come along and help. Probably there are not enough audiologists in the country to see all the patients and that is why it is on the list to bring these people in. What is good and is hopefully going the right way is that we are looking at educating and training and putting these things in place. But they take time. You cannot teach someone in a week. The BSc degree is four years with a one year clinical placement, so that we do have them in the department and we do have them working, and the foundation degree will be a minimum of two years. That has not started yet. In order to get the education levels up to match the technology that we are using in the ever-changing world of medicine, we cannot expect everybody to be fitted straight away, we just do not have those reserves. We are very fortunate that we have some excellent audiologists coming in from overseas to help us out.

Q91 Mr Campbell: Jeffrey, would you like to comment.

Mr Murphy: I have not seen their submission, but Specsavers are a spectacle company. I presume they do not have enough information of the hearing aid market to make a significant statement. That is my opinion. I do not think the system is failing. I think there are capacity issues, and, as I said before, the PPP has gone a long way to go to show how that can be resolved.

8 March 2007 Dr John Low, Mrs Ruth Thomsen and Mr Jeffrey Murphy

Q92 Mr Campbell: I am pleased to hear that. We can write that question off. Do you believe that vulnerable people who obviously will have to go and get hearing aids in the private sector could be looped up to get an upgrade when that is unnecessary?

Mrs Thomsen: I think they have very strict contracting rules because that has been a concern. I hope it will be the case that if they are going for an NHS fitting that is what will happen. I am sure the big companies will keep their houses in order and make sure that they deliver according to the contract to fit in NHS aid. There are issues about the cosmetics of hearing aids. Some NHS centres fit small ones in the ears but the majority of the digital hearing aids are still behind the ear. If a patient chooses to buy a hearing aid, that is their choice. Not during the PPP—it would be unfair to insinuate that, because I think the contracts were rigorously followed and the companies were very, very careful to keep their house in order during that period—but I do hear sob stories where a little old dear has maybe answered an advert in the newspaper and someone has knocked on her door, got their foot in the door, and sold them a hearing aid in the living room. That practice is checked by the Hearing Aid Council—which is disbanding now—but it is not allowed in the majority of countries in Europe. It is legislated against. There are possibly only two other countries in Europe where this knocking on a door and selling a hearing aid in someone's home is allowed. I think that is really not very nice. That is the sort of sob story we get time and time again.

Q93 Mr Campbell: Dr Low, do you have anything to add?

Dr Low: We know that hearing loss increases with age. Roughly 60% of people when they are over 60 have a hearing loss; 80% of people over 80 have a hearing loss. We know it is a phenomenon which increases with age. If you cannot hear very well, the chances are that by the time you have gone to do something about it, you are quite vulnerable. You do not know what you need. You do not know what kind of hearing aid to buy. You cannot go to *Which* magazine and choose because it needs professional advice. You are depending on the person who is advising you to advise you well. Occasionally in the private sector people have behaved badly. I have to say that they have tried as a sector very hard to eradicate bad practice but the Hearing Aid Council is controlled by the Department of Trade and Industry. It is a consumer protection issue and does not come under the remit of the NHS. Frankly, I think the two should come closer together. But we must protect the vulnerable people in our society. People ought to be able to hear well, regardless of whether they are wealthy or not. Everybody should be able to get a good quality hearing aid, well fitted, regardless of whether they have money in the bank or not. If they have money and they want something fancy and so on, that is great. If you want to get one immediately and you want all sorts of extra things, that is brilliant, but we must protect the vulnerable in our society.

Q94 Mr Campbell: Jeffrey, have we been behaving badly?

Mr Murphy: Not that I know of. Going back to your question, if there was an independent procurement, the contract in the PPP protected the patient more so than under the Hearing Aid Council. We had compliance issues; we had to follow the hospital procedures. I think the patients would be safe. From a practical point of view, we had to measure outcomes, and the reports that were published summarised that the patient was safe to go into the PPP. They are vulnerable patients. My answer would be that the contract, if it is continued, would protect the vulnerable patients and it did.

Q95 Chairman: Ruth, when we talk about 40% unemployment of graduates, where did the 40% go?

Mrs Thomsen: I interviewed one two days ago.

Q96 Chairman: Do they go into the independent sector?

Mrs Thomsen: He did not. The figures with the 40% are a little bit premature, in that there is only one cohort of students from Manchester that has exited this year. There is one lot of students educated to degree level at Manchester exiting this year. This summer there will be nine universities with students exiting. That is when the big concern comes. I am a little concerned that if they go directly into the private sector they will not get nurtured and grow and benefit from the crystallised thinking that you get when you come into a hospital department with lots of research and development and testing going on. I do worry about these people going into the private sector, a bit like opticians, and then just fitting hearing aids day in, day out. I have seen the adverts for the private sector jobs. They want people to work from eight to eight, 12 hours a day. This is for the contracting for the independent sector treatment centres. Be it for four days a week, fitting hearing aids day in, day out is not a good way to go.

Q97 Chairman: We could have that debate about a surgeon, because I would like to go to a surgeon who was doing what I needed every day, all the time. I would know then that I would be getting somebody who was experience and skilled.

Mrs Thomsen: Yes. I would not like to be that person's last patient at the end of the day.

Chairman: Let us leave that. It was just this issue of 40% of graduates then not doing anything. In actual fact, it is public money that trains them but they may go and work elsewhere, not in the public sector. That is what I was trying to get to. Could we move on.

Q98 Sandra Gidley: I have a question for Ruth. In your statement you commented that, when bidding for NHS contracts, private companies hide some of the costs. Are you able to elaborate on that?

Mrs Thomsen: Yes, we did go through the PPP. We went through the RNID to contract those services I think it is a location issue and I think it will be an issue that comes up, whereby they were unable to find premises to operate their PPP in the vicinity we were in. That was Hammersmith & Fulham,

Kensington & Chelsea, Westminster. I think they were unable to rent properties or premises with a soundproofed room that would meet our criteria for fitting hearing aids. There were none around. If there were, they were in private hospitals, and probably the fees were too high. The company we were using were operating through Boots. Boots was around the corner, but they were very busy with their own private patients and would not make room for the PPP so it came under our umbrella. They came to work in an audiology department we have, a small outreach hearing aid centre in Kensington. In these very affluent areas it is going to be very difficult for PPP to want to invest in premises and property, because the overheads are so high, so we bore the cost of that in order to get the patients seen.

Q99 Sandra Gidley: You are saying that they took the money and you bore some of the expense, in effect.

Mrs Thomsen: Yes. And our receptionists met the patients, our receptionists dealt with all the problems on the phone. There was another phone number but we were the local people. They wandered in.

Q100 Sandra Gidley: Were you able to charge for those services?

Mrs Thomsen: No. It is a very special contract. We said, "Let's have some rent, then. Let's income generate" because we are always told to do that, and we were told that it was not on the table, it was not an area on which we could negotiate.

Q101 Sandra Gidley: Would you like to comment, Mr Murphy?

Mr Murphy: I have no knowledge and I am quite surprised by what you are asking. We never experienced any of that. Every patient went through our private branches. We never went into the hospital. We had no costs to the hospital at all. In fact, at the end of the story, we probably subsidised the whole thing anyway, because we never got our investment back, but we had no experience of difficulty finding property. We have 120 branches in the UK anyway and 90% of the population were within our branches, so I cannot comment. I have no experience of that at all.

Mrs Thomsen: I can imagine it would also be a problem in high cost areas.

Q102 Sandra Gidley: Clearly it would be something to watch out for and maybe specify in future contracts.

Mrs Thomsen: Absolutely.

Q103 Sandra Gidley: Presumably you will be bidding for the new contracts when they come up. You said you had not recouped your investment yet, so is this an opportunity?

Mr Murphy: Yes. We would like to bid and try to recover our investment.

Q104 Sandra Gidley: That is fair enough. We have had some evidence from opticians groups who seem to be trying to muscle in on the act—I am not quite sure why. They have said that if private companies are only used short term to get rid of the backlog then this is just a short-term fix, in effect, and they would need to be involved longer term because the problem will recur. What is your comment on that statement?

Mr Murphy: There is a short-term fix if the waiting list was dealt with as a block to get rid of the hump. I think private companies and private contractors would scale up and invest to do that. If you want my opinion, I think it would create more demand. I do not think it does go away. I think the hard of hearing, once they realise there is a good service, will respond to it. I think the evidence was with the PPP. With the first contract, we talked about 30,000 patients, but when we got there it ended up to be 60,000 because the demand was there from the audiology departments, the demand was there from the clients. Short-term large movements of the waiting list are financially sustainable if the contract is at the right price and it is at the right length of time where you could scale up and get a return on investment, but, going forward, I think the demand will always be there. It will create more demand. Between the NHS with investment in audiologists and ourselves with investment in private procurement, I think that is the answer, and that is the long-term answer. Optical companies probably think it is close to spectacle provision. I do not think it is, but that is probably why they are making the submissions. I think we would welcome any type of contractor that would have capacity and could deal with the contract, why would the Department of Health not welcome that as well? I am sitting here thinking that I do not see an issue with anybody who could fit the compliance level, could meet the targets and could meet the contractual issues. If they are *bona fide* and are selected, that is okay.

Q105 Sandra Gidley: Is it a case that if there is no promise of continued involvement, then that is a disincentive to investment?

Mr Murphy: Yes. Depending on the length of the contract, people would scale up, and then if there could be a return on the investment, yes, there would be people out there. I think that is the key: there has to be a return on the investment. We learned that through the PPP. There is investment. It does not come free. There are investments in staff, property, software, hardware and if the contract was of a certain size you could get a return on investment there would be an appetite from commercial organisations to try to win that contract.

Dr Low: I would like to point out that this is not just a bulge; we do not have a one-off problem that needs to be fixed. Demographics are changing so we know that the number of people presenting is increasing but also, there is this huge unmet need and, as the waiting times come down, we know more people will present. There are 4.5 million people who do not

8 March 2007 Dr John Low, Mrs Ruth Thomsen and Mr Jeffrey Murphy

have a hearing aid today who could benefit from one. So there may be a bulge but it is a small one. There is an ongoing problem. There is an interesting debate to be had about where audiology services, hearing aid services, should be delivered from in the long term. Many people have the view that it would be better delivered in a relationship like optics rather than the current arrangement, where it is done in acute hospitals. As I say, from my own point of view, I do not mind where people are fitted provided they are fitted well and in a safe environment but the optical industry has a vision and many in the private sector have a vision that they would like to see the same thing happen with hearing aids as happened with optics.

Q106 Sandra Gidley: Looking at a graph provided by the Department of Health, it was very flat-line up until the advent of digital hearing aids. That bulge seems to be partly accounted for by the transfer and it does seem to be flattening out again but at a higher level. Is it the case that more people are coming forward because something is better? Do people not realise they are deaf, in fact?

Dr Low: Yes, there are many people who just do not acknowledge that they have a hearing problem. The issue of denial is enormous. The people who suffer, if I can use the word, are often the partners, the family and the work colleagues rather than the individual themselves. It is when the TV is blasting away. You know your diagnostic techniques are not very sophisticated. There is a huge unmet need and a denial, and the stigma has not gone away: "I am old, I am decrepit, I now have a hearing aid," whereas we accept reading glasses in our forties is just part of ageing and we get on with life. We are working hard, as are others, to change, this public health campaign to change attitudes. We established a telephone test so that people could test their hearing on the telephone.

Q107 Sandra Gidley: I have done it.

Dr Low: That is just to try and encourage people to think about their hearing and to take better care of all of their health, not just the bits that are popular.

Q108 Sandra Gidley: So really, we need some sort of assessment of what the problems are going to be in the future before we can plan the services.

Dr Low: I suspect the Department of Health will be able to give you more evidence in that area than I can.

Mrs Thomsen: Since we were modernised, we collect patient information at the touch of a button. I can tell you how many are waiting, how many are waiting for this, I can divvy the information up however you want it. Every audiology hearing aid centre has a computerised patient management system now. That information is there. People just have to ask for it and we can give it to them. I would also say that hearing loss generally due to the ageing process is progressive and an awful lot of direct access patients we get have a very mild loss that is not

helped by a hearing aid. We do not then say goodbye; we often look at other areas in which we can counsel them and help them through. It is not just about hearing aids. Again, it is looking at the whole patient and their needs. If a patient did not need a hearing aid but maybe could be benefiting from something else, then we would look at that. It is not just about hearing aids. Hearing aids are not like receiving glasses. They really are not.

Q109 Dr Stoate: You talk about the parallels with optical dispensing.

Mrs Thomsen: I do not!

Q110 Dr Stoate: That is the question really. You would not agree therefore that there could be a system whereby you go and get a prescription, like you can with your optician, and then have that prescription filled by anybody, not necessarily associated with the same firm. In other words, would there be such a thing as a hearing prescription after an audiology assessment which you could effectively get filled anywhere?

Mrs Thomsen: The basic hearing test that you would get when you first come to a hearing aid centre would be pure tone audiometry where we put little sounds in your ear and find out what is the quietest sound you can hear. If that is tested in a soundproof room, in the proper environment, using the proper techniques, then that audiogram can be transferred from A to B. It is not always done like that; if it is a busy high street Specsavers shop or somewhere like that, then the soundproofing has to be there as well. Therefore it needs to be viable to have that there. The person doing the test needs to be . . . It is a subjective test. You are relying on the patient to tell you whether they can hear it or not. Performing a hearing test is not like sticking electrodes on and you have a measurement for an ECG. Diagnostic audiology, a lot of the time, is subjective; you need to be aware of the correct techniques in terms of testing and coercing the information out of the patient in terms of the results.

Q111 Dr Stoate: Can I stop you there, because my point is, could you envisage a situation where people went for a properly skilled audiological assessment, on exactly the lines you are saying, and effectively come away, having seen a top audiologist, with a prescription saying this is what they need and perhaps—I am not saying I agree with it—is there a case to be made for saying "I have this prescription, I can go to Jeffrey Murphy's company and have that prescription filled"? Is that a realistic proposition or not?

Mrs Thomsen: I would not like to see that happen.

Mr Murphy: It actually happens in Germany and France . . .

Q112 Chairman: That is a different point, Ruth. Seeing it happen as opposed to being a realistic prospect are two different issues.

Mrs Thomsen: I think the person fitting the hearing

8 March 2007 Dr John Low, Mrs Ruth Thomsen and Mr Jeffrey Murphy

aid needs to be educated to a decent level. They still need to understand the whole basis of hearing aid provision. The profession itself is so small, to start chopping it up into little bits in terms of somebody does the test and somebody fits the hearing aid—I have seen it work. I have worked in other countries and I have seen it work there but they are all incredibly bored.

Q113 Dr Stoate: But it certainly happens with spectacles. Jeffrey, are you saying it could happen?

Mr Murphy: It happens in Germany, it happens in France, it happens in Italy, it happens in most of the Continent, where a prescription is issued by an ENT or in France I think they have changed it to a general practitioner, and then the client is free to go to whatever high street hearing aid dispenser he or she

wants to go to. The system certainly works in Europe. From our point of view, we would welcome that system in the UK.

Q114 Dr Stoate: It could happen and people would get a good service?

Mr Murphy: Yes, and they get a very good service on the Continent.

Chairman: Could I thank you. There are two things I would like to say. First of all, the evidence that has been referred to on several occasions has not yet been published because this is a one-off inquiry. It will be on the website some time next week. A report coming out of today's hearing is likely to be after Easter. Could I thank all of you very much for coming along and helping us with this short inquiry today.

Witnesses: **Mr Ivan Lewis, MP**, Parliamentary Under-Secretary of State for Health; **Mr Nick Chapman**, National Director, 18-week Target, Department of Health, **Professor Sue Hill**, Chief Scientific Officer, Department of Health, and **Ms Helen MacCarthy**, Director of Facilities Management and Utilities, NHS Purchasing and Supply Agency, gave evidence.

Q115 Chairman: Good morning. Welcome to our second evidence session this morning. I wonder if I could ask you if you could just introduce yourselves and the positions that you hold for the record.

Ms MacCarthy: I am Helen MacCarthy from NHS Purchasing and Supply Agency.

Mr Lewis: Ivan Lewis, the Minister for Care Services.

Professor Hill: Sue Hill, Chief Scientific Officer, Department of Health.

Mr Chapman: Nick Chapman, National Director, 18 Weeks, Department of Health.

Q116 Chairman: Could I actually start around that area about 18 weeks and really, I suppose it is to you, Minister. How can you justify keeping assessments of fitting of hearing aids outside of the 18-week target?

Mr Lewis: First of all, Mr Barron, can I say that I am delighted to make my first appearance before the Select Committee. I am a former member of the Committee. I can see one or two people are still on the Committee. I take accountability to this Committee incredibly seriously. The situation is—and I think in a way, in the context of the announcement we made this week, and a lot of people were not aware of this—there is already a commitment and an expectation, both, that the NHS will ensure that nobody waits for more than six weeks for an assessment by March 2008. So that is already an expectation that is out there in terms of what the NHS understands to be required. What this does really is it goes beyond that and says, for the 50% of people who are not covered by the 18-week target, which is a target which is about all the way from assessment to fitting in the context of audiology, that we are not prepared to tolerate excessive waits for those people, because 50% who go straight to ENT, who require highly specialist services, are already covered by the 18-week

target. What this week's announcement did was supplement the commitment to a six-week maximum assessment for everybody, irrespective of how specialist their problem is, by saying that we believe, with modern technology, quite a number of people could have their hearing aid fitted literally on the same day as the assessment and that the vast majority of others should only have to wait literally for a few weeks. It is complicated, and it would be much simpler to be able to say every single person is simply covered by the 18-week maximum but, because 50% of those who need audiology were excluded from the 18-week target initially, the Department's position, understandably, is if we start adding extra things into the 18-week target on a regular basis, it makes a mockery of the target. It creates instability and it sends out messages to managers and others who are expected to implement these changes which are inconsistent.

Q117 Chairman: Could I say, Minister, with all respect, this is about as clear as mud to me. We have had a written submission from the Department in relation to this, dated 8 February, where in 3.6 it talks about "The NHS Improvement Plan set out an ambitious new aim that by 2008 no one will wait longer than 18 weeks from GP referral to hospital treatment." We have had evidence earlier that says if we were to try and meet those targets in that timescale, we would never do it because the system would be in absolute chaos because of its inability to handle such a target. What is the reality? I am just confused about how we are going to move from where we are now, which my understanding is we get some waits after the initial referral and the initial test that go on sometimes for over a year or even two years, looking at some of the areas, before the hearing aid is fitted—obviously, this is the initial

8 March 2007 Mr Ivan Lewis MP, Mr Nick Chapman, Professor Sue Hill and Ms Helen MacCarthy

stage—which would never be able to fit round any of the targets we have from the evidence laid in front of us for today's inquiry. What is the real story?

Mr Lewis: First of all, the real story is that when we committed ourselves to the introduction of digital hearing aids and did the modernisation project in partnership with the RNID, in my view, there was no serious analysis or assessment of the consequences of that for demand. If you look at the graph in terms of waiting times and waiting lists, the irony is it is very flat and then suddenly, exactly coinciding with the time when we were embarking on this modernisation programme, when we were saying we were going to offer people digital hearing aids, waiting times and waiting lists rocketed. If you want my honest opinion, Mr Barron, there was little, if any, serious anticipation of the consequences of making that commitment. In the partnership that we had with the RNID, which was excellent in terms of that modernisation programme for the 0.75 million people who benefited from it, there was simply no anticipation of the strain that that would put on the system and the expectations that that would give to people. If I can just go back to your specific question, there are essentially two groups of people who access audiology services. There is a group of people with specialist, complex hearing conditions and they tend to be referred to ENT specialists. That group of people is already covered by the 18-week target. There is then 50% who essentially go, either through community health professionals of one kind or another or, more likely, a GP, who go straight to the audiology department because it is believed that their problem is not that complex or not that serious. It is that 50% essentially that we would not have been changing behaviour in the NHS to ensure that that 50% saw a massive slashing of the waiting times for those individuals. The announcement this week, coupled with the commitment that is there anyway for everyone that, not the fitting but the assessment—let us be clear—for everybody, must be everywhere in the country a maximum of six weeks by March 2008. The framework, alongside that commitment, in our view, means that the 50% of people who would not technically be covered by the 18-week target because they are not going through ENT will see, in every part of the country—and we will make this happen; this is a commitment from us to make sure the Health Service honours its responsibility in this area—will see waiting times and waiting lists slashed. The other thing I would say to you is, if you look at the variability of performance across the country in terms of PCTs and Strategic Health Authorities, there is no excuse for the excessive waiting lists and waiting times in some areas. The NHS has taken its eye off the ball to some extent. Audiology has not been given the priority it deserves. Alongside that, to be fair to the NHS, the demand, because of the new technology, because of medical advances, has shot through the roof.

Q118 Chairman: What research has been done to make sure you can hit this 2008 target? I think you have explained to us that there has been little

research done before the modernisation programme was put into place. Do we have any evidence of what is likely to happen between now and then?

Mr Lewis: The research that has been done is into a number of things: first of all, identifying best practice within the NHS in terms of pathways all the way from referral through to fitting: in areas where it works, why does it work, how do they organise their system, how do the different professionals work together, how do they make best use of technology and how do they make most efficient use of resources? That is one issue. There has been dialogue with the SHAs in terms of we can see massive variations in performance about what will be needed to achieve this very demanding target that we have placed on the system as a consequence of the new framework. As you know, we have said to them that there is the opportunity to procure, we believe, if you look at the capacity issues, our assessment is up to 300,000 additional pathways that would need to be purchased in order to meet demand and to get these waiting lists and waiting times down. What the SHAs have said to us, Mr Barron, is that is fine, but they want to be absolutely sure in terms of, first of all, their in-house capacity, whether they are making best use of their in-house capacity, because many of the SHAs acknowledge that frankly, they are not necessarily making best use of their in-house capacity. But then, very soon, we will be told by each Strategic Health Authority the number of pathways they believe will need to be purchased from the independent sector to enable them to slash these waiting lists and waiting times. So the research is about best practice in the areas where it is working but it is also about a very intensive dialogue, SHAs to PCTs to the Department, about the scale of the problem, the likely demand and how we close the gap in a very short period of time.

Q119 Chairman: Is there any measure about how long people will then wait beyond that in terms of, once they have had the initial test, how long they will wait for the fitting and everything else, or at this stage are we not too sure?

Mr Lewis: Our assessment is that over 50%, we believe, with modern technology that is now available could, based on best practice in areas around the country, have the digital hearing aid fitted on the same day as the assessment. The other 50%, we believe, also because of modern technology, should only have to wait a matter of weeks—certainly not months and certainly not years—from the stage when they have had the assessment to the point of having their hearing aid fitted, which is why we are able to be as confident as we are that these excessive, unacceptable waiting lists and waiting times can in a very short period of time be slashed.

Q120 Chairman: It is the case, is it, that currently, because of the excessive waiting times in areas, because a lot of hearing problems are in the elderly and it is something that deteriorates, that somebody will have an initial test at a cost to the British taxpayer, who then, because they have to wait a length of time, will have to have that same test again

8 March 2007 Mr Ivan Lewis MP, Mr Nick Chapman, Professor Sue Hill and Ms Helen MacCarthy

before anything can be done? It seems to me that to organise a system or for a system to be allowed to be run like that is enormously expensive to the taxpayer.

Mr Lewis: It is completely unacceptable and, based on the best practice in the best areas, unnecessary.

Q121 Sandra Gidley: I struggle with this 18 weeks. In the Department's submission it says it would not be appropriate for people who are directly referred to be covered by 18 weeks. I am sure the many thousands of people who are referred direct to audiology services cannot actually appreciate the difference. It is semantics as far as they are concerned. Why is it not appropriate for direct referrals to be treated in the same way, with the same targets, as those who are going via an ENT surgeon? Are you not actually putting in a perverse incentive for people to inappropriately refer?

Mr Lewis: The point is that before the publication of this framework and this clear new policy framework for the way audiology needs to be done in the NHS, that perverse incentive was absolutely at the core of the potential problem, that because those referred directly to ENT would be covered by the 18 week target and others would not, the system would say we might as well refer directly to ENT because that is the way were going to get our patient the quickest treatment in the most effective way. I believe the publication of the framework this week, this new policy for audiology in the NHS, will actually put an end to the danger of that unintended consequence. In answer to your question, there is only one answer I can give you because it is a straight answer. There were a number of things excluded from the 18-week target when the judgement was made about what treatments and the definition that ought to fall within the 18 weeks and this was one of them. If you then go back to the NHS and say, "Having looked at this, we are going to include this category of patients. Having reconsidered it, we're going to include another category patients," before you know where you are, you are essentially destabilising the system. That is the answer, but I genuinely believe and the expectation that has been made very clear to the NHS is, it has to be acknowledged—and this is not a new announcement; this has been an expectation that the NHS has had since 2005 that the maximum six weeks for assessment everywhere for everybody, whatever the nature of referral, which they have known about since 2005. Our point is—and I have these sheets to hand round later which explains the modern technology—if you look at the modern technology, as I say, there is absolutely no excuse, once you are able to achieve a maximum six-week wait for assessment, that you cannot then move to get the digital hearing aid fitted either immediately or very soon after.

Q122 Sandra Gidley: You said 50% could be done on the same day but in the short term, if there is a political imperative to do the diagnostics within six weeks, are you not creating another unintended consequence, where all of the effort is put into hitting the target and people just have to wait; despite the

fact that it can be done, the time constraints mean that it will not be done and people end up having to wait longer for a fitting if we are not careful. What is being done to prevent that happening?

Mr Lewis: What is being done is that the Department, the Strategic Health Authorities, and the PCTs are making absolutely clear that that would be entirely unacceptable and that audiology has been elevated this week to one of the NHS's priorities. If you want me to be very frank, I suspect that until very recently audiology was not seen as one of the NHS's top priorities. So every SHA and every PCT now understands that there will be accountability, there will be transparency, there will be performance management and there are the resources in the system—let us be clear about that—to enable them to slash waiting lists and waiting times. The proof of the pudding will be in the eating.

Q123 Sandra Gidley: You said there were the resources in July of last year. On 25 July Lord Warner said 300,000 new service areas for assessment fittings and follow-ups would be provided. You have just alluded to that. Nothing has happened since July. When is it going to happen?

Mr Lewis: It is going to happen . . . Sorry.

Chairman: You have just jumped down the agenda by about six questions.

Sandra Gidley: I am sorry. You can answer it later.

Q124 Dr Stoaite: I think you have a Herculean task on your plate. You said you believed the capacity exists to make a big difference but we have heard this morning from the RNID that the NHS does approximately half a million fittings a year. There were approximately half a million people currently waiting, in other words there is a year's worth of work currently in the system where people are waiting for a fitting. We also heard that there is potentially 6.5 million people in this country who actually suffer hearing loss sufficient to require a hearing aid should they make themselves available to have one fitted. In other words, the task is immense. I am very concerned that you seem to think that the NHS can somehow cope with all this within existing resources when we are hearing from lots of people, including witnesses, including in written submissions, and including the previous people we talked to this morning, that that is pretty unrealistic. How do you think you are going to achieve it?

Mr Lewis: I think we have demonstrated in areas where they work in an integrated way in terms of the different professionals that are involved in responding to this problem. We have slashed the cost of the whole process from referral through to fitting in an amazing way, from thousands of pounds to, I think, an overall cost of £260 for the entire process. We have already put significant amounts of resources into the system for this purpose. I really have to link Howard's question to Sandra's question. The reason that we have not yet proceeded with the tendering is because what the shareholders and the PCTs are saying to us is "We want to be absolutely certain that the amount of pathways you

8 March 2007 Mr Ivan Lewis MP, Mr Nick Chapman, Professor Sue Hill and Ms Helen MacCarthy

tender for are necessary because we do not believe that at the moment we are getting maximum use out of our existing capacity.” That is linked to this as well. But you are right. Howard makes the point, and you did, Kevin, that demographic factors are a reality in this area of policy as they are for the rest of the NHS and indeed for social care. People are living longer and longer, they have more more complex conditions, disabled people are these days having fuller lives, all of which is a good sign in terms of the kind of society we want to live in, but that does place new questions on the NHS, on social care, on public policy generally, that we need to reflect on and we need to ensure that we have a system that can genuinely respond to those demographic pressures and those demographic realities. I cannot today say to Howard and any other member of this Committee that it is not a challenge, because it is a challenge but what I am trying to say is that the levers and incentives and accountability that we have now put into the system, and the capacity that is available, we believe will lead to the slashing of waiting lists and waiting times for audiology in the NHS in every part of the country, which will also lead to greater equity. The inequity in terms of waiting times and waiting lists depending on where you live in relation to audiology cannot be acceptable, nor is it consistent with the NHS’s values.

Q125 Dr Stoaite: The worry is that you are setting yourself up for a fall, and the reason I say that is because currently GPs can use the system either by referring direct to ENT to get into the 18-week target or to audiology if they feel that audiology is working in their area. I do not yet see what disincentivises GPs from doing that. I know your aspiration is for a six-week audiology assessment and, hopefully, a one-stop fitting, and that would be wonderful if it happened but in areas where, let us be honest, that is not going to happen, at least, not very quickly, GPs are simply going to say, “We will have to go down the ENT route because that way I can at least guarantee my patients a fair service” and you will not get GPs simply trying to play fair, if you like, by what you are trying to do, because they will see in their patient’s interest which way to go.

Mr Lewis: I have a much higher opinion of your colleagues than you do, Howard.

Q126 Dr Stoaite: They are fighting for their patients and their patients will get a better deal if they go the 18-week route.

Mr Lewis: One of the things that is clear is where there is a good relationship between GPs, between primary care and audiology departments and ENT within acute hospitals, the quality of the service, the nature of the response, the waiting lists and waiting times are in much better shape. So one of the challenges for PCTs particularly is to ensure that not just they look at this as hitting a target but that they reorganise the nature of their service and the contribution of the respective professionals to ensure that in each locality they have a sensible system, but the consequence of everybody’s intervention is significantly reduced waiting lists and

waiting times for patients. I am an optimist; maybe you are less optimistic. That is the nature of politics. The other point I want to make today is I personally and the Department along with the RNID will be monitoring progress. We will not simply be publishing this document this week, appearing before the Select Committee and then moving on to the next agenda item. We will have to monitor progress on an ongoing basis to make sure the system is shifting, and shifting quickly on this issue.

Q127 Dr Stoaite: The problem with optimism is that the definition of optimism is it is someone who has not heard the bad news yet. That is the difficulty.

Mr Lewis: I am a Manchester City supporter, Howard. I do know the bad news.

Q128 Dr Stoaite: Clearly, one of the ways we are going to achieve this target hopefully is through a better skill mix. We have talked to witnesses before about improving skill mix. Why has that not happened yet? Why do we have to have this inquiry? Why has the skill mix not already been sorted out to try and increase capacity? Why are you talking about aspiring to improving capacity? If you can improve capacity, why have you not done so?

Mr Lewis: I can only take responsibility for the period for which I have been responsible but the reality is I do not think the NHS and in fact, to be fair to the NHS, the Department or our partners in the voluntary sector anticipated the explosion in demand as a consequence of the modernisation project. The explosion of demand has implications for resources, it has implications for waiting times and for patients. It also has major implications in terms of work force. To be fair though, if you look at the commissioned number of places in training, for example, for audiologists, there has been a significant year-on-year increase. You may want to ask me some questions about this but in terms of the number of training places that have been created now and will be coming through over the next few years, because obviously, as you know, the time lag between training, qualifying and being fit to practise is significant. We only started really investing in significant new audiology training places in a relatively recent period of time and the first graduates are coming out around now. So let us be clear. Audiology, I guess, was not one of the NHS’s most important services, and that is reflected across the board; it could be regarded as a Cinderella service. In my view, the inability to hear properly is about people’s quality of life. It is about their ability every day to function in their family, in their community, in their place of work, in society. It is massively important. It is not a minor issue. That is why I would say to you, all I can say is yes, clearly, it would be a nonsense for me to sit here today and say things could not have been done better and could not have been planned more effectively over a period of time. It would be a nonsense for me to say that, but my job now is to address the failings and weaknesses in the system, recognizing what levers I have to pull in a ministerial position because in the end, we do not want every PCT and every hospital

8 March 2007 Mr Ivan Lewis MP, Mr Nick Chapman, Professor Sue Hill and Ms Helen MacCarthy

and every doctor's surgery in the country—we need to be clear about that—but we do have a duty to put in place the levers, the incentives, the accountability framework to make sure that people with hearing impairments get the service that they deserve from the NHS, which in some parts of the country they are currently being denied.

Q129 Dr Storate: That is certainly very encouraging. So what you are really saying now is you are honestly able to say that audiology services are now a much higher priority in the NHS than they previously were?

Mr Lewis: The judgement I would make about that is, would a chief executive in an SHA or a PCT regard their responsibilities on audiology to be one of the things that they need to be keeping a very regular close eye on? That is how I would define my answer to your question, as well as the ability then to engage with the professionals on the front line, to get the professionals to work together, to believe the commitment is real, they will have the resources and we can make it happen. If that is the question, the answer is yes.

Q130 Chairman: We will wait with interest to see how this best practice spreads throughout that particular part of the National Health Service over the next few years, Minister. Could I just say, because it is not specific in the report but we have had evidence which will be published next week on the website, from the National Deaf Children's Society. Do you look at the issue of school-age children and waiting times differently to the general customer? It is normally obviously demographics that determine the need.

Mr Lewis: I have to be honest with you. I think we do look at it differently because the basis of the data I have for the Committee on this is minimal. So it is clear to me that we do not have anywhere near as much hard data on this issue as we could or maybe should have and we need to review that as a consequence of this process. What I will say to you, Kevin, is two things. First of all, the fact that we now test newborn babies in terms of hearing is a fantastic step forward and, as a result of that, we are able to get in really early with thousands of babies and prevent a deterioration which could end up in a far worse situation. I also believe anecdotally, by speaking to professionals on the front line, that even now, with the difficulties, in practically every health economy children with hearing problems are prioritised in the vast majority of cases. On the other hand, the caveat is I do not have as much hard data as I would like to give you cast-iron guarantees.

Chairman: It is just the issue that denying somebody of my age to hear better is a lot different to denying a five-year-old the ability to be educated like all their peers.

Q131 Dr Naysmith: Good morning, Minister. Welcome back to the Committee. I hope you are enjoying it as much as you used to enjoy it when you sat here!

Mr Lewis: I am waiting for David to speak before I can answer that.

Q132 Dr Naysmith: We are saving him till last today. Obviously, all the things you have been planning and announcing this week, you are not going to be able to manage to do it without the private sector, I suspect. We have had some experience of collaboration between commercial firms and the National Health Service and the so-called public-private partnership. Do you think it has been a success?

Mr Lewis: In this area? Overall, frankly, the modernisation programme, we spent £125 million, did in the end benefit three quarters of a million people. I think it is fair to say that those people regard that as a success and that the private sector's engagement with that really was significant and we would not have been able to do it without them. I also believe that, in terms of our ambitious programme to get the situation under control within a relatively short period of time, we will need to be able and willing to work in partnership in a sensible way with the private sector. I would say to you, Doug, that if you look at the national framework that was set out in terms of working with the private sector, it also meant we were able to get incredibly good value compared to how much we were paying previously. I know there have been one or two exceptions to this, and I will try and explain why, because some local NHS organisations have gone out and worked with the independent sector separately to the national framework that we have actually created and set out. Wherever that national framework has been used by the local NHS, the economies of scale, the efficiency of outcome is indisputable. Where some local NHS organisations have decided to engage with the independent sector themselves, I am afraid to say they have got a far worse deal off them, it has cost a lot more money and the outcome has not always been as good for patients as it should have been.

Q133 Dr Naysmith: We heard that this morning from the private sector representative very clearly. He said he did not recognize the criticisms that I am going to put to you now but we have had evidence, which unfortunately has not yet been published but it will be next week, witnesses saying that the costs to the National Health Service by using the private sector were twice the costs of doing things under the National Health Service, and that there were cases of work being paid for and not being done, because the patients were not supplied—that brings memories of things that have happened elsewhere in the system—and also that there were needs for re-referrals and so on that were not part of the initial contract. We need to wait and see exactly whether we are talking about the sorts of things you were saying, ad hoc arrangements and not under the contract, but we need to be sure that these contracts are properly tied up, do we not?

Mr Lewis: We do. I would say to you that variability in performance in this area is not necessarily about public or private, and I think there are arguments to

be had in other areas of public-private sector partnerships where there has been shoddy performance, etc, where you might say part of the problem is the private sector is new to it, they do not have the capacity, they do not have the expertise, and they do not invest the resources. In this area I think it would only be fair for me to say that I think a lot of the variability in performance is not about whether it is public or private.

Q134 Dr Naysmith: I wonder if I could ask Ms MacCarthy, because we have heard that you had some concerns in the supply Purchasing and Supply Agency about the public-private partnership. Is that true?

Ms MacCarthy: No. We have not had any negative feedback at all to suggest that the public-private partnership that we put in place at the national framework level that the Minister has described about the performance that has been provided, which is why we were saying earlier that there are instances where those private partnerships exist outside of that framework and we therefore encourage that governance comes back under the framework and we have that kind of control and monitoring and governance in place to make sure that those sorts of things do not happen.

Q135 Dr Naysmith: Were these ad hoc arrangements encouraged by the Department but not overseen by the Department, the ones that were not part of the public-private partnership?

Mr Lewis: I would not imagine so. I can write you on that.¹ I cannot be definitive. I think what we would encourage is for people to use the benefits of us having done a tremendous amount of work nationally to get this guidance or framework right to say to the local NHS use that, because that has delivered. It can demonstrate how you get quality outcomes but equally, it demonstrates how you can get amazing value for money compared to what has been done previously. I would not imagine we have ever been in a position where we have been encouraging them to do their own deals with the private sector outside that framework, no. It would not make sense. The only other point, obviously, if somebody, for example, gets an assessment on the NHS and then is so frustrated and is waiting and then chooses clearly to purchase the rest of the service in the market, the costs can be excessive. There is no doubt about that. That is clear, is it not? If you look at where this is done outside of the NHS, where it is not about the NHS commissioning from the private sector, people can end up paying an awful lot of money.

Q136 Mr Campbell: The Hearing Aid Council has stated that the regulatory framework for dispensing hearing aids was not fit for purpose.

Mr Lewis: Was this recent?

Q137 Mr Campbell: I believe it would be recent because they are going to be abolished shortly, are they not?

Professor Hill: The Hampton review has been reviewing a number of arm's-length bodies sponsored by the Department of Trade and Industry and the Hearing Aid Council is one of those. The Hearing Aid Council has been looking at ways in which private sector hearing aid audiologists will be trained in future, and indeed, in partnership with higher education institutes, they are introducing from this year a new foundation degree.

Q138 Mr Campbell: It says here “... unregulated professionals, coupled with a lack of common standards of education” of these people. Is this sour grapes on their part? I know there are going to be abolished, but why should they say “not fit for purpose”?

Mr Lewis: All I can say is that obviously, we believe that the regulatory framework that is in place is appropriate to secure protection, minimum protection, for patients and to ensure that we support best professional practice. We are not going to sit here and say as far as we are concerned the regulatory framework is flawed. That organisation is probably going through a period of change, from what I gather, and they may genuinely be concerned about what that change is going to mean in terms of protection, and I think they are entitled to say that if that is how they feel, but we are certainly not, in my view, leaving the system so unregulated that we are putting patients at risk of a poor service.

Q139 Mr Campbell: I am beginning to wonder, if it is, could this affect the running of the PPP?

Mr Lewis: There is a whole series of things that will affect it. Obviously, regulation is a very important factor in ensuring standards, protecting patients and making sure that there is accountability.

Q140 Mr Campbell: So when the Hearing Aid Council goes, what regulation will be in place? What organisation will take its place?

Professor Hill: There have been ongoing discussions between the Department of Health and the Department of Trade and Industry about the future direction for the Hearing Aid Council. The discussions have been considering private sector hearing aid audiologists being regulated by the Health Professions Council, which regulates a number of professions who also practice in the independent sector. Those discussions are ongoing, so that there would be a seamless transition from one regulatory arrangement into a new regulatory arrangement. The Committee will be aware that we recently published the White Paper on regulation of both medical and non-medical staff, and those discussions will continue now that that work has been outlined.

Q141 Mr Campbell: What you are saying is that we really do not have anything to worry about and that “not fit for purpose” may be a bit over the top?

¹ Ev 125

8 March 2007 Mr Ivan Lewis MP, Mr Nick Chapman, Professor Sue Hill and Ms Helen MacCarthy

Professor Hill: I think the White Paper also made reference to Hearing Aid Council and those hearing aid audiologists, so in terms of the regulation of the professionals' practice.

Mr Lewis: We are not going to leave the system without adequate regulation. It may be done differently.

Q142 Mr Campbell: That is what I am trying to get at.

Mr Lewis: It may be done differently but we would not leave the system without the appropriate regulation. I think that is the message.

Q143 Chairman: It will come under the changes that will come out of the White Paper that was published two weeks ago now?

Mr Lewis: Yes.

Q144 Mr Amess: Welcome back, and welcome back to the hot seat. Those who were colleagues of yours when you were on the Select Committee can certainly vouch for the fact that you took your duties very seriously and, as you have said, you regard this as an important occasion and, whatever the background to it is, I am delighted that an announcement was made on Tuesday. I think you have been brilliant in your tactics this morning. The wind has been taken out of the sails of the Committee by you very cleverly and very sensibly more or less agreeing with all our concerns. I really do congratulate you on your approach. I would simply caution, however—and I will come to Mr Chapman in a moment—that in a year's time, if you have delivered on all these aspirations, marvellous, but in a year's time, of course, this ploy may not work so well. I do not know you, Mr Chapman, and I do not know how much you are paid or whether you are going to be here in a year's time. We have the Secretary of State for Health who is going to resign if everything is not sorted out financially. I do not know what you are going to say but you are going to have a bit of a challenge with Bromley, where they are waiting two years—I am sure you have been on the hotline there—Plymouth, 108 weeks; Mid Staffs, 104 weeks. These are big, big challenges for you, are they not?

Mr Chapman: Certainly I would accept that, both in the context of 18 weeks overall and for patients waiting for audiology and hearing aids, yes, we have a big challenge, as the Minister said earlier on. What we know is that, in order to ensure that the appropriate attention, either in terms of redesigning the way that patients go through the system or in terms of resources, or work force, flows from good data, and good data about the extent and nature of the problems that exist in different localities. During the course of last year we instituted the first proper national data collection and modified that in October to ensure that we were capturing better information about long-wait patients. I have been involved in discussions with every SHA about their plans for hitting the diagnostic milestones that the

framework talks about and 18 weeks, and serious planning around the levels of activity that are needed to reduce the numbers of patients currently waiting.

Q145 Mr Amess: You share our Minister's optimism?

Mr Chapman: I share my Minister's determination.

Q146 Mr Amess: I would like to be privy to the conversation at the end of this session! To get back to our Minister and Lord Warner, who decided he wanted to retire, my colleague earlier got on to this particular issue with the statement that he made about these 300 patient pathways being procured. Could you tell the Committee what progress has been made?

Mr Lewis: Yes. First of all, welcome back to you as well, David. Nothing has changed. The thing is, first of all, in response to your original comments, I do not think any Minister should be in denial about reality, and what is real is that we spent £125 million, we benefited three quarters of a million people who got hearing aids who would not have got them if we had not done that, and prior to that there had been no modernisation whatsoever of audiology in this country. Having done all of that, we still have thousands of people waiting too long for their treatment and we have a duty and a responsibility to do something about it. That is what this is all about. On the pathways, essentially, we are ready to procure but the SHAs and the PCTs are saying to us "Hold on a moment until we are absolutely certain about our in-house capacity and if we did things better and differently within our areas we may not need you to procure 300,000 pathways." However, if we find that they are not actually able to back up that perspective with a great deal of evidence, we are still going to say to them "We believe we need to get on with the business of procuring that number of pathways." We have to respect the fact that they are saying to us they think if they can do things differently in some areas they can do this in-house, which would reduce, if you like, the number of pathways we would have to procure from the independent sector. The commitment from us is that there is up to 300,000 there to procure, and you are right to make the point about timing because, frankly, we are going to need to move on this relatively quickly and we are at the end of our period of dialogue with the SHAs on this and we expect them within a matter of, hopefully, a couple of weeks—not months—to be definitive in their position on how many pathways they think they can deal with within their existing organisations and how many will be necessary to procure from the private sector to meet these new requirements we have placed on them as a result of the framework we published this week.

Q147 Mr Amess: So, putting it in context, which I think we have all been listening to carefully, for very good reasons, nothing has really happened.

Mr Lewis: On those pathways.

8 March 2007 Mr Ivan Lewis MP, Mr Nick Chapman, Professor Sue Hill and Ms Helen MacCarthy

Q148 Mr Amess: Yes. Again, you have been honest. Just before I get to the main question, I just wanted to tip you off that when you were going for it and saying fitting these hearing aids on the same day and it is all going to be done very quickly, there was a bit of grimacing behind you in terms of the practicalities of that happening. I have no expertise in fitting these things but—

Mr Lewis: Who was grimacing?

Mr Amess: There may be a bit of concern.

Chairman: All the audiologists in the audience.

Q149 Mr Amess: I have to tell you, Minister, we nearly had audience participation this morning, where a representative from Specsavers wanted to put his hand up to join in one of the responses. It is worth reading the transcript on this. Will individual commissioners be free to decide whether they want or need to commission services from the private sector, and will there be any central commissioning of private sector involvement for these 300,000, which obviously you have now put in context?

Mr Lewis: Can I just be clear about the different involvements with the private sector that have gone on? We need to be clear about sequence. There was the first public-private partnership, which was about the modernisation project, and that basically ran from October 2003 to 31 March of this year. That is one stage of this. Phase two in terms of diagnostics procurement—and this is already agreed, so this is not about the dialogue we are currently having about the 300,000 pathways—40,000 audiology pathways will be procured between 2007–08 and 2011–12 per annum. That is already committed to and that is already taking place. The way that the tendering will take place on stage three, if you like, would be that we would issue a spec and we would ask providers to bid. The successful bidder would then be the provider that the local NHS would do business with. As I understand it, we would not really be encouraging necessarily the local NHS to enter into their own arrangements with the independent sector. We have heard today, I believe, that where that has happened in the past, it has not always worked out in a very satisfactory way. On the other hand, I have to say that if a local PCT chief exec said, “I could do business with a private sector organisation get my waiting lists and waiting times down incredibly quickly over a short period of time,” I am not sure that we could get in the way of that person who has the responsibility for making that decision. But our preference is for them to be absolutely clear about what is needed from the independent sector in terms of pathways, in terms of them being able to get these waiting lists and waiting times down in their particular localities, and then we will proceed with the national procurement. On the question of the people behind me—and I would be interested for you to name them privately later—let me be clear about this. I have brought to hand round the Committee an explanation of this new way of doing things, if I can. It explains in some detail in a technical way that I cannot explain, if I am honest. Essentially, we believe—and this is based, David, on what is happening in certain parts of the NHS right

now—that around 50% of those that end up being assessed and needing a digital hearing aid could, in the right circumstances, have that done on the same day. That is a major step forward. What this diagram attempts to do is explain to you why we know that to be possible. I agree in certain areas it will require them to reorganise their systems, their technology, the way they do this, but it most definitely is doable. That is the point. The other point I would make you is the other 50% who clearly could not have it done on the same day, because they will only be waiting a maximum of six weeks for the assessment, which is a major step forward, we should only be talking, as I say, about a relatively few number of weeks to move from that point to actually getting your digital hearing aid fitted. That is the grounds for optimism. It is not based on some fanciful hope, not backed up by evidence. I think there is hard evidence to believe that we can be optimistic and confident that we can get waiting lists and waiting times down in all parts of the country significantly.

Q150 Mr Amess: You are the chap in charge, and I think we salute you in your endeavours. I would imagine that when you chat privately, it is probably the human element in the practicalities of day-to-day management, I would guess. I do not know.

Mr Lewis: It is. You are right. In a sense, we are putting in place the levers and the incentives that central government should be putting in place to ensure that waiting lists and waiting times are slashed everywhere but, of course, we are dependent on the leaders and the managers and the front-line professionals to make this work in every health economy in every part of the country. But we do have confidence in them doing that and, as I say, I think what has probably changed as a consequence of this week is that if you are the chief executive of a Primary Care Trust or a Strategic Health Authority, you know that one of the items that is at the top of your list in terms of getting your act together where things are not going as well as they could be doing is audiology.

Q151 Dr Naysmith: Is this happening anywhere in the country? Is there a pilot? Can you give us the names of any?

Mr Lewis: Yes, there has been a series of pilots. I do not have them on me but we can certainly give you examples of where this has been deployed.

Q152 Dr Naysmith: Acoustic testing and fitting on the same day?

Professor Hill: Yes, this device has been tested in 12 sites in the NHS, including eight NHS sites that the Department of Health is working with and, not only looking at the benefits that new technology like you have in front of you can bring, we have also been looking at how this can be utilised in combination with greater efficiencies for better waiting list management, scheduling of appointments and also removal, for example, of some of the management and admin functions from qualified audiologists into a more central admin-based arrangement,

8 March 2007 Mr Ivan Lewis MP, Mr Nick Chapman, Professor Sue Hill and Ms Helen MacCarthy

improving the quality of referrals or the time that it is spent by audiologists supporting ENT clinics into a more manageable arrangement so that they can see more patients who are direct access patients. So it is looking at the combination of the technology—and this is one piece of technology, illustrating one type of open ear tip, used in predominantly mild to moderate patients. Another tip, the Comply tip, can be used in the more moderate to severe patient groups. So it is the benefits of the technology, streamlining the processes and matching the work force to that that has been trialled.

Q153 Dr Naysmith: And pre-selecting the patients?

Professor Hill: Yes, these approaches have been used on triaged patients but they have also been tried on new patients presenting to the service who have not been triaged at all.

Q154 Mr Amess: We are absolutely delighted that you have made audiology a priority.

Mr Lewis: I think the Select Committee helped us along the way. Can I describe these figures to you, which in a way illustrates the point. In the East of England the average wait for assessment in November 2006 was eight weeks. On the south-east coast it was 33 weeks. That is not about resources, in my view. It cannot be. That variation has to be about ways of working, prioritisation, focus. You cannot justify that level of disparity.

Q155 Mr Amess: Finally, in mutual admiration, I think, from our point of view, it is jolly useful to have two of the Health ministerial team who have been on the Health Select Committee, because you know the way we work and we do not want to waste our time and public money on having these inquiries and nothing happening. It is brilliant that it is appreciated and we can deliver on our report. Finally, the additional 42,000 pathways already procured by the Department: did you ensure the input of local commissioners in this? Why were NHS departments not able to bid for the business?

Mr Lewis: In terms of the 42,000, basically, that is specifically going to cover five regions, five Strategic Health Authorities.² They, in a sense, have worked with us and said that together we want about 40,000, and I suspect the answer to that question would be that they are the ones that said, in terms of our existing capacity, our existing organisational frameworks, the best way for us to make rapid progress in audiology is to actually do business with the independent sector. If they said that to us, we have to accept that. Other Strategic Health Authorities, looking at the next 12 months, two years, getting these waiting lists and waiting times down considerably, are saying “Actually, we have a pretty good service in-house and we think we can do

some of this through our in-house service getting even better.” That is what is holding up a decision on the 300,000.

Mr Amess: Thank you for your frankness. We wish you well and we look forward to finding out whether Mr Chapman is in his job in a year’s time.

Q156 Chairman: Before we move away from that, could I just ask you this. You say in five SHAs, so this is geographical?

Mr Lewis: On the 40,000, yes.

Q157 Chairman: We do not know where they are but on what basis were they selected as opposed to the other four of five SHAs?

Mr Chapman: They selected themselves. They said, “We want to take this forward.”

Q158 Chairman: So you did not look at the waiting times or anything? You have done this comparison between the east of England and the south coast; that was not one of the reasons why these shareholders were selected? Is that what you are telling us?

Mr Chapman: What I am saying is they were not selected; they selected themselves.

Mr Lewis: They said, “We need to do something about audiology in our region and the only way we can really do that effectively quickly is to procure from the independent sector. Can you do this in terms of 40,000?” But now we are having a dialogue, as you know, with all of the SHAs on this 300,000 and, to put it bluntly, if some of these worst performers come back and say they do not need any independent sector pathways, I do not think we would just say “All right then” and let them get on with it. We will be asking some hard questions about “You have not been able to shift this in-house so far, so how are you going to do it in the next 12 months?”

Chairman: I am trying to see this thing about decision-making being evidence-based in the National Health Service. I will keep trying.

Q159 Sandra Gidley: We heard earlier that, as a result of one of the private contracts, the hospital was the only place where some of the facilities could be provided. So effectively, NHS equipment and staff were used, unpaid, while the private provider took the money. What are you doing to ensure that that is not possible in any future commissioning?

Mr Lewis: Again, I cannot be absolutely certain, but from what I am aware of, this was an arrangement that the local PCT made with an independent sector provider outside of the national guidance and national framework that we issued, and in the national guidance and national framework that we issued, one of the things that we specify is the nature of the relationship between the NHS and the independent sector, the best practice, the outcomes, the value for money that can be achieved. Certainly, that should not happen in any circumstances. Clearly, I am not in every hospital and every PCT, so when you say what can I do to guarantee it, once we procure the independent sector pathways, the private sector starts working with the local PCT and

² *Note from the witness:* there will be five schemes across seven SHAs. South West SHA and South Central SHA will share one scheme, North East SHA and Yorkshire and the Humber SHA will share one scheme, and South East Coast SHA and South Central SHA will share one scheme. The West Midlands SHA and the North West SHA will each have their own scheme.

8 March 2007 Mr Ivan Lewis MP, Mr Nick Chapman, Professor Sue Hill and Ms Helen MacCarthy

National Health Service, frankly, it is managers' and professionals' job at a local level, engaging with the private sector, to make sure that that works properly.

Q160 Sandra Gidley: The former witness behind you is disagreeing with you when you describe the nature of the contract. So you are saying that this should not happen?

Mr Lewis: Can you explain to me what you say is happening, because I was not totally clear?

Q161 Sandra Gidley: We were told that, because some of the facilities provided are in effect quite specialised, you cannot just knock them up in the corner of Specsavers or whatever, in effect, the hospital ended up providing some of the facilities, such as the booths that they do the sound testing in and obviously the staff were used as reception staff—I am not clear whether they provided the testing—and that could not be recouped. There was no charging that could be made for that.

Mr Lewis: So what you are saying is the independent sector had the contract but they were using NHS facilities which they were not paying for?

Q162 Sandra Gidley: Yes.

Ms MacCarthy: The nature of the national framework, the PASA framework, for PPP that we heard Jeff Murphy talking about earlier, as he quite rightly described, is that that is provision outside the hospital environment, so we can only conclude therefore that the other evidence that you are hearing must have been something to do with a framework that they put in place with an independent sector provider that is not part of that overall national PPP.

Mr Lewis: The point that Sandra is making—Chairman, forgive me. Just let me be clear about this—even within the context of the national guidance and framework and best practice we have identified, could those circumstances arise and would they necessarily be a problem?

Ms MacCarthy: They should not arise, because the parameters that we have set into the framework are very robust in understanding the governance and the structures, and the reasons why we have put that framework in place is to support the NHS structure, not to compromise it.

Q163 Sandra Gidley: So this should be a one-off rather than something that is a problem?

Ms MacCarthy: Yes.

Mr Lewis: A note of caution. If part of the contract, part of the tender with the independent sector, is to allow them to use some of the NHS's facilities to deliver the outcomes—because that is what we all care about; we want to slash these waiting lists and waiting times—then frankly, we cannot comment on every single arrangement that is made at a local level. It may well be that if the NHS commissioner in that area made the decision that part of the deal with the private sector to achieve the outcomes—because that is, in the end, the bottom line, to reduce the waiting lists and waiting times—was to enable them

to use some NHS equipment, how can I sit here and second-guess whether that was the right thing for them to do?

Sandra Gidley: Hopefully, we will be able to have some written clarification on that possibly.

Q164 Chairman: Can I just intervene on that and say when we did our ISTC inquiry in the first phase, it was quite clear in those contracts: the additionality rule took place. Is that the same?

Mr Lewis: In principle, absolutely.

Q165 Sandra Gidley: As you have mentioned ISTCs, one of our criticisms of that programme was that there were no value-for-money assessments carried out. How is the value of private procurement in this sector going to be assessed? We have heard concerns that it is twice as expensive and perhaps does not represent good value for money.

Mr Lewis: I have been told that what our national framework and national best practice in terms of using the private sector demonstrates is that the cost per pathway from, as I say, assessment through to fitting should be around £270. The cost of the actual hearing aid is £70. We regard that, if you look at only a few years ago the overall cost of both the process and the hearing aid itself, as a remarkable slashing in costs for the National Health Service, and part of this is as a consequence, obviously, of the capacity, the volume, that we have been able to achieve as a result of the various procurements that have taken place and the modernisation programme.

Q166 Sandra Gidley: That was clearly a good piece of procurement but it is not actually the question I asked. I am asking how we assess the value for money in the private sector. We have heard evidence that it is costing about twice as much.

Mr Lewis: I have no evidence for that.

Q167 Sandra Gidley: It has not been assessed. That is the problem. We do not know the value for money.

Ms MacCarthy: If the question is around the current PPP framework, then the example we provided was exactly that; we have demonstrated value for money because those costs are coming out of that PPP.

Mr Lewis: They have come down massively.

Q168 Sandra Gidley: How was that provided again? Perhaps you can clarify.

Mr Lewis: Sorry, can I just be clear? You are not disputing the £270 but you are arguing that that may be more expensive than purely a process that went from assessment to fitting if it was done in-house by the NHS? Is that what your argument is?

Q169 Sandra Gidley: Yes. The overall cost seems more expensive.

Mr Lewis: Do we have benchmark evidence comparing a process from beginning to end that was pure NHS *vis-à-vis* this £270 per pathway?

Mr Chapman: We do. I do not have the detail with me.

Mr Lewis: What does it prove in a big picture way? That it is a lot cheaper or what?

Mr Chapman: The costs are broadly comparable.

Mr Lewis: We will write to the Committee on that issue.³

Q170 Dr Naysmith: Would it not be much easier if this were included in the payment by results system, and then you would be able to compare straightforwardly what it is costing the National Health Service and what it is costing the private sector? That would be much the simplest way to deal with it.

Mr Lewis: I think one of the things it says in the framework is that that is exactly the direction of travel we need to go in. The consideration of looking at a potential tariff for this going forward is something that we are now committed to doing but that is not where we are now.

Q171 Dr Naysmith: But you are probably moving in that direction? It would make it much easier for private companies to do bits of things.

Mr Lewis: Yes.

Q172 Dr Taylor: Minister, David's congratulations make me think I must be rather dense, because I really do not have these figures at all straight. I want to just try and clarify the figures. Lord Warner's announcement was an additional 300,000 service pathways per year for five years. The first thing is, how far have we got with that? The information we have is that funding for that is not going to be ring-fenced. The first patients are unlikely to be treated until the second half of 2007. How we going on that first 300,000?

Mr Lewis: I think I have said throughout this hearing that we are, as we speak, concluding discussions with the SHAs, individually and cumulatively, on how many pathways they want us to procure from the independent sector to enable them to achieve this massive reduction in waiting lists and waiting times that we have demanded of them this week. So we are willing; we are sat here, ready to go, but they are saying to us "Hold on a minute. Before you do that, we need to be absolutely clear that we are making best use of in-house capacity," and we know that in many areas there is an argument for saying, frankly, at the moment they are not making best use of in-house capacity.

Q173 Dr Taylor: So none of those 300,000 have yet been . . .

Mr Lewis: I have made that clear throughout.

Q174 Dr Taylor: Then we have a statement in the papers we have been given that around another 300,000 extra are needed, and then we have the 42,000 or whatever it is.

Mr Lewis: That has been already committed.

Q175 Dr Taylor: Is that 42,000 for each of these five SHAs or is it 42,000 in total?

Mr Lewis: In total, across five SHAs, per annum.

Q176 Dr Taylor: We have been told by RNID that there are something like 4.5 million people who still need these, so 300,000 for five years, that is 1.5 million; 42,000 for five years, that only comes up to 200,000. We are still terribly short, are we not?

Mr Lewis: No, because first of all, within the existing system the PCTs should be commissioning a far more effective service in terms of audiology than they are doing at the moment. So this is not just about the additional pathway capacity being procured from the private sector. It is also about, frankly, how they are using their existing NHS capacity and how they are commissioning, the priority they are giving in terms of their commissioning for audiology. Those are the other factors that are relevant. The figures that we are talking about purely the contribution, if you like, the Chairman's added value, added capacity argument, we will be getting through the independent sector procurement. There is an awful lot of progress that should and could be made in terms of in-house provision that is not about necessarily a contractual relationship with the independent sector.

Q177 Dr Taylor: I am afraid I also find the evidence you have given to us on the private sector incredibly confusing. If I can read your first paragraph, "Private sector provision for assessment and fitting of hearing aid devices and follow-up does not represent an out-sourcing of NHS audiology departments." So if you are using the private sector, why is it not an out-sourcing?

Mr Chapman: The reference there is because there will be a substantial increase in the output of both NHS and the independent sector. It is not a switch from NHS to independent sector; it is adding capacity in both sectors.

Mr Lewis: It is the Chairman's point really. We are using the private sector here to enhance our capacity because of the demand that is now evident.

Q178 Dr Taylor: So by use of the word "out-sourcing", you are assuming that one would think that one is taking something away from the NHS, which you are not doing.

Mr Lewis: Yes. You would say you have an existing range of provision and the only way you can make that better is to contract out. We are not doing that. We are using the private sector to build the capacity that we desperately need to be able to respond to demand.

Q179 Dr Taylor: Further down in that paper you are talking really about short and medium-term capacity to meet unmet demand. The evidence we have had in the first session really suggests that, with the increasing demand, it is not only going to be short and medium-term capacity that is going to be short. How do you respond to that? Do you think the use of the private sector will be needed in a much longer time course?

Mr Lewis: Hopefully, Mr Chapman will still be here in ten years and will be able to respond to that. The serious point is, I think there are two things that are going to happen as a result of this process. One is

³ Ev 125

8 March 2007 Mr Ivan Lewis MP, Mr Nick Chapman, Professor Sue Hill and Ms Helen MacCarthy

that certainly we are going to massively reduce waiting lists and waiting times, and at the same time we are going to give audiology a higher status and a higher profile and we are going to ensure much higher quality and standards and ways of working. Let us assume we achieve that. Once we have achieved that, it may well be the balance between what can be done in-house and what needs to be done and the contractual relationship with the private sector may change. On the other hand, it may well be, as you say, if you look at demography, demand, it seems to me, is going to continue to grow. It is probably not going to flat-line for a considerable period of time. If I were predicting ahead, I would hope that we would get in-house NHS provision in a far better shape than it is in now. But I personally, at this stage, would imagine that we are always going to need to have the independent sector helping us to cope with the inevitable demand.

Q180 Dr Taylor: Obviously, commissioning is the responsibility of the Primary Care Trusts. You are elevating audiology services to a priority. Is that actually going to cut any ice with the PCTs who are struggling to meet their deficits?

Mr Lewis: I would say that that is related to the much bigger picture debate that we have on almost a daily basis about the NHS these days. We have been the first Government that has looked the NHS in the eye, has not blinked and said, "You have to achieve financial balance." I do not apologise for it. You have been in the NHS far longer than I have but, if you are honest about it, it has been one of the NHS's great weaknesses over the years, and the consequences of not having financial discipline are not just about finance actually; they are also about the quality of the service that patients get, the value for money. We have heard in this process of how the cost from assessment to fitting for audiology has been slashed as a consequence of doing things very differently than historically than the NHS would ever have dreamt of doing things. My answer to you would be that all the evidence is that this financial discipline that we are placing on the NHS is working. Many organisations that were in danger of spiralling out of financial control have got their act together. There are a small number who are still facing pretty serious difficulties and will continue to need lots of support and help to get their financial balances sorted out but, in that context, the NHS continues to treat millions of people in an incredibly effective way in this country and in a way that we can be proud of. All I am saying today and this week really is that people who have hearing problems are entitled to be regarded as a priority. For me, hearing is not just another problem. It is a fundamental capacity to participate in everyday life. If the NHS in this country does not and cannot prioritise audiology, that would be a sad reflection on what we regard as being important. The bottom line will be, when we appear before this Committee or whoever in a year's time—and I will be delighted to be the person that comes back—have we made massive progress on waiting lists and waiting times? You know one benchmark, which is that by March 2008

there should be a maximum weight of six weeks everywhere for accessing audiology. That is a clear, transparent benchmark that you will be able to judge us against. You know that there is another benchmark that by the end of 2008 50% of people accessing audiology must do so within the overall 18 weeks, and you know as a consequence of the evidence that we have given to you today and the framework we published this week that the other 50% should be waiting far more reasonable times to have their fitting from the moment of assessment, because every body will be at six weeks, than they are doing at the moment. So I think we have given you, to be fair to us, some very clear benchmarks to judge the NHS's performance by, certainly by the end of 2008.

Q181 Dr Taylor: So you will keep a very close eye on the commissioners so that when you come back to us in 12 months' time you can say they have spent the amount of money they ought to have done on hearing aids?

Mr Lewis: What I commit to doing is, at a national level, with the RNID and other stakeholders, monitoring progress. I am not so much worried about reporting back to you on the amount of money we have spent; I will be reporting back to you on the outcome and hopefully that outcome will be considerably less waiting times both for assessment but frankly, more importantly actually, ultimately for fitting.

Q182 Chairman: Sir Humphrey would say, "That is very brave, Minister."

Mr Lewis: By the end of 2008 though remember.

Q183 Dr Naysmith: It seems a pity to break into that stirring speech. We have talked a lot about value for money and we have talked a lot about how much money is to be spent on waiting times but what about the quality of the service? Presumably, the hospital side is assessed by the Healthcare Commission but what about the private sector side of it? How will the quality of care in the private sector be monitored?

Mr Lewis: As far as I know, if the NHS has a contractual relationship with the independent sector, the Healthcare Commission monitors their performance, because essentially it is an NHS service that is using the private sector to ensure its delivery. I think there are also quality standards that apply in terms of any relationship which exists between the NHS at a local level and a private provider, where we give them guidance, if you like, about how to monitor, how to demand certain standards.

Q184 Dr Naysmith: That will be monitored as well?

Mr Lewis: Yes. So it is not just numbers, as you quite rightly say, Doug. It has also got to be about quality of experience for the patient.

Q185 Mr Jackson: Minister, and Mr Chapman, I listened carefully on the issue of collating of data, and you said you were working to very clear benchmarks. Given that we were told in evidence by

8 March 2007 Mr Ivan Lewis MP, Mr Nick Chapman, Professor Sue Hill and Ms Helen MacCarthy

the British Society of Audiology that there are no standards for recording referral or appointment types, no systematic interfaces with NHS systems, and no standard reports that can be aggregated easily, do you not think that it would have been appropriate to begin collecting data a lot earlier, and is not the true fact of the matter that part of the problem is that you do not know what the numerical situation is because you have no data that is accurate in measuring how successful or otherwise you are going to be?

Mr Lewis: I have a graph here that basically goes from 1984 through to 2006, and I am happy to give the Committee a copy of this, and what is fascinating is that basically, waiting times were practically flat from 1984 all the way through to the year 2000–01 and then shot up to coincide with the modernisation programme. The graph proves that beyond all reasonable doubt. So I think to argue that we do not have robust data is slightly unfair. In a sense, we would not know how bad the situation is in some parts of the country for people if we did not have robust data. We would not be able to sit with each of the Strategic Health Authorities and then sit with the PCTs to identify the capacity that will be required to slash these waiting lists if there were not robust, hard evidence to base our future planning on. It is slightly unfair. Could we have better data? I have no doubt that we could and I think that we need to work on that clearly as part of our monitoring of progress, but I think we have good data which tells us a story which is pretty clear, which is why we are where we are and the Select Committee is producing its report, and the Government has produced its framework.

Q186 Mr Jackson: Let me get this absolutely straight. Are you saying it is not the case that at the moment there is no central data collected on referral to treatment times? Are you saying that is the case? I only ask that because I have asked Parliamentary Questions and your colleagues have said you do not collect the data centrally, and in fact, the most accurate data has emerged from professional organisations like the RNID rather than the Department of Health.

Mr Lewis: Can I be clear? I want to be clear about this. I think the data that we have, that is absolutely clear and robust, is on time waiting for assessment. So at the moment that is absolutely robust and clear. What we do not have is robust data on the moment from referral through to fitting.

Q187 Mr Jackson: Do you not think that is apposite though?

Mr Lewis: Of course. Absolutely, and as far as I know, and I will be absolutely clear about this, from next month we will be collecting that data at a national level. Is that accurate?

Mr Chapman: Yes. As far as patients going through the 18-week pathway are concerned, we will be collecting referral to treatment data.

Mr Lewis: The ENT group?

Mr Chapman: The ENT group and, as it says in the framework, we would consider during the course of 2007 whether it was appropriate to extend that referral to treatment data collection to all patients going through audiology.

Q188 Mr Jackson: On what basis would it not be appropriate?

Mr Lewis: The fact that Honourable Members like yourself and many others complain, understandably, about the bureaucracy that we place on the NHS at a local level which gets in the way of them delivering patient care. We cannot have it both ways. We cannot constantly say we are fed up with all this red tape and the requirement to keep statistics and numbers and all of that, and then say what we demand is detailed information on every aspect of the service. That is the tension all the time, that Honourable Members do say contradictory things on these issues. They ask questions and they say they want absolute detail on every issue nationally, and then when we debate regulation and bureaucracy, they say we want this slashing, it is ridiculous, the front line professionals are spending all their time ticking boxes and filling in forms. Genuinely, I think what you are saying is reasonable. I personally think, although I am not committing to it, that what we should aim to be doing is having comprehensive data for all people. Because of the state we are at with audiology, which we are aware of as a result of the reason we produced the framework, which is that we are not in as good a shape as we need to be in all parts of the country, I think there is a strong case for collecting data on all of the people who access audiology, not just the people that are covered by the formal 18-week target. We are going to have a look at that. I am not making an absolute commitment to do it but I will certainly have a look at it.

Q189 Mr Jackson: I am pleased to hear that. The only reason I sought to press you on that was that a previous witness, Ruth Thomsen, effectively said that this data is available locally on a database at the touch of a fingertip. So we are not talking about splitting the atom, we are not talking about Soviet tractor figures; we are talking about data that is already available, Minister, and that is why I pressed you. But thank you. I am gratified to hear that we are moving in the correct direction.

Mr Lewis: I just bring to the attention of the Honourable Member that we have been New Labour for some considerable time, even the Chairman, probably longer than most of us. There is an important point here but actually, you have just identified one of the great tensions about the debate about how the NHS should be run in this country. You are saying, and I do not know whether it is true, but if somebody said it, I assume it is true, but there is a lot of data kept at a local level because, in a sense, if PCTs are going to make sensible commissioning decisions, they should be keeping that information as a management tool anyway. But then the question is, how much of this information should flow

8 March 2007 Mr Ivan Lewis MP, Mr Nick Chapman, Professor Sue Hill and Ms Helen MacCarthy

upwards constantly to the Department of Health and central government? As you know, the whole debate about foundation trusts, about autonomy—frankly, Stewart, your party pushes this all the time, maximum autonomy for the front line—why do we need constantly front-line professionals to be pushing more and more information up to the centre?

Q190 Mr Jackson: Because my constituents who are waiting 66 weeks in my local trust deserved to know. That is why, Minister.

Mr Lewis: As I say, we ought to be consistent with our positions on these issues.

Chairman: Just before I finish the session, these two sessions have tended to overlap this morning. We expect that the transcript will be on our website by Wednesday of next week, and if anybody in the room has any comments on what has been said, we would greatly appreciate if you send that in. It will be after Easter when we will look at drawing up a report of today's hearing. Could I thank you all very much indeed for coming and assisting us, and thank the gamekeeper as well.

Written evidence

Evidence submitted by the Department of Health (AUDIO 1)

INTRODUCTION

1. The Government welcomes the opportunity to set out its position on audiology services. This memorandum covers the five areas of particular interest expressed in the Health Select Committee's Terms of Reference together with detailed background on related issues.

TODAY'S AUDIOLOGY SERVICE

2. Audiology involves a wide range of hearing and balance services which include assessment, therapeutic intervention and rehabilitative strategies. These assessments determine the functional ability of the auditory and vestibular system, the effect of possible pathologies and the impact on related daily activities.

3. Following assessment, an appropriate care pathway is selected for treatment (eg surgery for cochlear implant) and for support. The most common audiology pathway is associated with the restoration of degenerative hearing loss in adults through the provision of digital signal processing (DSP) hearing aids. Pathways also include counselling and the provision of assistive listening devices.

4. Most services are based on acute hospital trust sites and range in the number and complexity of services provided but all offer direct access primary care services for adult hearing loss. Some offer outreach adult and paediatric services and there are a small number of primary care based services. There are an increasing number of private sector providers.

5. There is the potential for more services to be provided directly in primary care settings. Paediatric audiology services work in partnership with local authority services, who provide the major ongoing rehabilitative support for parents and their children.

6. Estimates based upon the Medical Research Council (MRC) and the Department of Health Survey of Audiologists in England 2004 suggest about 60% of audiology staff time is spent on adult patients, with the majority of time spent on care pathways associated with adult hearing aid services.

7. The major elements of audiology services include:

- Assessment of patient needs and selection of appropriate care pathways.
- Hearing function (including pure tone audiometry) and tinnitus assessments.
- Fitting of digital hearing aids to new and existing patients.
- Diagnostic audio vestibular function tests (ie balance tests and electrophysiological tests of hearing and balance).
- Assessment for implantable devices that aid hearing and communication (eg bone anchored hearing aids and cochlear implants) and for patients with central auditory processing disorders (provided by a small number of centres).
- Hearing and tinnitus patient management and follow-up.

8. Most referrals to audiology services are direct referrals from GP for assessment of hearing loss and provision of digital hearing aids in adults. A small number of patients for this service are still referred via Ear Nose and Throat (ENT) consultants. In addition, there are intra-departmental referrals. Patients can also refer themselves back in for reassessment, maintenance and repair. Most other referrals for the complete range of hearing and balance services are traditional GP to hospital consultant usually via ENT (although for balance problems maybe via other hospital consultants). Children's referrals might arise via community paediatricians direct to audiology or from the Newborn Hearing Screening Programme (NHSP).

9. For some services offered by an audiology department, referrals are received late on in the patient pathway from specialties other than ENT, which can have a significant impact on the total patient journey. These referrals particularly impact on some of the lower volume tests offered by audiology departments. For example, many patients that require vestibular/balance assessments associated with dizziness or falls.

10. Audiology services work closely with a range of agencies, including education, social services and voluntary sector providers to support the provision of NHSP and services for children and adults with learning disabilities, dual sensory impairments and complex needs.

11. There are 158 audiology departments in England, 124 sites for Newborn Hearing Screening Programmes (NHSP) and 16 cochlear implant services.¹

12. Skill mix and the number of staff varies between organisations to reflect the services being provided but there is variable output in terms of service activity. The service is primarily delivered by healthcare scientists (clinical scientists and technologists). In paediatric audiology in particular, a proportion of staff are audiological physicians, who may undertake some assessments. In general practice, some GPs may

¹ Figure based on the number of providers also submitted returns as part of the Department of Health's National Monthly Diagnostic Data Return (December 2006 return).

undertake baseline hearing assessments and arrange for hearing aid services to be delivered within their practices. In paediatric audiology the service is often led by a consultant clinical scientist. There is scope for new roles to be developed and for skill mix to be reviewed to match the workforce to the main functions delivered as well as focus on greater productivity and efficiency.

13. Audiology requires specialist diagnostic equipment. Generally, audiology tests are undertaken in quiet clinical rooms, sound-proofed rooms or electrically shielded and sound-proofed rooms. However, newer technology means that requirements may change in the future.

14. Demand is increasing due largely to a combination of an ageing population and more people seeking to benefit from the advances in digital technology. In addition to the overall increase in hearing impaired people, recent initiatives have put further pressures on the capacity of audiology services to deliver the major care pathways within recognised quality guidelines:

- Royal National Institute for Deaf People (RNID) reports and campaigns.
- Introduction of Newborn Hearing Screening Programme (NHSP).
- The MHAS programme ensured that all NHS audiology departments were able to routinely fit digital hearing aids by April 2005.
- The replacement of analogue hearing aids with digital aids—digital hearing aids enable greater personalisation that requires more time for adjustment and more frequent replacement (as they are more likely to be used).

15. Approximately 20% of audiology staff time is spent managing referrals from ENT and providing pure tone audiometry and other hearing tests in ENT outpatient clinics. The increased demand on ENT services is also having a significant knock-on effect to audiology. In addition, reassessments of current patients also contributes significantly to the workload. This may include those patients switching to digital aids who require a new diagnostic workup and provision of rehabilitation support strategies, or those where hearing function is being reassessed and optimised after the provision of a new high power digital aid.

16. Audiology services are subject to pressure not only from direct referrals, unmet need and the increasing demand for adult hearing services but for all the services they provide. There are a range of steps which need to be taken to address these challenges. This includes issues such as the development of priorities and guidelines and ensuring that local commissioning and workforce planning is sufficient to address the need.

17. In order to provide digital hearing aids at an affordable cost to the NHS, contracts exist with certain manufacturers for a range of aids. The decision as to whether to purchase an aid on or off contract is made locally.

DEFINING THE PROBLEM

18. Historically there has been a lack of focus and understanding in the provision of audiology services in the NHS. The Audit Commission identified problems with the NHS hearing aid services in their report, *Fully Equipped*, (2000). The report examined five services from the user's perspective—orthotics, prosthetics, wheelchairs and specialist seating, community equipment, and audiology. The report found that the current level of services across these services was unsatisfactory in many respects:

- there were unexplained variations in all aspects of service provision, bearing little relation to underlying levels of need;
- the quality of services owed more to custom and practice, rather than to a considered view of the contribution that equipment services could make to the overall needs of the population; and
- eligibility criteria were often unclear to users, carers, voluntary organisations and staff, and they were often applied inconsistently.

19. The report made a number of recommendations in relation to audiology, which included:

- to reduce waiting times, health authorities should ensure that there are mechanisms in place to allow direct referral from GPs to hearing aid centres. They should also ensure that the capacity of the hearing aid clinics is adequate to manage an increased workload and range of tasks;
- investigations into the provision of improved hearing aids should attempt to compare the opportunity cost of providing better hearing aids against the current cost to society of the isolation experienced by deaf and hard-of-hearing people;
- health authorities, in conjunction with local trusts, should review their current service standards for the delivery of audiology services and the delivery of quality improvements;
- health authorities and social services authorities should establish joint audiology services.

20. In response to the report the Government invested £125 million between 2000 and 2005 into modernising NHS audiology services through the Modernising Hearing Aid Services (MHAS) programme. The Royal National Institute for the Deaf (RNID) ran the programme on behalf of the DH.

21. The MHAS Programme successfully achieved the target that all 164 audiology services in England should be able to fit digital hearing aids routinely from April 2005. Other outcomes included:

- the RNID estimate that 750,000 patients had been fitted with digital hearing aids through the MHAS programme by April 2006;
 - a reduced cost to the NHS of digital hearing aids; and
 - MRC findings of patients reporting a 40% increase in benefit with the new service.
22. Capacity initiatives through MHAS included:
- the development of the National Framework Agreement for the supply of hearing aid services through a Public Private Partnership (PPP); and
 - the introduction of “Hearing Direct”—12 sites run by NHS Direct to provide follow-up care and advice for selected hearing aid users.
23. The NHS Improvement Plan (June 2004) set out an ambitious new aim that by 2008 no one will wait longer than 18 weeks from GP referral to hospital treatment. With the inclusion of all diagnostic tests and the initiation of treatment within the 18 week target definition a physiological measurement diagnostic programme was established within the Department of Health’s 18 week programme. Audiology was one of the eight clinical specialities included. The work of this programme, and the lessons and information gained from it, have contributed in identifying the problems facing audiology services and finding solutions to those problems.
24. Despite the success of the MHAS programme, the physiological measurement programme has demonstrated that there is still a considerable challenge to be addressed with regard to those people on waiting lists for audiology services. The key challenges facing audiology services are:
- unmet and increasing demand;
 - inadequate capacity;
 - workforce skills and competencies not matched to service functions;
 - inefficient service models and processes;
 - modern technology not encompassed; and
 - large waiting lists which have not been managed.
25. In order to address these challenges the Department of Health announced, in June 2006, that it would develop a national audiology action plan. In addition to this, on 25 July 2006, Lord Warner announced the central procurement of up to 300,000 audiology pathways from the independent sector, which was additional to the Wave 2 diagnostics procurement, which also included 40,000 audiology pathways.
26. The audiology action plan, or framework, is currently being finalised and has been developed drawing on the views of stakeholders, including audiologists. The framework will address the broad range of patients who suffer from audiology problems including:
- adults with a hearing loss;
 - children with hearing and balance problems;
 - tinnitus sufferers;
 - patients with balance disorders;
 - bone anchored hearing aid users; and
 - cochlear implant users.
27. Linked to the publication of the audiology framework, and as part of the outcomes from the physiological measurement programme, will be plans to publish:
- good practice guidance on new audiology service models based on findings from nine NHS pilot sites;
 - key information to support the commissioning of audiology services; and
 - a model pathway for adult hearing loss.
28. A stakeholder event took place on 1 February 2007 to discuss the challenges facing audiology services and the publication of the forthcoming framework.
29. The audiology framework will move towards the achievement of shorter waits by December 2008 and if this is achieved, will provide a solid base for the future sustainable delivery of audiology services.

INQUIRY TERMS OF REFERENCE AREAS OF INTEREST

Whether accurate data on waiting times for audiology services are available

30. The Department does not collect waiting times for hearing aid fitting. However, a trajectory has been set to deliver diagnostic tests within 13 weeks by March 2007 and six weeks by December 2008. Waiting time data has been collected for audiology diagnostic tests since January 2006 and is published on the Department’s website at <http://www.performance.doh.gov.uk/diagnostics/index.htm>

31. The monthly diagnostic data for audiology consisted of waits for pure tone audiometry until October 2006 (published in December), when this was extended to cover all audiometry assessments.

32. As of November 2006, there were 166,740 patients waiting for an audiology diagnostic assessment. Of these, 108,628 were waiting over 13 weeks, and 80,941 over 26 weeks. The median waiting time was 25 weeks.

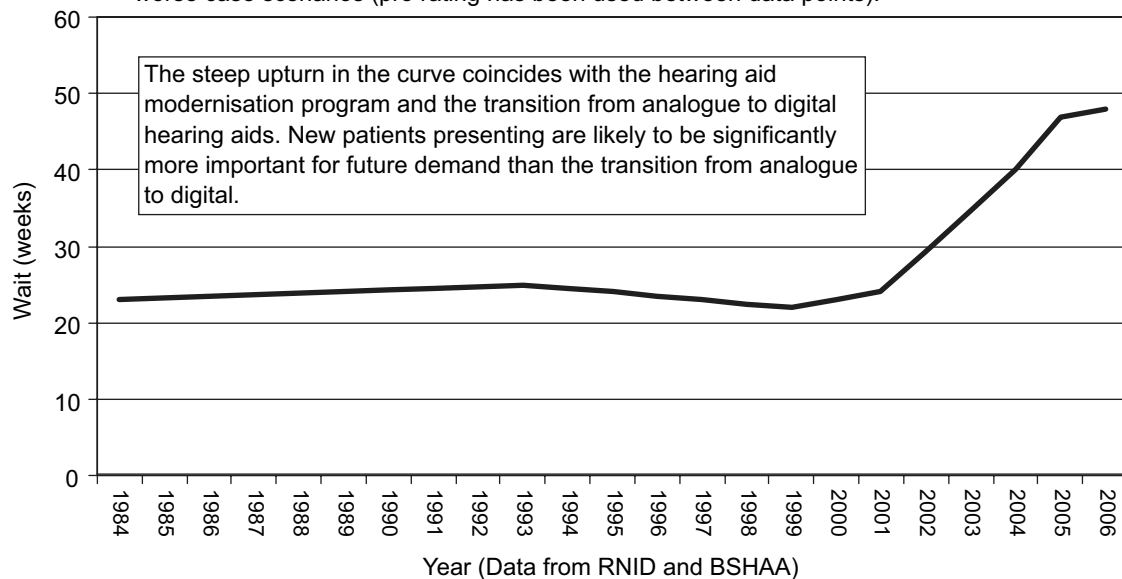
33. Regarding the quality of this data, this is a relatively new data collection, and there remain some problems in the accurate collection of audiology assessment waiting times. However, the published figures have been signed off by PCTs and should be seen as a realistic reflection of the waiting times experienced in the NHS.

Why audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed

34. The Department of Health acknowledges that there are long waits for adult hearing services compared to other specialties. These waits have largely built up because of the rapid increase in demand created by the MHAS programme and transition from analogue to digital hearing aids. The audiology framework will set out the plan for addressing these waits.

Growth in Total Wait for Hearing Aid obtained by Direct Access from GP to Audiology Department in England

Data is based upon surveys asking for informed opinion on the wait to be seen by an audiologist and the subsequent wait to have an aid fitted and as such may represent worse case scenarios (pro rating has been used between data points).



Whether the NHS has the capacity to treat the number of patients waiting

35. The audiology framework will help address the capacity challenges currently being faced by those patients waiting for audiology services.

36. Analysis and modelling of the limited data available indicates that there is a significant capacity problem. The framework will set out ways in which the NHS can address these challenges.

37. Initiatives to address the capacity issue include:

- independent sector procurement; and
- re-engineering the care pathway to increase efficiency in order to streamline the process and reduce the waiting times.

38. The November monthly collections suggests over 100,000 patients are currently waiting at least 13 weeks for the following audiology assessments:

- Referral for hearing aid assessment (new patients).
- Re-referral for hearing aid assessment.
- Referral for complex needs hearing aid assessment.
- Bone anchored hearing aid (BAHA) assessment.
- Referral for cochlear implant candidacy assessment (adult).
- Adult audio-vestibular assessment.

- Tinnitus assessment.
- Balance assessment.
- Referral for cochlear implant candidacy assessment (paediatric).
- Paediatric hearing services following newborn screening.
- Audiological assessment at 2nd and 3rd tier clinic (pre-school and school-age).

39. The rate at which the population is ageing suggests that demand will increase in the coming years. To reduce waiting times to within 18 weeks and hold them there will require significant increases in capacity.

Whether enough new audiologists are being trained

40. The Department of Health recognises that in order to address the challenges currently being faced in audiology services we would need to increase capacity some of which will need to come from improvements in productivity. This is currently being investigated at a number of physiological measurement development sites, together with an assessment of their current workforce profile and the service output.

41. An integral part of this process will also be to ensure that there are sufficient staff, of the right skill mix, to address the capacity challenge. Some of which may include the use of administrative staff; the development of new roles at lower career pathway stages; the development of the audiology assistant role; and creating flexible roles to remove ear wax.

42. We have already taken a number of steps to increase the number of new audiologists being trained. In 2003–04, we introduced the new Bachelor of Science in Audiology. We have also implemented initiatives to improve recruitment and retention for all staff, including audiologists, by improving pay and conditions; encouraging the NHS to become a better, more flexible and diverse employer; providing help with accessing childcare; and running national and local recruitment campaigns.

43. Through a DH programme with Skills for Health we are working on the competencies and associated skill and knowledge requirements to support the introduction of an associate level practitioner in audiology to support the new care pathway. This will have synergy with the requirements of the independent sector providers for skilled practitioner who can undertake routine adult hearing service functions.

44. Additionally each year the Workforce Review Team in conjunction with the SHAs and other service representatives undertakes a workforce requirement review of audiology services, which is available to the whole of the NHS to direct and inform local workforce planning arrangements.

Background

45. A BSc course in audiology was introduced and commissioned by the NHS in 2003–04. Prior to that the NHS Non-Medical Education and Training (NMET) levy funded both Grade A clinical scientist training (which it continues to do) and a multiplicity of different training arrangements for audiology technicians, together with diploma programmes in hearing therapy. The first cohort of BSc (Audiology) students entered training in 2003–04 and graduated in 2006.

46. The most recent data on the audiology sector, states that at 30 September 2005 there were 1,651 (1,421 fte) qualified healthcare scientists working in audiology, an increase of 4% since 2004 when there were 1,582 (1,389 fte). Prior to 2004, it is not possible to separate healthcare science staff working in audiology from other scientific, therapeutic and technical staff.

NHS HOSPITAL AND COMMUNITY HEALTH SERVICES: QUALIFIED AUDIOLOGISTS

<i>England as at 30 September</i>	<i>2004</i>	<i>Headcount 2005</i>
Qualified staff	1,582	1,651
Consultant Clinical Scientist (Grade C)	16	14
Managers	40	51
Clinical Scientist (Grade A and B)	233	242
MTO/Technician	1,293	1,344

Source: The Information Centre for health and social care Non-Medical Workforce Census

47. As at 31 March 2006 the rate of three-month vacancies for qualified healthcare scientists working in audiology stood at 3.2%. This was a decrease of 1.6% from 31 March 2005. Prior to 2004 it is not possible to separate the vacancy rates for healthcare scientists from other scientific, therapeutic and technical staff.

48. Whilst the introduction of the new BSc is a positive step, we are aware from discussions with SHAs that there has been limited planning locally to increase posts at trust level, to take account of the increased output from training. The first cohorts graduated in 2006 and we are working with SHAs to address the planning issue.

How great a role the private sector should play in providing audiology services

49. Private sector provision for assessment, fitting of hearing aid devices, and follow-up does not represent an outsourcing of NHS audiology departments. In fact, it would lead to a significant increase in NHS capacity and is not intended to include any transfer of services to the independent sector. This should drastically reduce the waiting time for receipt of a first hearing aid.

50. It is intended that the independent sector procurement will help reduce the backlog without recourse to public capital investment funds. The NHS remains free to reconfigure and expand their services, although it is likely this procurement will bring innovative approaches to the delivery of these services and this will be a healthy challenge to the NHS.

51. The core benefits of a national independent sector procurement include:

- Provide additional short and medium-term capacity and meet un-met demand to support the NHS in delivering adult hearing services.
- Reduction in the significant waiting times for hearing aids.
- Increase patient access and choice (patients will still have a choice between direct access in a community setting or GP referral to NHS trust audiology departments).
- Increase the private-public mix of services.
- Provide VfM solutions for the NHS; the involvement of the independent sector will drive a more commercial approach to the provision of audiology services. This could potentially increase efficiency and levels of innovation.
- Shift care from hospital settings nearer to patients, in-line with the *Our Health, Our Care, Our Say* White Paper “Shifting Care” commitment.

Public Private Partnership (PPP)

52. Following a public tendering process, the National Framework Contract Public Private Partnership (PPP) with David Ormerod Hearing Centres and Ultravox Holdings plc was announced in October 2003. The contract was due to run until October 2005 but has now been extended until April 2007.

53. The contract allows NHS Trusts to use the two specific private hearing aid dispensers to see NHS patients. It ensures that the patient receives care to the same standard as used in the NHS, is provided with the same hearing aids and remains the responsibility of the NHS.

54. It is fundamental to the National Framework Contract that the quality of service, and hearing aid, that the patient receives mirrors those of the local department. Quality assurance is key in the initiative. Both companies have demonstrated their commitment to meeting these standards and have invested resources in terms of equipment, IT and staff training in order to do so.

NEXT STEPS: AUDIOLOGY FRAMEWORK

55. The Department of Health plans to publish its national audiology framework on 15 February 2007. The framework will set out the challenge and will provide commissioners with the tools to meet this challenge.

56. The Department will forward the Audiology Framework to the Health Select Committee upon publication.

The Department of Health

8 February 2007

Annex A

GENERAL BACKGROUND

THE MODERNISING HEARING AID SERVICES (MHAS)

1. In January 2000, Minister of State for Health, John Hutton MP, announced a pilot study to introduce digital hearing aids to the NHS, with details of the pilot sites confirmed in May of that year. Jacqui Smith MP, Minister of State for Health, announced expansion of the scheme beyond the pilot sites in 2001, with a commitment to full roll-out and modernisation by 2005, confirmed in February 2003. In 2002, the Minister announced the formation of the NHS Negotiating Team, comprising a partnership between the Department

of Health (DH), the Royal National Institute for Deaf People (RNID), the NHS Purchasing and Supply Agency (PASA) and the Medical Research Council's Institute of Hearing Research (IHR) to support this programme and drive change.

2. The aim of the programme was to provide high quality digital hearing aids, as part of a modernised service, which was re-designed around the needs of people with hearing impairment. It recognised that people also need appropriate support and continuing care in order to use their hearing aids effectively and achieve a better quality of life. The MHAS programme was an important demonstration of the Government's NHS Plan commitment to modernise and improve the quality of services and to make them more accessible to patients.

3. The programme was managed by the Royal National Institute for Deaf People (RNID) on behalf of the Department of Health. The aims of the programme were:

Adult services

- Introduction of modern digital signal processing hearing aids to all new and reassessment patients.
- Introduction of uniform clinical protocol and patient journey.
- Introduction of audiology patient management system to capture all patient demographic and clinical data, appointment, stock etc.
- Introduction of routinely gathered data on outcomes for service management and individual patient rehabilitation.
- Fostering an evaluative, modernising culture among the staff.

Children's services

- Modern digital signal processing hearing aids to be routinely fitted to new cases, and offered to all existing aid wearers managed by the service within 24 months.
- Aids to be fitted to an authorised software version of a paediatric fitting procedure with probe tube microphone verification.
- Fitting to be followed by regular and ongoing reviews.
- Impression and ear mould protocols to conform to new standards.
- Close liaison with education services, including joint training, review appointments, and shared information.
- Individual audiological management plans, agreed between parents, Health and Education services, with copies of all reports and assessments to parents.
- The service across health, education and social services to be monitored by a multi-agency children's hearing services working group including parents.

REDUCING THE PRICE OF THE HEARING AID

4. Working together, the NHS Purchasing and Supply Agency (PASA) and RNID negotiated a favourable contract for procurement of digital hearing aids. The aids were sophisticated models similar to those sold on the high street for up to £2,000 each. They were made available to the NHS at around £70 each—very little more than the cost of analogue aids.

5. NHS PASA developed a new supply strategy in order to bring advanced technology to the NHS market. Detailed research was undertaken to understand the cost breakdown for digital hearing aids and the key drivers in reducing the cost to the NHS.

6. A tender process was carried out and a national contract was awarded to two suppliers for the key product line. The contract achieved an average reduction in the price of digital aids of 86%.

AUDIOLOGY AND 18 WEEKS

7. The 18-week pathway focuses on hospital pathways (and in particular hospital medical consultant pathways) as funded in the 2004 Spending Review agreement with HMT.

8. Audiology, and adult hearing services in particular, are mainly accessed directly by primary care and are therefore predominantly outside the scope of the 18-week pathway, which is focused on changing traditional hospital consultant pathways.

9. The Department considered the results of the listening exercise on the principles and definitions to govern the 18-week referral to treatment pathway, but because the majority of adult hearing services are accessed directly from primary care it would not be appropriate for them to be covered by 18 weeks.

10. The 18 weeks target focuses on hospital consultant pathways. Over time, patients with hearing problems who do not need to see a hospital consultant have increasingly been referred direct to audiology services, enabling services led by ENT consultants for example to focus on more complex cases. Direct access services should be quicker for patients because they cut out a stage of the potential pathway, and it would be perverse to reverse this.

11. It was recognised and identified within the 18-week implementation plan that direct access to audiology departments is the result of the introduction of innovation into the care pathway. This has led to a decrease in the number of patients who have needed to be seen by an ENT consultant, thereby freeing up the capacity of ENT to see patients with other problems.

FUNDING

2000–01—2004–05

12. £125 million was invested between 2000–01 and 2004–05 through the MHAS programme.

2005–06

13. In 2005–06 £12 million revenue and £26 million capital was allocated to NHS Trusts and PCTs for audiology services as part of the general allocations.

2006–07

14. In 2006–07 revenue allocations for audiology services were included in the SHA bundle. DH allocated approx £5.5 billion to SHAs as a single bundle of budgets, with the aim being to give SHAs as much flexibility as possible in the management of funding and delivery of services. It was the responsibility of individual SHAs to decide, in consultation with local stakeholders, how best to deploy the funding. In addition £26 million capital was allocated to NHS trusts and PCTs for their audiology services.

2007–08

15. There will not be any specific audiology allocations in 2007–08. Decisions about funding levels for audiology services will need to be taken locally, with consideration given to the need to have sufficient direct access activity to substantially reduce waits.

16. *The NHS in England: Operating Framework for 2007–08* confirmed that there would be another SHA bundle of central revenue budgets for 2007–08 with a proposed value is £6,945.8 million. The bundle will be supplemented by a service level agreement between DH and SHAs. This agreement will include details of the services to be provided from the bundle.

17. A new capital regime has been put in place from 2007–08 under which NHS trusts can draw down as much capital as they can afford to service, rather than having it allocated to them. The new guidance for trusts, *New Capital Regime for NHS Trusts*, was issued on 13 December 2006. Allocation arrangements for PCTs remain unchanged, with a significant increase in the resources that are allocated for investment by the sector. This increase in resources to PCTs has removed the need to allocate additional capital specifically for many initiatives, including audiology.

Evidence submitted by Terry Allen, North Manchester General Hospital (AUDIO 33)

I qualified as a Hearing Therapist and then as an Audiologist in 2004, and am currently practicing in the NHS at North Manchester General Hospital.

EXECUTIVE SUMMARY

My basic concern is how any changes within Audiology Services may impact on patients, ie their independence, their quality of life and wellbeing—as well as the effects on their families. I am also extremely suspicious of attempts to somehow downgrade and cheapen Audiology as a profession and/or as a service. Some of the modernisation thinking we hear about is shockingly regressive. Instead of promoting quality of care it seems to suggest the priority for change should be based on reducing costs and the professional status of Audiologists. It implies the mentality of an accountant (knows the cost of everything but the value of nothing), rather than one which should be seeking to improve standards in quality of care.

1. As a team here in North Manchester, we have worked damned hard over the last few years rolling-out the digital hearing aid program. We even helped a neighbouring Audiology Department to do the same, in what was a huge effort to replace our patients' analogue aids with digital aids. Clearly, completing such a massive task takes time but our waiting list has been beaten, and for some time it has been down to zero.

2. Fitting new hearing aids to people, whether they be first-time users or those converting from analogue to digital, often involves overcoming a variety of technical, and personal, issues which patients bring to clinic. Anyone who thinks diagnosing and then simply fitting appropriate hearing aids to the many different people who attend audiology clinics, is very sadly, way off the mark.

3. By its nature, hearing impairment very often affects the aged, the vulnerable, the disabled, deaf/blind people. As a hearing therapist/audiologist, I am only too well aware that aural rehabilitation and support should never ever ever be underestimated or undervalued. To do so would demonstrate a total ignorance of what Audiology services should be really about. Being able to hear well, understanding the nature of your hearing loss, being aware and confident in strategies needed to employ with the use of hearing aids, being confident in the ongoing support (without delay and when it is needed)—these are basic patient requirements and should be intrinsic in everyday Audiology services. I would be extremely worried for all our patients, should audiology services be ruthlessly hived-off to the private sector—who whilst providing a good service to those people who chose that route, I feel are ill-placed to accommodate the complete patient-centred approach needed by NHS patients. These patients frequently have much different needs, in terms of lifestyle, dependence, confidence, capability, disability and so much more. I feel very strongly that NHS patients themselves would be totally against a move towards Private Sector care—and listening to patients should be uppermost.

4. Audiology Departments are, of course, involved with many procedures other than fitting hearing aids. For example at North Manchester we have welcomed an even closer working relationship with our colleagues in ENT, by fully embracing the Tier 2 strategy. Consequently, our ENT patients' appointments are now also scheduled and seen much quicker than was previously the case.

5. I strongly suspect we have sufficient Audiologists in the UK, especially with those currently coming through the graduate route. We should look to employ them in the NHS, take our profession forward, copy and standardise proven good practice and ignore calls to fragment what I feel is an essential lifeline to those millions of people in the UK needing our care. Proposals to for the private sector to take on NHS patients, which somehow are envisaged by only a few as being modernistic and the way forward (to resolve what is a temporary problem only, ie converting analogue to digital fittings), should be seen for what they really represent. An opportunistic strategy to reduce costs (which may ultimately be passed-on to patients anyway), and lower the profession status of our profession.

6. I refer to the voice of one with 32 years experience in both NHS and Private Sector Audiology Services, as quoted recently:

Dr David Reed—Chair of Education Committee for the British Society of Audiology

It is not obvious how the Independent Sector can deliver this service more effectively than the NHS. The NHS has lower fixed costs of accommodation and equipment and its staff costs are very competitive compared with private sector salaries. Since the NHS buys hundreds of thousands of hearing aids per year, it is able to buy at low unit cost due to volume discounts. In addition to lower costs, the NHS does not need to make a profit for its shareholders.

It would appear that the only way for the Independent Sector to compete on a level playing field with the NHS would be to employ staff that are paid less for their service and/or give less time to the patient. Professor Sue Hill used the analogy with the ambulance service which uses a number of NHS staff at band four or below. Band five equates to the BSc level Audiologist. So what is the prospect for the new graduate BSc Audiologists? Before they come into the work place their potential jobs are being down graded in the interests of improving the NHS?

European Countries have a BSc as their basic qualification to practice as Audiologists. In the United States we see that they have recognised the advancing science of Audiology and from next year their minimum qualification to practice will be a doctorate in Audiology.

Why is Sue Hill leading the UK Audiologists backwards and in isolation from our colleagues around the world?²

7. In conclusion—my own questions:

- Why all the fuss, the analogue/digital conversion of patients' hearing aids will be completed in the not too distant future—what then?
- The technical aspects of hearing aid prescription and fitting, whilst clearly important, are just part of the process of ensuring people can communicate to their best capability, why downgrade the profession in a cheap attempt to reduce waiting lists?
- Why not look at the successes achieved, and widen/build on them?
- How on earth do people expect qualified Audiologists and new graduate Audiologists to study for, work for and accept Band four salaries?
- Should people who dream-up such things even have a voice on this important issue?

² AUDIO infos—The Magazine for Audiology Professionals.

- Hearing loss, if not treated sensitively and professionally, frequently isolates patients from family, friends and occupation. They lose their confidence, potential and can easily become increasingly reliant on other costly services. Audiology is not simply a technical fitting service. Aural rehabilitation and a holistic patient-centred approach is absolutely vital—and intrinsic in any reputable audiology service. Why should anyone with even the slightest regard for, or experience of, audiology patients think otherwise—unless for reasons of sheer basic economy?

Terry Allen

Audiology Department, North Manchester General Hospital

8 February 2007

Evidence submitted by Amicus (AUDIO 19)

Amicus is the UK's second largest trade union with 1.2 million members across the private and public sectors. Our members work in a range of industries including manufacturing, financial services, print, media, construction and not for profit sectors, local government, education and the health service.

Amicus is the third largest trade union in the National Health Service and represents approximately 100,000 health sector workers. Amicus has members in primary care, mental health and acute NHS Trusts.

EXECUTIVE SUMMARY

- Amicus believes the role being awarded to the private sector in audiology services poses a threat to the future of NHS Audiology services.
- Amicus is concerned at the lack of accountability in private sector health provision and the limited amount of consultation that has taken place regarding serious changes to an important area of service provision.

1. Amicus is deeply concerned about long-term NHS Audiology services due to the extensive future role the private sector is to play in service provision. This therefore forms the focus of Amicus' submission. The threat to NHS Audiology services outlined below must be placed within the context of wider NHS reforms and the drive to fragment healthcare provision between multiple providers outside of the public sector.

2. In July 2006 Lord Warner announced that 300,000 audiology pathways per year for five years would be purchased from the private sector,³ due to come on stream during 2007. There will also be a national procurement of audiology services in the second phase of the ISTC programme.⁴ Despite government assurance that both of these initiatives are additional to NHS Audiology services Amicus does not believe this will be the result.

3. It is unclear what evidence base there is for the "extra" 300,000 figure per year for five years in the purchase of pathways from the private sector, as figures for audiology services only began being widely collected last year. It is therefore difficult to project what resources are needed to meet future demand.

4. The RNID estimated for the British Academy of Audiology (BAA) the maximum number of episodes achieved in one year during the highly successful RNID managed modernisation programme was 200,000.⁵ The purchase of 300,000 pathways is supposed to be in addition to the ISTC procurement which will take place, representing a substantial increase in volume. Amicus fully supports effective attempts to cut audiology waiting times which deliver high-quality services to patients whose lives can be transformed. However, it is not clear the infrastructure exists within the private sector to deliver such volume, creating further future problems in service delivery. As stated above, both of these initiatives are supposed to be in addition to NHS capacity. However, it is feared that as both of these initiatives with the private sector involve a contracted and purchased number of episodes "up front" there will be pressure to route patients through the private sector to fully attain the contracted volume. This would be at the expense of NHS Audiology services.

5. The ring-fencing of NHS Audiology services ended in April 2006. This has led to Audiology departments experiencing disruption to services and being subjected to the same financial pressures as other sections of the NHS, due to the inappropriate funding and accounting policies pursued by government. Audiologists have reported vacancy freezes and service cuts, such as not having sufficient funding to buy enough hearing aids for patients. This must be considered when looking at the audiology waiting times.

6. Amicus does not believe it makes sense for the government to plough additional funds into private sector audiology services when NHS audiology departments are experiencing funding reductions. Amicus is concerned the government have adopted this approach rather than ring-fencing and investing these funds into NHS Audiology departments and allowing them to build capacity to reduce waiting times as they feel

³ HL Deb, 25 July 2006, Col 1641.

⁴ For example, see Hansard, Written Answers, 14 December 2006, Column WA 222.

⁵ BAA, *NHS Audiology—Building the Service*, 2006, page 7.

appropriate. The funded route of private sector provision effectively incentivizes financially pressured PCTs to transfer core NHS audiology services to the private sector, threatening the future existence of NHS audiology departments. Amicus believes the outcome will be the privatisation of audiology services by default.

7. The procurement of both private sector audiology initiatives will fall under commercial confidentiality restrictions. As the committee is aware this limits democratic accountability, preventing a value for money comparison with NHS services to take place.

8. The transfer of core audiology services to profit-generating private sector providers will result in a portion of tax-payers' money being diverted away from service provision.

9. Finally, Amicus wish to echo the disappointment expressed by the BAA over the lack of staff consultation regarding the two private sector initiatives. The purchasing of 300,000 annual audiology pathways and the inclusion of audiology in the ISTC programme were announced prior to the publication of the National Action Plan. Staff have a wealth of experience to contribute to planning, and all stakeholders must be involved in the designing of future services if reforms are going to be for the better.

Kevin Coyne
National Officer for Health
Amicus

8 February 2007

Evidence submitted by Amplifon UK (AUDIO 20)

EXECUTIVE SUMMARY

Waiting times for uncomplicated hearing impairment have increased mainly due to the improvement in patient treatment through the provision of digital hearing aids. More audiologist time and therefore resources are required, yet the number of audiologists being trained for the NHS has reduced and that the number of audiology graduates is making no discernable contribution to capacity.

The private sector has a role to play in providing capacity in terms of dealing with the excess waiting times and supporting NHS resources ongoing. The recent PPP has already demonstrated that waiting lists can affordably be reduced from two years to one to two months, with no reduction in quality of patient care or service.

INTRODUCTION TO THE SUBMITTER

Amplifon UK Limited and its subsidiaries is the largest private sector audiology dispensing group in the UK and has been involved in adult hearing aid services since 1935, treating over 500,000 patients both privately and through the NHS.

The subsidiaries include Ultravox, Amplivox + Ultratone, Sietech Hearing, Hearing Health and Amplivox. Amplifon, as the largest employer and training company within the profession in the UK, has participated in public and private committees and activities including:

- MAWFET—National workforce planning committee chaired by DoH;
- BSc Steering group—National committee involved with establishment of BSc Audiology;
- Patient management user groups—NHS Audiology departments compile their data using one of two patient management systems, Auditbase or Practice Navigator. Amplifon (through Ultravox) was a member of both user groups giving us a clear insight into how data is defined and collated across NHS audiology;
- PPP Contracts—As the largest contractor working with over 75 PCTs and Hospital Trusts on the largest public private partnership in Audiology.

Whether accurate data on waiting times for audiology services are available

1. In short, the answer to this important question is no. There are many reasons for the data's inaccuracy but they can be summarised thus: Diagnostic activity (in other words, "hearing assessments") is the only data being collected and/or reported. Audiology activity in its fullest sense, from referral to treatment by way of hearing aid provision, is not measured. It is this which ultimately impacts on waiting times. A hearing assessment can be given to a patient many times along their pathway before final discharge. Therefore, the collected data contains duplications. Local pressures can affect the interpretation/definition of the data presented (for example, ALL patients or NEW patients, ALL assessments or NEW assessments).

2. Nevertheless, we believe that data trends are reliable and thus the length of waiting lists reported can be taken as a minimum with some confidence. A survey carried out by the British Society of Hearing Aid Audiologists (BSHAA) reports increasing waiting times. At the last report this was in excess of nine months in England.

Why audiology services appear to lag behind other specialities in respect of waiting times and access and how this can be addressed?

3. NHS Audiology is comprised of essentially five categories:

- Paediatric services.
- ENT support.
- Vestibular.
- Newborn screening.
- Adult hearing aid services.

NHS services are provided by trained and qualified audiologists who provide service across the categories. There are approximately 3,000 NHS audiologists.

4. The greatest part of the NHS Audiology service is made in the “Adult hearing aid services” category. This is Amplifon’s area of specialisation and we contain our comments to this category.

5. In terms of this category, the principal reason that the NHS lags behind other specialities is the additional time demand as a result of the introduction of digital hearing aids (to replace analogue) as part of the MHAS (Modernising Hearing Aid Services) initiative. The results of this are:

- The quality of the improvement in hearing and patient satisfaction is considerably improved, yet the cost of the hearing aids has not significantly increased.
- The time spent by the patient with the audiologist has increased threefold (from 45 minutes to 135 minutes per patient journey).
- The technical expertise requirement for the audiologist is increased because of the fitting requirements of the digital hearing aid. This continues to be the case as technology evolves and improves.

6. NHS clinical priorities do not include those with uncomplicated hearing impairment as they have no directly associated acute or chronic health conditions. This lack of priority for adult hearing aid services is in spite of there being a highly cost effective solution for maintaining active, independent living, improved quality of life and reduced risk of ill health.

7. The population of NHS audiologists has not increased commensurately, so waiting times have increased and are increasing. Looking forward, the ageing population will result in proportionately more patients requiring adult hearing aid services, thus requiring more resources. There are no national targets applicable to adult hearing aid services as they are not Consultant-led services.

8. This issue can be addressed by one or both of the following:

- increase the number of NHS audiologists to meet expected ongoing demand;
- partner with the private sector to reduce the waiting lists while NHS audiologists are recruited and trained; and
- partner with the private sector fully and transfer all adult hearing services and resources to the private sector.

Whether the NHS has the capacity to treat the numbers of patients waiting?

9. This question was recently addressed by Dr Sue Hill, Chief Scientific Officer at the British Academy of Audiology annual conference. The statistics she produced show there is not enough capacity from within the NHS alone to deal with the patients waiting the anticipated future demand on the service.

Current NHS activity	258,000 new patients 258,000 reassessments 67,000 DNA (Did Not Attend) 420,000 hearing aids fitted 40,000 do not require a hearing aid (medical referral)
Waiting lists (estimated)	250,000
Rate of growth	63,000 per annum
Estimated unmet need	60,000 per annum

10. Any reduction in the waiting list or elimination of the increase in waiting time cannot be achieved without significant additional resources. We believe the NHS will need to draw upon all the resources available to it, both within the Service and within the private sector.

Whether enough audiologists are being trained?

11. We are not aware of the details of numbers or skills being trained for the NHS system. However, we believe that the number of audiologists being trained for the NHS has reduced and that the number of BSc (Audiology) graduates is making no discernable contribution to capacity.

12. The independent sector has a continuous programme of training Registered Hearing Aid Dispensers (Amplifon trains and qualifies 60 per year), which is managed under the Standards of Competence of the Hearing Aid Council.

How great a role the private sector should play in providing audiology services?

13. NHS Audiology is comprised of essentially five categories:

- Paediatric services.
- ENT support.
- Vestibular.
- Newborn screening.
- Adult hearing aid services.

14. In terms of Adult Hearing Aid services, which is Amplifon's specialism, the characteristics of appropriate private sector companies we recommend that the Committee considers the following:

- Primary competence in hearing aid audiology.
- Availability of sufficient numbers of hearing aid audiologists with the skills to address the waiting lists and posing minimal risk to the Department of Health, through its practices, processes and demonstrable quality of service.
- Sustainable with a long term commitment to hearing care.
- Availability of practice staff.
- Consulting room capacity.
- Proximity to patient groups and hospitals and, especially in conurbations, in High Street locations.
- An established IT infrastructure and connectivity.
- Prior experience through PPP involvement.
- Product knowledge and key manufacturer relationships.
- Capacity and willingness to apply investment in joint venture working and improvements in cost of service provision.

15. The private sector has already played a successful role in providing audiology services to the NHS through the PPP and ISTC diagnostics.

- 80,000 patients have been supplied with a digital hearing aid via PPP.
- Patients have been assessed within four weeks.
- Fitting takes place within four weeks of assessment.
- The patient journey is completed within 12 weeks of fitting.
- Waiting lists reduced from two years to one to three months.
- In Bournemouth PCT for example over 4,000 patients were successfully supplied with digital hearing aids within 18 months.

16. Professor Adrian Davis, Head of the Institute of Hearing Research (Medical Research Council) has evaluated the PPP and published his findings including the following:

- Patient satisfaction from patients who were seen by IS providers via PPP was at worst equal to and usually better than NHS partners.
- He further went on to report that with the PPP providers (Amplifon, through Ultravox, being the largest), compliance with contract protocol and specification was 99% compared to 60% with NHS services.

FURTHER INFORMATION

17. As the world's largest provider of hearing aid services we have an enormous reservoir of information and experience we would be happy to share with the Select Committee. If the Select Committee decides to take oral evidence we would be a willing participant.

Jeffrey Murphy
Chief Executive, Amplifon UK Ltd

12 January 2007

Evidence submitted by Ultravox (A subsidiary of Amplifon) (AUDIO 20A)

In the first session of oral evidence, questions were asked regarding whether the private sector is competitive on price with the public sector and why there is such an apparent disparity between the pricing of hearing aids in the private and public sectors.

While I attempted to answer these questions in my oral evidence, this is a complex area with many variables involved, not all of which I could adequately cover in the time available. Having sought advice from your Committee Clerk, I am therefore writing briefly to clarify the position, from my company's perspective, on the two themes of questioning that arose in this area.

Is the private sector able to supply NHS patients at similar cost to the public sector?

The answer to this is an unqualified "yes". Statements given in written evidence by others have suggested that the cost to the NHS of private sector provision might be double, or more, that of public sector provision. However, these statements tend to compare only the marginal cost of NHS provision (or sometimes only the cost of the device itself) with the full economic cost of private sector provision. The quoted costs of internal provision, therefore, often exclude the cost of buildings, support services and other overheads—all of which are real costs to the NHS, even if they cannot be readily allocated to hearing aid provision under current accounting systems. In order to be clear on this important point, for a valid comparison of the cost of NHS hearing aid provision to be made with that of the private sector, both must contain the same cost elements.

In support of this, the general comparability of public and private sector costs was confirmed in the oral evidence given by the Minister which indicated that the emerging "tariff" was not dissimilar to the costs charged by the private sector for NHS patients in the current PPP. A point of view also made by the RNID representative in oral evidence.

Why are hearing aids for private patients so much more expensive than NHS hearing aids?

I understand that evidence submitted by others, as referenced at the oral evidence session, has compared the £40 [sic] cost of an NHS hearing aid with the £2,000 [sic] cost of a private one. I would contend that both figures are incorrect.

It would appear that the £40 figure quoted relates to the price to the NHS of the device itself. Firstly, it is my understanding that the average cost to the NHS of digital hearing aids is £70 excluding the cost of individually made earmoulds. Secondly, it does not include the cost of all the services associated with hearing assessment of the individual, the fitting and validation of the device, as well as the overhead costs referred to above and long term after-care services.

There does not appear to be any current definitive information regarding the actual full economic cost of NHS hearing aid provision. The closest proxy is probably the figure of £270 plus the hearing aid cost which was given by the Minister in oral evidence as the emerging "tariff" cost. However, even that cost possibly does not include all overheads and it certainly does not include after-care costs.

The figure of £2,000 quoted as being typical for private sector hearing aids is also incorrect. I cannot comment upon the prices of other suppliers but the hearing aids provided to private clients by my own company, over the last 12 months, have an average price of £1,155 including VAT. However, I would emphasise that the prices paid by private sector clients include not only the hearing aid system itself but also all professional and aftercare services for the lifetime of the hearing aid system and VAT.

I would therefore respectfully suggest that, rather than comparing £40 with £2,000, the nearest comparison which is possible, between NHS and private provision, is £270 (plus hearing aid cost) and £1,155 (including hearing aid cost).

This still represents a discrepancy, which can be accounted for by the following five main elements:

1. *Scope of Service*

The NHS cost, as with the contracted PPP service, comprises the device and a patient journey of three sessions. By comparison, our private patient service comprises the device, typically six sessions during the first year and an open-ended after-care service typically comprising two sessions per annum for the lifetime of the device, all included in the price.

2. *Cost of Device*

The NHS is the largest purchaser of hearing aids in the world. They are able to secure prices from their suppliers that are a fraction of the price that the much smaller, and fragmented, private sector can achieve. Typically, for our private customers, we pay three times the price that the NHS pays for equivalent devices (although NHS patients benefited from NHS pricing under the PPP).

3. *Economies of Scale*

As the dominant provider of hearing aids, the NHS has much higher patient throughput and can potentially organise itself to achieve economies of scale that are not available to the private sector for their private patients. A properly structured, large-scale PPP would enable the private sector to achieve similar economies for NHS patient provision.

4. *Flexibility of Service*

The private sector typically offers services over a longer working day, often into the evening, and on Saturdays. This involves staff rostering arrangements which add cost but benefit our clients.

5. *Commercial Overheads*

Like all providers of private services, we need to promote those services within a competitive market place to attract clients. We have advertising and additional marketing costs that do not apply to the public sector and would not apply to private sector provision to NHS patients.

I trust that the above provides additional clarity which I hope will be of use to the Committee. I would conclude by remarking that private sector hearing aid provision is a competitive industry, with recent new entrants adding additional competition. This is driving down prices and will continue to do so. The current PPP and any future PPP will also be competed heavily and will ensure the most competitive pricing for NHS patients comparable, we believe, with the true cost of in-house NHS provision.

Jeff Murphy

Chief Executive, Ultravox UK

Evidence submitted by the Association of British Dispensing Opticians, the Association of Optometrists and the Federation of Ophthalmic and Dispensing Opticians (AUDIO 40)

EXECUTIVE SUMMARY

1. The optical sector has been the field leader in delivering access, quality and choice for all in eye care, spectacles and contact lenses. The sector has delivered and trained its own high quality workforce to meet demand and established its own clinical governance, quality and regulatory frameworks to ensure consistently high standards to patients. As a result, quality and patient satisfaction rates in optics are extremely high.

2. Some optical providers also already provide hearing services. These and other providers stand ready to expand their services to meet demand and to take on much of the work currently causing long waiting lists in the NHS and distress for patients and carers.

3. All that is needed to bring this about is a speedy agreement about a partnership framework between providers and the NHS. We would argue this should be based on the optical model with an NHS prescription or voucher and agreement with the sector on costs. Using the readily available resource of optical practices in easily accessible locations, and building on their expertise in clinical quality and service to patients, must be a cost-effective way forward.

4. This could rapidly be put in place and, within months, could significantly expand audiology capacity in the UK. In the foreseeable future, this could lead to resolution of access and waiting times problems in audiology in the same way as it has in optics and to the same high standards of quality, access and patient service.

5. The optical bodies stand ready to enter into discussions with the Department of Health and NHS to bring this about. We would also welcome the opportunity to give oral evidence to the Committee to explain how we have achieved what we have achieved in optics and how these principles might rapidly be carried across into audiology to transform services for patients.

INTRODUCTION

6. This evidence is submitted by Professor Nick Bosanquet on behalf of the Association of British Dispensing Opticians (ABDO), the Association of Optometrists (AOP) and the Federation of Ophthalmic and Dispensing Opticians (FODO), some of whose members already provide hearing services and where capacity could be rapidly expanded to meet national demand.

7. FODO speaks on behalf of 70% of the UK optical market including the supermarkets, substantial high street companies such as Specsavers, Boots, Dollond & Aitchison, Vision Express and Scrivens, and mobile domiciliary providers such as Healthcall. The AOP represents optometrists in the UK many of whom run independent optical practices in the community. The ABDO similarly represents dispensing opticians (of which approximately 25% specialise in the fitting of contact lenses) many of whom also run community optical practices.

8. There are some 7,000 optical practices in the community in highly accessible, convenient locations close to where people live, work and shop.

PARTNERSHIP ROLE OF PRIVATE SECTOR

9. The Committee has expressed a particular interest in the issue of whether the private sector could expand its role in providing audiology services. We set our evidence in the context of the analysis that existing NHS services are already under severe strain and, without effective changes in the way that hearing aids are provided, cannot possibly meet either current or future demand. We concentrate therefore on three issues:

- (a) What has been the record of private/public partnership in opticians' services? Has this provided safe and effective services which have offered value for money for patients and the NHS? Is it a model that might be followed for audiology?
- (b) What has been the record so far in providing audiology services? Have companies been able to offer these services?
- (c) What is the scope for expansion in public/private partnership in providing care to patients in need of hearing aids?

SUCCESS OF THE OPTICAL MODEL

10. The optical sector has been the field leader in delivering access, quality and choice for all in eye care, spectacle and contact lenses.

11. The original intention at the start of the NHS was that sight testing should be carried out in hospital ophthalmology departments. There was a "temporary supplemental arrangement" for sight testing by opticians.⁶ However, the opticians' service developed beyond this, partly as a result of lengthening waiting lists, and was ultimately recognised as a permanent part of the NHS under the Health Services & Public Health Act 1968, which made provision for General Ophthalmic Services of sight testing and supply of spectacles (administered like the General Medical and Pharmaceutical Services). In 1985 the dispensing function (supply of spectacles) was deregulated following which there has been intense competition in the optical market to the benefit of both patients and the NHS.

12. As a result there has been a rapid growth in the use of spectacles and contact lenses whilst clinical standards in sight testing have improved rapidly. Before 1985 the technology of sight-testing had shown little change for the previous 60 years. Since then there has been a rapid rise in standards with new technology improving the accuracy of sight testing and the ability of practitioners to detect conditions such as early glaucoma during the sight test examination. This provides a very early and effective low cost method of screening which benefits the health and well-being of the patient, preventing longer-term costs for the NHS. Empowering patients through the optical voucher scheme has also resulted in up-to-date developments in spectacles and contact lenses being made available far earlier than would otherwise have been the case.

13. The main focus of the NHS general ophthalmic services (GOS) until now has been on sight testing and the issue of spectacles. This partnership has involved the NHS purchase of eye tests for children, older people and at risk groups and the provision of vouchers for spectacles. The opticians have provided a highly regarded service from widespread and easily accessible locations.

⁶ Bosanquet N, 2006, Developing a New Partnership Contract for Community Eyecare in England. Imperial College; Bosanquet N, 2006, The Key Role of Dispensing Opticians. Imperial College.

14. The supply of NHS ophthalmic services through the private sector has ensured that NHS patients receive a high quality of care. The same service levels are delivered to NHS and private patients alike. Private sector funding of ophthalmic practices has enabled the NHS to benefit from high standards of equipment and clinical training in the delivery of NHS services to patients. This has also enabled the NHS to deliver ophthalmic services in an extremely cost-effective way.

15. As an indication of the high quality and highly reliable service provided by the optical model, last year there was only a very small number of complaints from 17.5 million consultations.

EXPANDED ROLE IN DELIVERING CARE OUTSIDE HOSPITAL

16. Following a recent government review, the government and representative bodies FODO, AOP and ABDO are now in discussions with the NHS about new contractual arrangements which would cover a wider range of eye care services in the community. This is intended not only to increase patient access and convenience but also to help tackle long waiting times and bottlenecks in hospital ophthalmology departments. This follows on successful pilot schemes for direct referral of patients with cataracts or glaucoma by optometrists. The first Report of the National Eye Care Steering Group has also contributed through its detailed definition of care pathways. Most recently the Department of Health has published a report on the development of local commissioning to provide the wider eye care service. It is recognized there is substantial unmet need for early diagnosis especially among older people and that it would be possible to use private/public partnership to offer a much more accessible service.

ENSURING QUALITY

17. The optical sector has been at the forefront of driving up standards and ensuring clinical and service quality. Notwithstanding world-beating innovations in product and quality control, the sector has also, on its own initiative and without public investment, developed a Code of Practice for all providers of domiciliary care as well as—recently—new optics specific standards for clinical governance (attached). The commitment to quality and patient service is what drives optical providers and on which their success depends. This has already read across into audiology.

WORKFORCE

18. The optical sector also has a successful track record in developing its own highly trained workforce to meet demand. Not only does it fund its own workforce training and development but, faced with potential shortfalls in recent years, has funded a new School of Optometry at Anglia Ruskin University, its own Dispensing College in Kent and optical conversion courses at Bradford. Unsurprisingly therefore there has been a substantial increase in numbers of qualified staff working in the service with increases between 2001 and 2006 of 7,500 to 9,200 for optometrists and 4,500 to 5,200 for dispensing opticians. There is an extensive competency and qualification programme developed by the regulator (the General Optical Council) informed by the profession.

WHAT HAS BEEN THE RECORD SO FAR IN PROVIDING AUDIOLOGY SERVICES? HAVE COMPANIES BEEN ABLE TO OFFER THESE SERVICES?

19. There has already been a development of services for testing hearing and fitting hearing aids involving a number of companies such as Boots, Scrivens, Specsavers and Healthcall. As in optics, the sector has shown itself very ready to respond in innovative ways to opportunities to improve services for patients.

20. After pilot schemes in Leeds and Shropshire the Department of Health has also contracted with David Ormerod Hearing Centres and Ultravox to fit hearing aids. So far these contracts have served 68,000 people. These contracts have recently been extended and in July 2006 Health Minister Lord Warner in a speech in the House of Lords spoke of the possible further extension of a similar type of service to procure an additional 300,000 patient pathways from the non-NHS sector from the early part of 2007. This procurement together with the wider Audiology Action Plan are still awaited. An additional 48,000 patient journeys by way of the second wave Independent Sector Treatment Centres have also been tendered for. However there is far more that could be done.

COULD OPTICIANS EXPAND THEIR ACTIVITIES IN AUDIOLOGY?

21. The answer is a resounding yes. There is good evidence of the need for more accessible services, especially for older people. The national Study of hearing carried out by the MRC estimated that 67% of the over 80s population in the UK have some form of moderate or severe hearing loss, ie 1.57 million people (Davies 2003).⁷ FODO, AOP and ABDO members have already invested in audiology and could expand

⁷ Davies A (2003) A National Study of Hearing. MRC.

the number of patients served in months rather than years. The Committee will have received evidence from Specsavers about their potential role and other providers including Boots, Scrivens and Healthcall, independent optical practices and others are all willing to become more involved.

22. The practice whereby companies provide a duality of an optical and audiological function is already well established. Scrivens have been providing such a service within their practices for almost 50 years, have been providing a hearing aid service within Dollond & Aitchison for the past 15 years and also provide similar services in Ronald Brown Opticians, Conlons Opticians and Alton Murphy Opticians. Scrivens currently provides such a service from its 140 optical/hearing practices as well as a further 250 centres including its own high street stand-alone hearing centres, other optical outlets and health centres. Specsavers offer a hearing aid audiology service through 220 of their high street outlets at present and plan to expand this to more than 350 over the next two years.

23. Hearing care at Boots is operated by David Ormerod Hearing Centres (DOHC) who operate in 111 High Street Hearing Centres nationwide within Boots Opticians; with an additional 50 Hearing Centres operating in stand alone high street stores or from within NHS Audiology Departments. The Company also operates a nationwide domiciliary service through a second brand Advanced Hearing Services. DOHC has established a proven track record through the successful delivery of Public Private Partnership (PPP) to provide a high quality nationwide adult hearing aid audiology service in the community and on the high street.

24. Healthcall Optical and Hearing Services also operate a nationwide domiciliary eye care service for people who are unable to attend a fixed practice and a private hearing aid service for this group of patients. Their experience shows a high level of audiology need for housebound individuals which is not being met and does not appear in NHS statistics.

NEW PARTNERSHIP

25. All that is needed to bring about a quantum leap in service and quality is a speedy agreement on a partnership framework with the NHS. As in optics, a tried and tested method would involve an NHS prescription of a hearing aid and an agreement with the industry on costs. It could also provide for some choice in that the prescription could be used with any accredited supplier. The service could also be extended to those users with mobility problems. In optics FODO, AOP and ABDO members have already developed a dedicated service for housebound individuals ensuring that vulnerable individuals have much better access to eye care. It would be very possible to develop a similar service in audiology. At present many elderly housebound individuals go without hearing correction and many die before they get access to the service.

26. It is often alleged that non-NHS providers would be limited to patients with the least severe problems. This is not so in the case of audiology where a new partnership could involve better service for people with the most serious problems of access. Professor Ian Philp, the National Clinical Director for Older People, has recently stressed the importance of early intervention and assessment for a range of conditions including hearing.

GROWING DEMAND

27. The new partnership could also expand to serve the additional requirements which would arise from population ageing and the greater availability of the service. It is likely that some people are deterred by the length of waiting lists. It is vital that future partnership should be seen as a long term commitment to greater variety of supply and choice rather than a one off exercise for reducing waiting times. However, if taken forward only in this latter short term context, the problem will simply recur after a year or two whereas there is now an opportunity to solve the access problem once and for all.

RECOMMENDATION

28. FODO, AOP and ABDO members are ready to develop a partnership with the NHS which could deliver a better service within months. Using the readily available resource of optical practices in easily accessible locations, and building on their expertise in clinical quality and service to patients, must be a cost effective way forward for audiology. When the original programme was announced in February 2003 the press release was headed: "Digital hearing Aids available to all by April 2005". This clearly has not happened but a new private partnership could greatly improve access within months and make this a reality for patients, the NHS and government.

Professor Nick Bosanquet

Association of British Dispensing Opticians, the Association of Optometrists and the Federation of Ophthalmic and Dispensing Opticians

9 February 2007

Evidence submitted by Adam Beckman, Plymouth Hospitals NHS Trust (AUDIO 38)

I am the Head of Audiology Services for Plymouth Hospitals NHS Trust, where I have been for just under two years. Prior to this, I was the Team Leader for Adult Rehabilitation/Hearing Aid Services at the Royal National Throat, Nose and Ear Hospital, and a lecturer at the Institute of Laryngology and Otology (a post-graduate institute of University College, London). I therefore have personal experience of leading hearing aid services in two highly different services, and have a high level of theoretical expertise.

I was also seconded to the RNID as the Project Audiologist for the Modernising Hearing Aid Services Programme. This gave me an incredibly broad perspective of audiology services across England.

Since moving to Plymouth, I have been responsible for developing the service to manage the huge waiting lists that had developed. Now that funding has been approved by the PCTs, we are in the process of clearing these, and are on target to see all 6,000 patients with waits of greater than 13 weeks by 31 March 2007. This is being achieved with a combination of NHS provision and short-term private sector partnership.

EXECUTIVE SUMMARY

- The reasons for the large numbers of patients waiting excessive lengths are complex, but are largely a result of under-staffing for a long time.
- I believe that there could be sufficient capacity within the system to provide the services required within a sensible timeframe.
- However, I have grave concerns for the adequate treatment of our patients with the current round of independent sector commissioned work which is due to come on stream in April 2007, and fear that it will have a negative impact on NHS Audiology services.

WAITING TIMES

1. I believe that accurate waiting time data for Audiology services can be available. However, due to the variety of systems used to manage waiting lists, the accuracy of data is reliant on high level support from Trust performance information teams, which may not always have been made available. Thus, current data may not be wholly reliable.

There is an additional confounding factor. For most basic diagnostic testing provided by Audiology services, there is a zero waiting time. However, this activity—direct support to ENT services—is not typically counted.

2. Audiology services appear to lag behind many other services in terms of waiting times for many and complex reasons. However, I believe that the key reasons can be summarised as follows:

(a) Failure to invest in the workforce long-term

Many Audiology services have had too few staff for many, many years. They have been able to keep going through a combination of hard work, recurrent “waiting list initiatives” and, frankly, very poor quality working practices. When higher quality, evidence-based practices were introduced, there was insufficient capacity in the system to manage this.

(b) Impact of waiting time targets for ENT services

Consecutive efforts, year on year, successfully reduced waiting times for ENT services. However, to do this, additional ENT outpatient clinics were required. These needed Audiology support, taking staff away from hearing aid services that were already stretched.

(c) Impact of changes to community audiology services

In many areas, clinical medical officers used to run paediatric community Audiology services. It has generally been recognised that this was inappropriate, and the services now typically come under Audiology. However, there were often no additional Audiologists made explicitly available in workforce planning to take on this work.

(d) Impact of the introduction of digital hearing aids and evidence-based protocols

The huge investment that has been made to improve the quality of hearing aid services for patients is wholeheartedly welcomed. The improvements in outcomes and quality of life are extraordinary. However, the changes created a huge surge in demand. As many services were stretched already, and as resources were actually being diverted away from hearing aid services to the “targeted” ENT services, this resulted in greatly increased waiting times.

(e) *“Rapid” introduction of the 13 week waiting time targets*

Many of us involved in the Modernisation of Hearing Aid Services (MHAS) Programme could identify a pattern across services of a five year trajectory. It became evident that the surge in demand would take approximately that long to manage in most services. Those services which were among the first to join the programme (First Wave) have now returned to the steady state. Those which only started in later stages, such as 2004–05, are still in the process of managing this surge in demand whilst now having to contend with the 13 week targets.

3. In areas that have had investment over a long period, NHS Audiology services are clearly able to manage the demand. This is shown by the wide variation in waiting times (and numbers waiting) across England. Should the higher levels of funding available in some areas be made available to struggling services, along with the introduction of the proven methods for reducing queues and matching capacity and demand, I have no doubt that NHS Audiology services could meet the current demand.

4. It is not obvious that there is sufficient capacity to meet the “unmet need”. Early intervention studies do suggest some advantages to this approach. However, it is not obvious that, in the current framework, seeking additional work should be the priority.

5. It is likely that enough Audiologists are being trained. However, there has been a failure of the DH and professional bodies to ensure the introduction of the Associate Practitioner to support services.

6. Having worked with the Public Private Partnership, with some success, I believe that there can be a role for the private sector in providing Audiology services. However, I have extremely grave concerns for the welfare of our patients in the current round of IS commissioning.

7. By grouping audiology with diagnostic services, it is apparent that the successful bidder, certainly in our region, does not have a clear understanding of what is meant by an audiology service. They are on a very steep learning curve, but as they are supposed to “go live” in less than two months, I fear that the quality of service that patients in our area will receive will be significantly compromised.

8. I am also concerned that the funded levels of activity for the IS are based on old data. Therefore, in areas where waiting lists are being successfully reduced now to help meet the 13 week waiting time targets, there is likely to be over-capacity in 2007–08.

9. As the IS provision comes from ring-fenced funding, I fear that commissioning decisions will result in resources being moved from NHS Audiology services, despite the best intentions of the DH. This would result in the individual and institutional expertise in managing our patients being lost or broken up.

RECOMMENDATIONS

- There is a need for “joined up planning” at the DH. The 13 week/18 week pathway work, which covers many specialties, is running ahead of the National Audiology Plan. It is essential that these strands are developed rationally, so that the NAP is not driven by the political need to reduce waiting times rather than ensuring that we have services that will most effectively meet the needs of our patients long-term.
- There must be rigorous and transparent Clinical Governance pathways with appropriately qualified specialists to ensure that the centrally managed IS providers are accountable as locally funded NHS providers are.

Adam Beckman

Head of Audiology, Plymouth Hospitals NHS Trust

8 February 2007

Evidence submitted by John Beadle (AUDIO 6)

My PPI Forum Working with Darent Valley Hospital has been researching the situation with regard to Audiology Services for three years. Initially this was related to those provided at our own Hospital but this was expanded as we found common problems throughout Kent and then elsewhere in the UK.

We have produced a comprehensive Report on our findings, which I can provide if required. However, I have also prepared a Resume document which provides a summary of our findings. I am enclosing a copy of this, together with a background paper on Audiology Services, generally, and a summary of the possible causes of the current situation.

I hope you and your Committee will find these useful in their deliberations.

BACKGROUND

1. It is estimated that one in seven of the UK population suffer from hearing loss of some sort. Hearing loss can be caused by numerous factors. These include:

- Deafness from Birth.
- Severe Infection.
- Side Effects of certain Drugs.
- Exposure to Loud Noise both short and long term.
- Otosclerosis.
- Sudden Changes in Pressure.
- Ageing.

2. In the vast majority of cases a hearing aid, which amplifies the sound passing through the ear, can be used to “restore” hearing to a greater or lesser degree. For small hearing losses such aids can be worn in the ear canal, but for more severe losses a behind the ear aid has to be used, or in very severe cases a body worn aid.

3. In a small number of cases, regular infection or allergic reaction to ear moulds, may make it necessary to use a hearing aid which functions by transmission of sound by vibration through the skull to the nerve cells in the cochlea. When neither air transmission aids nor bone transmission aids can be used due to cochlea impairment, the final resort is to have a cochlea implant. This involves major surgery.

4. Originally, simple air transmission hearing aids were of the analogue type. These give a relatively crude sound, open to distortion from background noise. Modern aids use sophisticated digital technology providing a much clearer sound, which in some instances can eliminate much of this background noise.

PATIENT OPTIONS

Private

5. All forms of aid for the correction of hearing loss are available privately from hearing aid dispensers. These dispensers are subject to control by The Hearing Aid Council. These dispensers operate from High Street premises; Private hospitals or visit patients in their own home. No referral by a GP is necessary.

6. From initial contact to supply of an air transmission aid, usually of the digital type, the time frame is in weeks. Costs can vary from about £500 to several thousand pounds depending on complexity of the aid chosen. Digital hearing aids have been available from the private sector for many years.

7. Regular follow-up is given to ensure that the Aid is being used correctly and re-testing is offered at regular intervals to check for any progressive hearing loss.

NHS

8. The majority of patients rely on the NHS to provide their hearing aids from Audiology Departments in selected Hospitals. Aids are provided on loan, free of charge. This procedure requires referral from the patient’s GP.

9. Until 1998 only analogue hearing aids were available from the NHS but at that time a small number of pilot hospitals were selected to introduce digital hearing aids on a trial basis. This has gradually been broadened to other Audiology Departments and by 2005 it is expected that all will convert to supplying digital Aids—for new patients. Digital aids were not introduced into Kent hospitals until late 2003.

10. It is stated Government policy that, in the long term, all patients with existing analogue hearing aids will have their aids changed to digital. However, this process will take up to five years.

11. It should be noted that the fitting, and adjustment, of a digital hearing aid requires more time and sophisticated technology than that needed for an analogue hearing aid. Thus, given the same staffing levels and outlets as currently exist, the number of patients able to be provided with a hearing aid will reduce, thus increasing waiting times. Current waiting times vary from weeks to several months, or even years, depending on the location of the service.

ASSOCIATED PROBLEMS, NHS

Battery Supply

12. All Hearing aids use batteries which require replacing at regular intervals. These can vary from weekly to monthly depending on the frequency of use and the power of the aid. Supply of new batteries is usually via personal attendance at an Audiology Department or by post. Batteries are occasionally available from GP’s surgeries or medical centres but this is rare.

Repairs/Replacements

13. A few audiology departments provide “walk-in” clinics at certain times when aids can be taken for repair or replacement. This also gives the patient the opportunity to have their ears checked at the same time for signs of infection or excessive wax build-up. Other audiology departments only carry out repairs by post or by appointment.

Clinical Problems

14. The act of wearing a hearing aid that requires ear mould causes the production of excessive ear wax in some patients and occasionally frequent infections. When this occurs sound is either distorted or even no longer transmitted. This can be extremely difficult for those patients with a severe hearing loss.

15. Excess wax may require physical removal by syringing or by using a suction technique. Syringing is usually carried out in local medical centres but in difficult cases or for those patients with severe hearing loss referral to a Hospital ENT Department where the suction technique is applied, may be necessary. In cases of infection the patient’s GP may prescribe antibiotics to be applied in the form of drops in the ear, or as capsules to be taken orally. It should be noted that a hearing aid cannot be used if ear drops are being used. In severe cases the patient may be referred to the nearest hospital ENT unit for treatment.

16. It should be noted that for patients with a severe hearing loss, any excessive wax build up or infection can cause total deafness. Thus rapid treatment is essential.

17. In a small number of patients, severe allergic reaction or frequent infections, may prevent the use of a conventional hearing aid. In these cases, a bone conduction aid may be offered, providing the cochlea is still functioning. The preferred aid is the Bone Anchored Hearing Aid (BAHA). However, funding for this aid, which requires minor surgery, is not universally available within the NHS, despite the fact that this type of Aid is the only one able to restore some hearing for the patient.

COMMENTARY

18. It is strange that the correction of defective eyesight and defective hearing should receive such extremely different treatment within the NHS. For minor changes in vision it is normal for patients to visit an optician. These are widely available and the patient has considerable choice. They can usually be found relatively close to the patient’s home, no referral from a GP is necessary, and the optician will carry out tests for glaucoma, cataract and other conditions in addition to checking for vision. If spectacles are prescribed the patient has the option of selecting basic NHS standard or paying extra for better quality. If the optician identifies other problems the patient is referred back to their GP who will refer them to the nearest NHS hospital for treatment. Regular one or two year re-checks are offered, by reminders from the optician. Patients who are blind or partially sighted, to a specific degree, are recorded on a national register. Thus the number of such persons is available for forward planning purposes.

19. For hearing loss the only treatment available is via a private audiologist or via an audiology department at an NHS Hospital. Treatment by a private audiologist must be paid in full by the patient. Not all NHS hospitals have an audiology department. Thus the patient may have to travel a considerable distance to get treatment. Patients can only attend audiology departments for treatment and supply of a hearing aid following referral by their own GP. Compared with private practice NHS audiology departments can offer only a limited range of NHS hearing aids and there is no possibility of up-grading to a better quality aid even by paying an extra fee.

20. There is normally no arrangement for regular reviews of the patient’s condition and this will depend totally on the patient initiating a re-examination via their own GP. This same arrangement applies to those patients who wish to upgrade from analogue to digital technology as there is usually no system in place to automatically offer an upgrade.

21. No national register is maintained of the number of patients who are deaf or have a profound hearing loss. Indeed there are no national statistics recording the number of hearing aids issued by the NHS. Thus it is not possible, currently, to predict the needs of patients for the future.

James Beadle

PPI Forum member, Working with Darent Valley Hospital

10 January 2007

Annex 1

NHS AUDIOLOGY SERVICES TIMELINE

2000—NICE Guideline No 8 Issued

Recommended universal use of digital hearing aids but also recommends an audit of facilities to ensure that they are adequate to accept this new technology. Few NHS Trusts appear to have acted on this latter recommendation. Manchester Supra District is a notable exception with an excellent published Audit Report.

2001—“Audiology in Crisis” Published

This Report from the RNID identifies many weaknesses in NHS audiology services. Also recommends the separation of audiology from ENT to provide greater accountability and efficiency. Few Trusts appear to have taken notice. Report mysteriously withdrawn from circulation.

2002—“Best Practice Standards for Adult Audiology” Issued

This booklet produced after several years of work by various organisations associated with the deaf and hard of hearing issued jointly by the DoH and the RNID. The booklet has a foreword by the then Health Minister, Jacqui Smith, which states “These standards describe a service which all audiology departments will want to work towards. These efforts, together with Department of Health investment into Modernisation of Hearing Aid Services will produce the best possible outcomes for deaf and hard of hearing service users.”

These standards are comprehensive and cover all aspects of service and not merely the issue of hearing aids. Few Trusts have implemented these standards or even attempted to do so. The current DoH view is that these standards are not standards but “aspirations”.

MODERNISED HEARING AID SERVICE (MHAS) PROGRAMME

The Modernised Hearing Aid Service (MHAS) programme was first piloted in a small number of selected hospital Trusts and then introduced into all Trusts in 2005. Despite the title the system serves solely to introduce digital hearing aids and focuses on new patients. It appears to assume that the “Best Practice Standards” are in place.

The MHAS programme was said to be “fully funded”. However this is not strictly true. The funding covers only the major extra cost of providing digital hearing aids plus associated computer testing equipment, with some funding of additional staff to administer the system, it does not cover accommodation or refurbishment to house the necessary staff and equipment.

The basis for the funding of the programme is not transparent and appears to be related to the number of conventional analogue hearing aids previously issued by the Departments concerned. Thus fully modernised facilities, complying with “Best Practice Standards” are given more funding than the sub-standard ones leading to an increase in the “post-code lottery” variation in service. Shortage of qualified audiologists, many of whom have defected to the private sector, has exacerbated the problems.

THE PPP SCHEME

In 2005 the DoH authorised two private companies, Ultravox and David Ormerod, to dispense NHS digital hearing aids. This arrangement is purely to help reduce the embarrassingly long waiting lists and times in NHS Trust hospitals, and relates mainly to new patients. Money spent on the PPP scheme is then not available to modernise NHS facilities.

These private companies are happy to receive NHS Patients who can be “persuaded” to purchase “better” private aids, and it is significant that one of the companies has recently stepped up national advertising for these “better” aids. In some cases these companies are provided with space in NHS Trust Hospitals to operate, and this situation is also featured in their advertising.

Money spent on the PPP Scheme is not additional money. Money used for this purpose may prevent improvements to NHS audiology departments. Cost per patient is probably higher via the PPP Scheme than via NHS Trusts.

Annex 2

BASIC CAUSES OF CURRENT PROBLEMS IN SOME AREAS

- Issue of *Best Practice Standards for Adult Audiology* in 2002, by the Department of Health, but failure to ensure that they were instituted or even read.

- Failure to identify the numbers of patients expected to require digital hearing aids or even set up a data collection system for that purpose.
- Failure to adequately fund the MHAS programme funding not related to catchment area size.
- Failure to monitor performance of audiology departments by the healthcare commission either in star rating programme or in current annual healthcheck.
- Failure to review management of audiology departments and relationship with ENT, as identified in “Audiology in Crisis” published by the RNID in 2001.
- Total indifference to “post-code lottery” situation by a succession of Health Ministers.
- Too great a concentration on digital hearing aids for new patients by RNID and the Department of Health.
- Introduction of a telephone hearing test by the RNID, without discussion with NHS audiologists, which greatly exacerbates existing capacity problems.

Annex 3

DEFINITION OF TERMS

Standard—A definitive level of excellence or adequacy required, aimed at, or possible

In 2002 the Department of Health in conjunction with the RNID issued *Best Practice Standards for Adult Audiology*. This followed publication of the document *Audiology in Crisis* published in 2001. These Standards were drawn up by an eminent Group of people associated with the Deaf and Hard of Hearing together with the NHS and Medical Practitioners.

The foreword to *Best Practice Standards for Adult Audiology* clearly states the Government view at that time. No attempt was made to ensure that these Standards were put in place. Currently the Department of Health state that these Standards are not Standards but “aspirations” and they are not applicable to the NHS.

Services

The Scope of Audiology Services is clearly defined in the *Best Practice Standards for Adult Audiology* published in 2002 (Section 3 pages 23 to 28).

The RNID issued a Summary Booklet *A Good Audiology Service—What You Can Expect*, following production of the “Best Practice Standards” in 2002, for use by patients.

The Modernised Hearing Aid Service (MHAS) introduced by the DoH during 2005 relates solely to hearing aids and is concerned solely with the introduction of digital hearing aids. It does not cover the total service as defined in “Best Practice Standards” but seems to assume that the Standards are already in place.

It should be remembered that not all patients can benefit from a digital hearing aid.

Concentration of effort to provide digital hearing aids to new patients has resulted in a marked diminishing of the total service for long term hard of hearing patients.

Annex 4

DARENT VALLEY HOSPITAL

Audiology Services prescribed by Best Practice Standards for Adult Audiology

Catchment area	200,000
Hearing test rooms	Four
Rehabilitation rooms	Five

Size of Rooms

Hearing test	11m ²
Rehabilitation	13m ²

Staffing

10 audiologists

Access to reception and waiting areas, treatment and testing rooms should be suitably adapted for all users. Planning should take into account the fact that the majority of users will be deaf or hard of hearing. The audiology department should be well signposted. Even with the latest renovations (April 2006) Darent Valley Hospital fails to provide the above.

For comparison the following hospitals with a similar catchment area to Darent Valley have been identified.

Fairfield Hospital, Bury

Catchment Area	185,000
Staffing	10 audiologists plus 2 clerical
Equipment	26 audiometers
Waiting Time (Referral to Fitting)	9 weeks

Ormskirk Hospital, Ormskirk

Catchment Area	200,000
Staffing	8 audiologists plus 2 clerical
Equipment	4 audiometers
Waiting Time (Referral to Fitting)	18 weeks

Manchester Royal, Manchester

Catchment Area	189,000
Staffing	8 audiologists
Equipment	14 audiometers
Waiting Time (Referral to Fitting)	21 weeks

Birch Hill Hospital, Rochdale

Catchment Area	207,000
Waiting Time (Referral to Fitting)	16 weeks

Barnsley General Hospital, Barnsley

Catchment Area	250,000
Staffing	8 audiologists
Waiting Time (Referral to Fitting)	11 weeks

All the above audiology departments comply with best practice standards with regard to facilities.

Evidence submitted by Mark Brindle, Queen Elizabeth Hospital King's Lynn NHS Trust (AUDIO 32)

EXECUTIVE SUMMARY

It is possible to provide record accurate data on waiting times however the Audiology patient management systems available through the NHS Logistics do not lend themselves to obtaining this information easily.

There are still a large number of people waiting to be reassessed and changed from an analogue hearing aid to a digital one. New referrals are being seen within the targets.

Additional support staff are required in Audiology departments not additional audiologists. This would be a more effective use of resources.

If the private sector were to be involved in providing Audiology services would the continuing care required also be provided by the private sector or would the Audiology department be expected to see them for their continuing care?

INTRODUCTION

I have worked within the field of Audiology for the past 25 years. Starting as a student and now running a typical medium sized department. Working as a team we have always tried, and mainly succeeded, in introducing many new and innovative ideas. A good number of the ideas for modernisation and creative ideas for Audiology Departments were introduced locally some time ago. For example, Assistant Audiologists first started working in the department over 10 years ago. They are now invaluable and release significant amount of Audiologist time for performing more technical and demanding tasks.

This memorandum is written from the perspective of a forward thinking, award-winning medium sized department providing hearing and balance services to a wide range of people numbering over 12,000. All services are provided at the main centre and most of those services are also offered at six centres located in the local community.

1. Accurate data on waiting times are possible, however at least one of the two, if not both Audiology Patient Management Systems available through NHS purchasing, do not allow for easy recording and extraction of statistical information. Until the Guidance on completing the diagnostic waiting times and activity monthly data collection, valid from the 31 October 2006 was published the information of what to include and what not to include in the monthly return was very much open to local interpretation.

2. The historically low investment in Audiology was only part resolved when the service went through the Modernisation of Hearing Aid Services (MHAS) process. Very little account was taken of the large numbers of current NHS hearing aid users who would want to be reassessed and have their analogue hearing aid replaced with a digital one. Thus there are large waiting times for reassessments at many hearing aid centers.

3. This department is able to provide a service to patients following the MHAS protocols and keep within the Government targets with the present or near to the present level of resources. It cannot however provide this service to new referrals, keep all present NHS hearing aid users operating and reassess those who wish to change from an analogue hearing to a digital one, in sufficient numbers the result being very long waiting lists for the latter.

4. If all analogue hearing aids could be changed over to digital ones then the reassessment waiting times would shrink significantly. With only those having difficulty with their present digital aid requiring reassessment. Therefore the pressure on the department could be greatly eased if this cohort of people were taken out of the equation. It may be possible for the private sector to perform this task.

5. There are 4.6 WTE Audiologist in the department, 2.5 WTE Assistant Audiologists and 1.2 WTE Clerical staff. The ratio of Audiologists to other staff is much lower than in most Audiology Departments. This ratio could be further reduced with the introduction of the Associate Audiologist grade. These AfC Band 4 staff could perform some of the routine work of the Audiologists thereby freeing up some of their time. Thus the capacity of the department could be increased with much less investment and in a much shorter time and with less pay expenditure than Audiologists. There clearly needs to be sufficient numbers being trained to replace those leaving the profession and some extra for the aging population. There need not be a “dumbing down” of services simply because additional staff are employed within the profession who do not have a degree qualification. There need to be clear and agreed roles so that the work of Audiologists is not performed by inappropriate staff.

6. Consideration will be required to be given to the sustainability of providing an open-ended service to all people once they have been issued with an NHS hearing aid. With an ever-increasing elderly population it is almost certainly unaffordable to continue to provide the present level of hearing aid service.

7. Following on from other specialities the wide and varied work performed by Audiology Departments needs to be included within the Payment by Results remit using costs that accurately reflect the work performed. Only then will the work performed by each department and their associated costs be comparable.

8. If the private sector were to provide audiology services to significant numbers of people, then would they be willing to provide the continuing care that hearing aid users require to get the most from their aids. If not, then those people would have to return to the NHS Audiology Departments who in turn would not be able to keep waiting times down without some investment.

RECOMMENDATIONS

Employ many more Assistant Audiologists (AfC Band 3) and the widespread and urgent introduction of Associate Audiologists (AfC Band 4) using a competence based training program such as the one being looked at by the heads of Audiology in the East of England. These staff groups to perform many more of the routine tasks in Audiology by support staff.

To begin a debate on the appropriateness and financial sustainability of Audiology Departments providing an open-ended hearing aid service to NHS hearing aid users.

Mark Brindle

Audiology Services Manager, The Queen Elizabeth Hospital King's Lynn NHS Trust

8 February 2007

Evidence submitted by the British Academy of Audiology (AUDIO 16)

EXECUTIVE SUMMARY

The British Academy of Audiology (BAA) is the largest professional body representing Audiologists, mainly in the NHS with a percentage of the membership working within the independent sector.

The Academy is concerned about the limited amount of consultation regarding the changes to a major part of NHS Audiology Service Provision. In particular the second wave ISTC contracts being awarded to the private sector, the potential threat to the future of NHS Audiology Services and the lack of clinical governance arrangements of these contracts.

INTRODUCTION

1. Audiologists are the professional group with primary responsibility for treatment of people with hearing difficulties. The BAA is the professional body representing Audiologists, mainly in the NHS with a percentage of the membership working within the independent sector. The Academy has over 2,000 members in the UK and its members have been at the forefront of new developments in the provision of services to hearing-impaired people. We have a major stake in the successful delivery of effective and innovative services for our clients and therefore wish to be fully involved in the planning and provision of services for hearing people. The Health Select Committee offers us an opportunity to become more involved.

2. There is substantial unmet need for services for hearing-impaired people, partly through reluctance of people to come forward for treatment and partly through perceptions of long waiting times and unsatisfactory performance of hearing aids. Audiologists and the voluntary sector have pressed for many years for improvements in the quality of NHS hearing aids, culminating in 2000 with the DH programme of Modernisation of NHS Hearing Aid Services. This programme introduced modern (digital) hearing aids as standard NHS provision instead of outdated instruments manufactured specifically for the NHS. This step entailed very extensive re-training and development of information technology skills in the workforce and the learning of new techniques and approaches for management of people with hearing difficulties. The Modernisation programme was specifically funded by the DH and completed in 2005.

3. Alongside Modernisation, we have introduced a programme of graduate training as the basic entry qualification for professional audiologists, bringing the UK closer to the practices of other developed countries where graduate, postgraduate and doctoral qualifications are required. These degree programmes have been launched very successfully, selected and funded by the DH, and their output has just started to feed into the profession. During the development of these programmes, the alternative non-graduate routes into the profession have fallen away.

4. A consequence of Modernisation has been an increased demand for Audiology services, especially treatment of adults. The availability of better services has probably released some pent-up demand from unmet need, while there has been a “bulge” from patients wishing to upgrade from old NHS hearing aids earlier than they would have done otherwise. These consequences have increased waiting times to an unsatisfactory amount because there was not the increased capacity available immediately.

5. In order to increase capacity temporarily, the DH launched a Public Private Partnership (PPP) in 2003. Two private companies worked in partnership with the local Audiology Departments, who monitored the quality of the service and data was transferred between both parties.

6. The results of the PPP have not been published but our impression is that the scheme met with some success, although there have been examples of the private sector partners not fulfilling their obligations, being paid for work not done and up to 50% of these patients requiring access the NHS Audiology Service for further rehabilitation. The costs of PPP activity exceeded the marginal costs of treating the patients in the NHS by at least a factor of two, and hence the programme should be considered as a temporary stopgap. Following the removal of DH ring fenced funding of these services the PPP programme closed. Furthermore, increased financial constraints on PCTs and NHS Trusts have led to even more freezing of vacant posts for audiologists. As a consequence, many Audiology Services now have long waiting lists and access times for their services. Worryingly, the extent of frozen posts threatens the career prospects of new graduate audiologists who have been trained at NHS expense exactly to meet the circumstances that we are facing.

7. Hearing Aid Services have been included in the second wave ISTC contract and independent providers are being contracted to assess and fit patients with hearing aids. The detailed outcome of negotiations for ISTC services and the consequences for take-up by PCTs of NHS provision are not yet clear. However, given that hearing aid provision has been specifically excluded from the 18-week waiting time target,⁸ there is great concern that there will be reduced funding for NHS Audiology Services that will squeeze Trust budgets and exacerbate capacity constraints in the NHS—exactly the opposite of what has been planned for over the past decade.

8. In addition to the second wave ISTC contracts; Lord Warner in July 2006 announced further independent sector capacity of 300,000 pathways per year for five years for Hearing Aid Services. Strategic Health Authorities had to give firm figures to the DH as to their requirements prior to Christmas 2006. This was prior to any output from the National Audiology Action Plan. The difficulty this causes is that the PCTs do not know the number of pathways they will have to achieve and by when. These pathways committed by the Strategic Health Authorities may be in fact too high, which will undermine core Audiology Services.

BAA CONCERNS ABOUT ISTC CONTRACTING PROCESS

9. The BAA has major concerns regarding these contracts and their consequences for people with hearing impairments: in particular:

- The cost effectiveness of ISTC provision.
- Quality assurance/clinical governance arrangements of these contracts.

⁸ NHS Audiology Services are now faced with referral for hearing aids from GPs being excluded from the DH *Delivering the 18 week Patient Pathway* Updated 18 week Clock Rules of 11 December 2006.

- Destabilising effects on NHS Audiology services and workforce development.
- Determination of the numbers contracted.
- Treatment of patients with complex needs or pathologies requiring referral.
- Access to a full service including counselling, repairs and maintenance, hearing therapy and assistive listening devices.
- Data transfer of hearing aid specifications to the NHS Audiology Services.
- Quality of the hearing aids provided.

THE AUDIOLOGY ACTION PLAN

10. In conjunction with this work the DH have commissioned a National Audiology Action Plan. Progress on the Action Plan has not been revealed but the BAA has been invited to the Stakeholder meeting where we hope to address these issues. The BAA has not been involved in the planning and decisions affecting the provision of services to the extent that might be expected.

11. What is desperately needed is a long-term strategic plan for Audiology that builds on the successes that have been achieved through Modernisation and educational reforms. This should differentiate between the short-term adverse impact on waiting times from the success of modernisation, the adverse impact on waiting times of reduced funding and frozen posts, and the progress that will be made when the new graduate workforce starts to fill posts that currently are empty or frozen in the near future. The plan must recognise the potential for ISTC contracts to threaten this future progress, leading to a vicious circle of reducing NHS provision and increasing expenditure at greater unit cost outside the NHS.

12. The BAA recommends:

- re-directing the ISTC funding back to NHS Audiology Services where better value for money is available (provided the funding is not creamed off for other activities); and
- a robust analysis of these issues needs to be undertaken to provide a proper commissioning framework for the PCTs and future GP-led commissioning.

Whether accurate data on waiting times for audiology services are available

13. Currently the DH is collecting information on waiting times for certain types of audiology services. There are concerns within the profession over the accuracy of the data seen so far, as some Trusts are reporting monthly figures, other Trust tri-annual figures through the census. The exact information that has been required from Audiology Services was not explicit, labelling waiting lists as “Pure Tone Audiometry”, which is not meaningful in the current context. Audiologists are unsure of the specific data that are actually required about their services. We are concerned that planning is being based on inappropriate data.

Why audiology services appear to lag behind other specialities in respect of waiting times and access and how this can be addressed

14. As described above, Audiology Services appear to lag behind other specialities due to increased demand for digital hearing aid technology both from new and existing hearing aid patients, introduced as part of the Modernisation of NHS Hearing Aid Services. Increased funding associated with Modernisation has been appropriated by Trusts to feed into their general funds rather than directing this funding to Audiology. This can be addressed by introducing tariffs into Audiology whereby funding follows the patient and services will be funded appropriately. As there is a backlog of patients waiting, there is a requirement for additional short-term investment in NHS Services.

Whether the NHS has the capacity to treat the numbers waiting

15. The planned workforce developments will ensure that the NHS has sufficient capacity to treat the numbers waiting in the medium term. It will take some time for currently frozen and unfilled posts to be filled. Ensuring that funding goes to Audiology Services rather than being spent elsewhere will assist this. The increase in capacity required to shift the backlog of waiting patients is not great and once the backlog has been shifted the planned workforce developments should cope with increased demand associated with unmet need and demographic changes.

16. NHS capacity may be undermined if ISTC contracts lead to audiologists trained by the NHS leaving, or not starting work in the NHS.

17. There are issues of quality that cannot be separated from capacity. The NHS service is in the best position to following the guidelines, protocols, and complete care pathways in a quality assured service, as it has worked hard to establish these standards. Treating patients is more than assessment of hearing impairment and “click and fit” of the hearing aid; it must take into account the specific needs of the individual patient and the counselling /rehabilitation they require.

Whether enough new audiologists are being trained

18. As part of the DH Modernisation of Education and Training, Audiologists are now being trained in nine Universities in the UK, seven of which are in England. The BSc Audiology programmes at the Universities of Manchester and De Montford in Leicester have now been running for five years, with their first cohorts graduating in 2006. Some of these Universities also offer MSc and Postgraduate courses in Audiology. In total over 220 students are expected to complete both graduate and post-graduate courses each year. However, due to financial constraints in the NHS, there is a lack of money to enable Trusts to open posts to accept all these graduates and the cutting back on commissions for BSc courses by the NHS will restrict NHS capacity.

How great a role the private sector should play in providing audiology services

19. There is a role for the private sector to play in providing audiology services. Private provision of hearing aids has always been available to those who prefer to pay directly and this activity plays an important role alongside NHS provision. There is a possible role for the private sector to subcontract NHS work to meet short-term needs, as demonstrated by the PPP scheme. However, it should not take place at the expense of destabilising existing Audiology Services but as a planned part of the NHS Commissioning Framework. This needs to be discussed with local services and the PCTs in the context of the requirements of their own health economy. It needs to be fully regulated, with proper quality assurance, working in partnership with the local departments.

20. This partnership should ensure that patients are presented with a seamless service rather than fragmented services that do not exchange information nor coordinate provision. It is only by developing services in an atmosphere of cooperation and consultation that patients will receive the sort of service they are entitled to expect. Unfortunately, current developments have not been planned with this philosophy.

Pauline Beesley

President, British Academy of Audiology
On behalf of the BAA Board and Membership

February 2007

Evidence submitted by the British Society of Audiology (AUDIO 27)

Whether accurate data on waiting times for audiology services are available

1. Audiology services provide:

- end-to-end diagnosis and on-going management for about 24 care pathways:⁹
 - concerned with hearing and balance,
 - for adults and for children.
- diagnostic services for other care pathways.

2. As part of audiology services hearing aid services have been equipped with modern audiological equipment and given funds to provide one of two patient management systems.

3. These systems are used for the whole variety of audiology services and are capable of recording date of referral and do record date and time of any significant patient activity including appointments, assessment and fitting of hearing aids.

4. However there are no standards for recording referral or appointment type, no systematic interfaces with NHS systems and there are no standard reports that can be aggregated easily.

5. We suggest that, whilst there has been considerable advance in the last year with the data collections that the DH has established, there are:

- no “accurate” data available on all the pathways in audiology;
- no “accurate” data to enable good strategic planning of services eg differentiation of new referrals, existing patients, existing patients with urgent needs; and
- good enough data to show that hearing services are high volume and have long waits.

Thus the data show that there is a problem but are difficult to use in a strategic planning sense.

Why audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed

6. Access is a major element in quality service provision and in many respects audiology services occupy two ends of the spectrum. Newborn hearing screening for instance has improved access to services and reduced social and ethnic inequalities in those services. This has done this through specific commissioning of screening and associated services together with clear quality standards and a commissioning specification

⁹ See Do Once and Share—Hearing project report on www.mrcheat.info

for PCTs. Clearly this service does not lag behind other comparable services in the UK or elsewhere. On the other hand cochlear implant services for the profoundly deaf seem to be far less accessible and in some cases have associated long waits that clearly lag those in other specialties.

7. However, in terms of adult hearing aid services, such simple comparisons are not easy to make. In many areas of the country reported waiting times are minimal and in others they are simply staggeringly long. Whether this difference relates to the extent to which waiting times for existing patients is variably included in data (by differential referral criteria, or by judging existing patient assessment as repairs) is unclear.

8. There are four components of access that need to be considered:

- Hearing impairment (deafness) is insidious in its effect, on average hearing impaired people who consult wait 12 years (HTA report, Davis *et al* in press) before getting a service but only about one in three receive a service. So access needs recognition of the problem (often others recognise before the patient).
- A third of people who present at GP surgeries with hearing problems are referred for assessment. There is a need for good referral criteria and clearly GPs are deterred from referring to a system that has long waits.
- There are many people who have not formally asked for help who would benefit substantially.
- Many other people who would benefit from services are not seeking services due to lack of knowledge or due to the lack of appropriate local services eg this is particularly the case for those people with moderate to severe hearing loss who may have been told in the past that “there is nothing much that we can do for you”. Due to lack of formal recall and review arrangements these people and their GPs do not know that advances such as DSP hearing aids, implantable devices and environmental aids may be especially helpful if tailored to their requirements.

9. Waiting times are long because the demands on the system are not appropriately understood and taken into account in commissioning services. This is typically the case where prevalence of need outstrip demand eg there are at least 4 million adults whose hearing might be cost effectively improved with hearing aids,¹⁰ but only 1.2 million of these use hearing aids (with about 0.3 million hearing aid users having mild hearing loss outside this definition), with about 0.75 million seeing their GP and with 0.25 million being assessed and fitted with hearing aids for the first time each year. Small upward variations in referral could quickly lead to long waits. The demography of hearing impairment means that needs will continue to grow quickly at 1% per year for the next 15 years even with no change in prevalence rate due to the profile of the baby boomers and longer life expectancy. In addition to these factors there are two other features that have added to the demand on the services. These are (1) that Digital Signal Processing (DSP) hearing aids are providing far better outcomes and choice for patients than ever before—meaning that there is greater demand that have grown (2) there has not been a consistent policy about exchanging current analogue hearing aids used by patients for the more successful digital hearing aids. It is clear that this policy is variable and variably applied across the country leading to shorter or longer waiting lists.

10. There is no doubt that in terms of workflow that there are not many processes in common across departments and that skill mix is not deployed to make the best use of audiological skills. Good practice needs to be applied in terms of waiting list management and DNAs. Better working practices also need to be adopted in respect of working with ENT consultants as a diagnostic service, so that time is used more effectively. These practices would enable better productivity of staff in hearing aid services.

11. In order to provide better access to hearing healthcare consideration should be given to providing a screening, assessment or triage service in primary care. Together with more local accessible hearing services (that could capitalise in NHS Direct and NHS Walk in Centres as well as appropriate use of local authority infrastructure) this would ensure that need is equally met across the country. In order to ensure that waiting times are in line with other services, commissioners need to make robust commissioning arrangements against agreed quality standards with appropriate monitoring arrangements.

Whether the NHS has the capacity to treat the numbers of patients waiting

12. If appropriate commissioning and management arrangements were in place it is probable that the NHS might be able to assess and treat the numbers of new patients waiting.

13. Under current policies it is unclear whether existing patient care, hearing aid upgrade and hearing reassessment could be undertaken with the current capacity.

14. Clearly, there is not enough capacity to treat those who would benefit from services.

¹⁰ Davis, A, Smith, P, Ferguson, M, Stephens, D, and Gianopoulos, Acceptability, benefit and costs of early screening for hearing disability, HTA 2007 (in press).

Whether enough new audiologists are being trained

15. The workforce plans for ENT, audio-vestibular medicine and for audiology show the profiles for each of these workforces that play an increasingly inter dependent part in audiology services. The numbers need to be viewed and planned as a whole for audiology services to benefit the most over the next 10–20 years.

16. Graduate training in audiology in the UK is in its infancy and the first graduates are just beginning to take up posts. The indications are that these graduates are of incredibly high quality and could play a huge part in taking audiology forward in terms of leadership, scholarship and clinical practice. Clearly, it would be a big mistake not to train sufficient graduates of this calibre and deploy them.

17. However, it is clear that despite the workforce review recommending, for example, employing 200 additional paediatric audiologists to meet the changing service requirement, this has not happened, nor have graduates been recruited in the numbers that were envisaged when graduate courses were set up. This needs to be tackled. There is an additional requirement for assistants and associates to enable more efficient and productive services that are not being provided at the moment.

How great a role the private sector should play in providing audiology services

18. The private sector provides a good proportion of hearing aids in the UK to people who pay (about 20% of those who have aids, about a third of these also have NHS hearing aids). The private sector has expanded its services in the UK and there is a reasonable choice of hearing aid on the high street at a variety of prices. The private sector has also been procured to provide services (some places this has been additional capacity, in a few places this has been a replacement) for the NHS. It has done this with outcomes that are on a par overall the same compared with the NHS. Local health economies need to decide what sort of partnership, extent and type, they have with the private sector and ensure that they specify the services, including maintenance, training and audit to good quality standards. If the role is not a quality partnership that is managed then it will not provide good long term services to hearing impaired patients—most of whom need about 12 or 15 years of support post assessment.

British Society of Audiology

January 2007

Evidence submitted by the British Society of Hearing Aid Audiologists (AUDIO 10)

BSHAA is the professional membership body for Hearing Aid Audiologists in the High Street.

Across the UK there are 1400 practitioners: trained, state-registered and regulated specialists in assessing, fitting and rehabilitating patients who need hearing aids. They are up-to-date in constantly improving hearing instrument technology. They practice in almost every town centre and undertake domiciliary visits.

Their standards of professional, clinical and consumer practice have been regulated by the statutory Hearing Aid Council for over 40 years. They welcome the prospect of becoming registered and regulated healthcare professionals within the Health Professions Council in the near future. Most already have good professional relationships with NHS audiology departments, GPs and local hard of hearing voluntary organisations.

We believe that Hearing Aid Audiologists in the High Street are a unique and unparalleled professional resource, with the potential to provide an immediate, quality, locally accessible and cost-effective hearing aid service to NHS patients.

EXECUTIVE SUMMARY

The NHS does not appear to collect full information on the local and national pictures on patients waiting for audiology and hearing aids, at all stages in the journey from presenting need to final delivery of service.

Estimates have been made that 500,000+ patients may be on various forms of waiting lists.

The NHS does not give priority to non-acute hearing disability. As a result there is insufficient investment in hearing aid provision, and NHS audiology departments have neither the funding nor staff to reduce waiting lists. Indeed, waits are getting longer, and new graduate audiologists are not able to find NHS jobs.

Declared Ministerial aims for “a long-term, sustainable, low wait solution” and “a digital hearing aid for everyone who needs one by 2005” appear far from achievable. The numbers of patients, the length of their wait, and the underlying unmet need—requires immediate, substantial and sustained government action and investment. The Government needs to get serious about giving patients the means of access to hearing care—free at the point of delivery—which the NHS accepts that they need.

The skills and capacity of NHS professionals for specialist audiology; and independent Hearing Aid Audiologists for adult hearing aid dispensing; need to be fully engaged and the systems freed up to allow this to happen efficiently and effectively.

The 1,400 Hearing Aid Audiologists practising on the High Street have the potential to provide an accessible, flexible, quality assured, specialist hearing care service to NHS patients. Using marginal capacity could offer almost immediate delivery. Opening up the NHS to the hearing aid market would benefit patients and consumers. Competition would improve choice, quality and cost.

The National Audiology Action Plan should develop the national frameworks and funding; for PCTs to be enabled to commission hearing care from the local market place; giving patients timely choice and access to services which meet their needs.

Whether accurate data on waiting times for audiology are available

1. The NHS does not appear to collect, and certainly does not publish, full information on the local and national pictures on patients waiting for audiology and hearing aids, at all stages in the journey from presenting need to final delivery of service. Estimates have been made by the RNID of 500,000+ patients needing a hearing aid, on a waiting list for assessment or fitting, or waiting for reassessment for a digital up grade.

2. Declared Ministerial aims for “a long-term, sustainable, low wait solution” and “a digital hearing aid for everyone who needs one by 2005” appear far from achievable. The scale of the problem—the numbers of patients, the length of their wait, and the underlying unmet need—requires immediate, substantial and sustained government action.

3. SHAA’s survey of the length of time it takes for someone with a hearing loss to obtain a hearing aid from an NHS hospital or community clinic records the experience of patients.¹¹ In England the average wait has risen for the third successive year, to 48 weeks. In some areas patients have to wait up to 117 weeks for their first hearing aid, and up to five years for a digital replacement. Things have improved over the past year for people living in Scotland, Northern Ireland and Wales, but things have got significantly worse in England with 41% of hospitals having increased waiting times.

4. There are significant regional variations. The North East and the South West saw significant increases in waiting times for a first hearing aid; the North West is the worst for people seeking to replace analogue with digital. Our survey is not a substitute for the NHS collecting and publishing its own information on the total length of the wait, and the number of patients waiting for hearing aids.

5. NHS information on the numbers and lengths of patient waiting lists for audiology assessments is now published as one of 15 diagnostic tests. 160,000 patients were recorded as waiting to be assessed in NHS Audiology departments in November 2006. Worryingly, although audiology patients are only 20% of the total number of patients waiting for any kind of test, they comprise nearly 60% of all patients waiting over 13 weeks, and over 75% waiting over 20 weeks. Over 100,000 patients are waiting over 13 weeks for an audiology assessment, with no indication how long any subsequent hearing aid fitting will take. 80,000 of them have been waiting for over six months. Many thousands of patients waiting for a “re-assessment” to have their hearing aid upgraded to current digital technology do not appear in any national figures.

6. Estimates of 500,000 and more have been made by the RNID for the real number of patients with a need, waiting for hearing assessment, for hearing care, for a hearing aid or for a digital up grade. Published demographic information suggests that c 3 million people in this country could benefit from a hearing aid. With an ageing population needs can only increase.

Why audiology services appear to lag behind other specialities in respect of waiting times and access

7. Audiology suffers from the simple fact that progressive hearing loss is an invisible condition, is not life threatening and affects older people in the main. Any commissioner having to make financial decisions between competing disciplines will always relegate hearing care and audiology to the bottom of their list of priorities.

8. There is no national target driving across the board reductions in waiting times or the number of patients waiting. Providing a hearing aid for an adult experiencing disability through a progressive hearing loss is highly cost-effective, and health and socially beneficial. It does not however appear to be a priority for the NHS.

9. We had believed that the announcement of 300k additional pathways of hearing aid care signalled government’s determination to solve the waiting problem once and for all. However it now appears that this 300k is not supported by additional ring-fenced resources. In the absence of investment, PCTs are not going to be able to commission more local services; from either NHS or independent providers.

Whether the NHS has the capacity to treat the number of patients waiting

10. Many NHS audiology services appear stretched beyond breaking point; under funded, under staffed; and with huge backlogs of patients waiting for assessment, for their first hearing aid, or for an upgrade to digital.

¹¹ BSHAA, *Suffering in Silence*, 2006.

Whether enough new audiologists are being trained

11. New graduate audiologists coming off degree courses commissioned by the NHS appear not to be able to get jobs. Responding to increasing customer demand, independent sector employers are funding the training of 300+ additional Hearing Aid Audiologists coming on to the High Street each year for at least the next four years. By 2008–09, these students will be graduating from the new Foundation Degree in Audiology, with the specific knowledge and skills to assess, fit and rehabilitate patients needing hearing aids.

How great a role the private sector should play in providing audiology services

12. In our view, the government needs to get serious about giving patients choice and the means of access to hearing care—free at the point of delivery—which the NHS accepts that they need. The skills and capacity of the NHS—for specialist audiology—and the private sector—for adult hearing aid dispensing—need to be fully engaged and the systems freed up to allow this to happen efficiently and effectively. Opening up the NHS to the hearing aid market would benefit patients and consumers. Competition would improve choice, quality and cost. There are also increasing benefits from technology and quality innovations, which could be locked in to the patient outcomes specified.

13. Using the independent sector in the High Street could offer local PCT commissioners an innovative, flexible, long term and cost-effective route for meeting patients' hearing aid needs. The patient's NHS prescription for hearing care could be dispensed from the patient's choice of local, approved, registered hearing aid specialists; within a nationally agreed local contracting framework and tariff; to agreed, locally monitored standards of clinical and quality assurance. Establishing nationally the service outcomes, quality standards, contracting framework and tariff would ensure the commissioning of a consistent NHS service across the country; give clarity, consistency and assurance to large and small scale providers signing up to providing an NHS service; and reduce transaction costs. Locally, PCTs could commission quality and cost-effective delivery from a wide range of local providers; increasing flexibility, accessibility and patient choice.

14. Given assurances that the NHS tariff would properly cover their costs of delivering an NHS service to a good comparable standard of care, many High Street practices would be very well prepared to provide an on-going NHS service for local patients. The potential High Street capacity at the margin—from up to 1,400 practitioners in over 1,000 locations—is considerable, and almost immediately available to start meeting local needs, at least for new patients being referred by their GPs.

15. The huge backlog of patients currently waiting would only be able to be cleared by a large scale national waiting list initiative, to which only the large national hearing aid dispensing companies in the sector would have any significant capability or potential capacity to contribute.

16. All developed countries are experiencing similar increasing levels of hearing aid need in their populations. How they have chosen to address this need in terms of state funding and support varies, but forms of portable entitlement are common. In our view, the government should consider what if anything can be learned from our European neighbours, and from Australia which has a mixed economy of hearing service provision. It has recently published hearing rehabilitation outcomes for voucher-holders, which could be readily transferable as quality standards into the delivery of hearing aids to NHS patients by the independent sector on the High Street.

17. The National Audiology Action Plan should in our view develop, fund and pilot the necessary national frameworks within which PCTs can locally commission flexible audiology and hearing aid provision from the market place of NHS, High Street and third sector provision.

The Action Plan needs to:

- be realistic and achievable in terms of the resources, investment and timescales;
- be the route plan to achieving a sustainable low wait solution for hearing aids for new patients and to clear the backlog of current patients with long waits;
- make the NHS service entitlement clear—and couched in terms of outcome standards for the patient, not processes and inputs—for commissioners, providers and patients;
- establish a robust and realistic tariff structure to fund the patient's entitlement to NHS hearing aid care, whether they choose to have it delivered by NHS or private provider;
- establish a national contracting and quality standards framework within which PCTs can commission the hearing aid care required to meet the patients' entitlement to NHS care, from a choice of NHS audiology departments and local private providers; and
- use the full potential of the NHS and private sector skills and capacity working in tandem, to meet the needs in every local area.

Alan Torbet

Chief Executive, British Society of Hearing Aid Audiologists

2 February 2007

Evidence submitted by Cardio Analytics Medical Services (AUDIO 11)

BACKGROUND

Cardio Analytics is a diagnostics service provider based in Plymouth in the South West of England. We provide a range of cardiac based diagnostic tests including Echocardiography, Holter ECG and Ambulatory Blood Pressure Monitoring. Alongside these tests we have also introduced Audiology/Hearing Aid services. We are contracted by local hospitals and PCTs to carry out these services as well as providing a private service for those patients who wish to do so. In light of our diversification into Audiology, Cardio Analytics Medical Services arm will soon be rebranded as Express Diagnostics, a name which will reflect the broader scope of work we are now able to undertake.

Having read your questions regarding Audiology services in the UK, our answers are as follows:

Whether accurate data on waiting times for Audiology services are available

1. As we are a local provider, our answer can only reflect our experience of the Plymouth area. By and large, waiting times here were largely anecdotal ranging from two years up to four years for an initial hearing assessment. As you may already be aware, Plymouth had a waiting list longer than most, hence the utilisation of organisations such as our own. The accuracy of lists will decrease the longer they become due to a number of factors. These may include factors such as patients remaining on the list who have passed away or who have chosen to “go private”. We are also aware of cases where GPs will not refer patients because waiting times are too long, so the true number of people who require Audiology assessments may be even greater than that reflected in the waiting list.

Why Audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed

2. There could be many reasons for this but more than likely it could be that hearing impairment issues are not regarded as acute/life threatening conditions and therefore do not attract the funding/attention other areas may enjoy. Obviously from our point of view we feel that Audiology services (as well as many other diagnostic services) should be carried out as much as possible outside of major hospitals, giving them the time and space to focus on acute treatment and care issues.

Whether the NHS has the capacity to treat the numbers of patients waiting

3. Once more from our local perspective, we can safely say our own Audiology service would not be in existence if the NHS had the capacity to treat the numbers of patients waiting. I think it is common knowledge that Plymouth currently has a chronic problem with its Audiology waiting list.

Whether enough new audiologists are being trained

4. Recruiting Audiologists proved to be quite a slow process for us, due to the fact that there didn't seem to be many in the job market. If this reflects whether enough Audiologists are being trained remains to be seen.

How great a role the private sector should play in providing Audiology services

5. We feel that the private sector should be contracted by the NHS to a much greater extent. For example if a number of local providers were available on the Choose and Book system; patients would have a genuine choice of where to go within their local area, not just a choice of centres in their region. The introduction of a real competitive environment would increase quality and efficiency levels and would also potentially drive down costs for the NHS.

Jamie Hubbard
Cardio Analytics Medical Services

5 February 2007

Evidence submitted by Byron Carnell (AUDIO 26)

1. The target waiting time for initial assessment of hearing is 13 weeks however anecdotal evidence suggests this is somewhat longer. However, the waiting time for provision and fitting of hearing aids is on average 6–12 months. Audiology was originally excluded from the Government's 18 week waiting time target for treatment. The effect of this means Audiology slides down the priority list for funding.

2. The Modernising Hearing Aid Services programme and the fitting of digital hearing aids has meant an improved service. However, waiting times have risen due to a combination of factors, including increased demand both from people who need a hearing aid for the first time, and those wanting to upgrade to the new digital technology. So patients now receive a far better service but many have to wait a long time to get it. Children usually benefit from a priority arrangement and receive treatment quicker.

3. For faulty hearing aids open access for repair is offered, however if re-assessment is required then the waiting time is in the order of 13 weeks again.

4. The capacity to treat patients depends on whether the PCT will be in a financial position to recruit staff, and also whether sufficient funds will be available for purchasing hearing aids.

5. To try to alleviate waiting times the PCT plans to use a private company ATOS in Devon from April 2007. This is intended to reduce waiting lists and help with reassessments. The role the private sector can play will be dependent on the resources made available to boost service capacity.

Byron Carnell

Chairman, Devon PPI Forum

7 February 2007

Evidence submitted by Claire Carwardine (AUDIO 13)

Why audiology services appear to lag behind other specialties in respect of waiting times and access, and how this can be addressed

1. NHS audiology deals with two quite different areas:

(a) Diagnostic services

This area of work is predominantly to support the ear, nose and throat consultants (ENT), usually referred from clinic. The vast majority of hearing assessments referred this way, are performed on the same day as their consultant appointment. Diagnostic testing also includes neonatal screening (usually performed before the baby is discharged from the labour ward), balance testing, electrophysiological tests of the inner ear and nerve function and middle ear function.

(b) Rehabilitation Services

Hearing aid provision and counselling. This is the most time consuming. Following initial assessment and impression taking, a further appointment is required to fit the manufactured earpiece and hearing aid to the patient. This can take up to an hour to fit, it is not simply “given” to the patient. Programming, measurement and verification of the aids performance in the user’s ear, explanation of how the aid works, what it is trying to achieve, operating the different functions, fitting and removal from the ear, instruction on battery replacement, and advice on what to do if the aid goes wrong.

2. However, we are being grouped together with diagnostic services, when our waiting times are being looked at, even for hearing aid provision. It would be more appropriate to put us with other therapists and counselors, given the amount of time required to see our patients through their journey (assessment, fitting, follow-up, on-going care).

Alternatively, the two service areas should be assessed separately, diagnostic waiting times, and rehabilitation waiting times. This seems to be the most logical.

Does the NHS have the capacity to treat the number of patients waiting?

3. Without accurate figures of current waiting times, the number of patients waiting to be seen and the number of practicing clinicians, it is impossible answer this question fully, or accurately. The RNID, I believe, is trying to collate this information. However, it appears that there are huge variations in the time that patients are expected to wait across the country. These vary from 13 weeks to up to three years (the latter is obviously an unacceptable amount of time to wait).

4. In an attempt to try and reduce the waiting times in areas with long waits, some audiology departments with “zero waits” are providing additional cover to adjacent trusts/PCTs to help reduce their waiting times. These additional patient journeys are seen by staff on their days off, or at weekends. This eliminates any affect on their own departments’ service. In this way, it may be possible to bring all waiting times to a similar period of time, without the involvement of external parties. This ensures a uniform service, maintained within the NHS, who all provide care and service to the same standard (as laid down by the MHAS guidelines). This way the patient remains within their local NHS based audiology department, leading to a seamless service (ie: they are not seen in one place for a set period of time, and then referred through a different system on a different site, after a period of time).

5. The question should be: Whether the NHS audiology service can be flexible enough to deal with the problem of waiting lists, itself. There appears to be little discussion or consideration of this proposal, although it is the most logical. Why consider the introduction of external parties before assessing the ability of the current national service to resolve its own challenges?

6. Recognition of departments that have managed their waiting times appears to be overlooked. Using departments of best practice can only benefit the national service of hearing aid provision, through the NHS, and thus the patient.

How great a role the private sector should play in providing audiology services

7. Split services will not provide the most economical solution, or a set standard of care. It is true that the task ahead is a mighty challenge for NHS audiology services, and there are likely to be areas of the country where it is not possible for the NHS to reduce waiting times by itself, even with the help of nearby departments. In these particular areas it would be useful to have some support from the independent sector, where appropriate, as long as this service is provided to the same standards and quality of care laid down by the MHAS guidelines.

8. However, we are currently at a peak in terms of the number of patients waiting to be seen nationally, as those patients that have been fitted during the past 30 years, or more, make up the vast majority of those patients waiting to be seen, for an upgrade to modern technology.

9. It is true, therefore, that this is an acute problem, requiring an acute response. A short term involvement by the independent sector, until waiting times are reduced, may then be welcomed in certain areas that are genuinely struggling with their waiting times. This concludes that their involvement need only be minimal.

10. Once these patients have been upgraded the waiting lists will not maintain the numbers that are currently waiting to be seen. If we look at new referrals alone, the current NHS service could cope adequately, but it is the patients that have been seen previously that all need changing over from analogue to digital, that have created these waits.

Contracts setting out a set number of visits for this service simply will not work:

“Our patients are for life, not just a hearing aid fitting”

Claire Carwardine

6 February 2007

Supplementary evidence submitted by Claire Carwardine (AUDIO 13A)

I was fortunate enough to attend the Inquiry last Thursday, into Audiology services in England. I am an NHS audiologist myself, and was pleased with the way that the Meeting went.

However, I did feel that there were certain areas that could have been investigated further, and certain questions remain unasked:

- With regard to hospitals struggling financially, it would have been useful to understand how the D of H expects hospitals (and more specifically audiology departments) to improve their financial situation, if the PCTs redirect “business” and funding to the independent sector. This is, after all, tax-payers money, ending up in the pockets of private companies, not hospitals!
- How much of the MHAS funding went into technology and equipment, as opposed to staff? Modernising poorly staffed departments with computers allows staff to fit modern technology, but does not increase the ability or capacity of that department to see more patients.
- Waiting times alone do not give a full picture. There is a need to include number of patients waiting, staffing levels and size (in terms of population) of catchment area, then real comparisons can be made in terms of measuring resources versus waiting times.
- Where is the evidence to back up the statement that 50% of hearing aid referrals fall into the 18 week wait (as referred to by the minister on a number of occasions), as they come through ENT? This has not been the case for many years, since the introduction of direct access to audiology departments. At least, not in my experience, having worked in three areas of the country, or having spoken to colleagues in other departments.
- I imagine this may become the case, if GPs realize that patients referred through ENT are being seen more quickly, because they are included in the 18 week target.
- How do you pre-select patients who would be appropriate for “instant fits”? This cannot be determined until after the assessment. To expect GPs to screen the patients first, adds to their workload, and is dependent on the conditions in which the screen takes place.
- The time taken to perform a hearing assessment is approximately 15–20 minutes, the time taken to programme the aid, verify the fitting and counsel the patient is between 45 minutes to an hour.

It is difficult to plan for “instant fittings” as you cannot determine who will be appropriate audiology and free of wax. If the patients fails to attend, or has wax, discharge etc then that 45 minutes that has been allocated, will be wasted.

- Finally, an audiogram is not a prescription, Mr Murphy stated that it is common practice in Europe for a doctor or practitioner to issue a prescription. This, in fact, is not how it works. There is no free provisions of hearing aids (or NHS) in Europe. The practitioner will advise an individual that they require a hearing aid, and then they are, as he stated, free to go where they like. It is not strictly speaking, a prescription, and the customer pays for the hearing aid and service. I include a document, in which I have highlighted huge variations between commercial practice in Europe, and here in the UK. An audiogram is an assessment result, not a prescription for treatment. Hearing aids are not the same as glasses. You only need to listen to a hearing aid to realize that.
- I am very fortunate to work for a Trust (in a neighbouring county to where I live), that has been wholly supported by our PCT from the very beginning of our modernization. We had three additional staff—on top of the three funded by MHAS—and having been well staffed, we have not developed waits in area of our service. We are currently a year ahead of our six week target for 2008. New patients are assessed within six weeks, with the hearing aid fitted four weeks after that. Reassessments are usually seen within six weeks, and we are now beginning to retest patients who have already received a digital aid, but whose hearing has changed since it was initially fitted. We are now “selling” our services to adjacent counties to help reduce their waiting times, as we are surrounded by areas that have been poorly funded, since before MHAS, leading to unacceptable waits. This is obviously good for generating additional income into our area, but does not address the lack of funding for audiology in those same hospitals.
- If all the PCTs had funded their audiology departments well from the beginning of the change, we would not have all these people waiting for hearing aids throughout the country. It does come down to a lack of funding and a lack of staff, due to frozen, or cut, posts.

I thank you for your concerns about the services available to the hearing impaired, and if I can, in any way, be of further assistance, please do not hesitate to contact me.

Claire Carwardine
Principal Audiologist

March 2007

Evidence submitted by Charing Cross Hospital (AUDIO 21)

This submission is from Audiology Services and Training Centre, Charing Cross Hospital, Hammersmith Hospitals NHS Trust, London. Our expertise includes all areas of Audiology/Training and we have on average 22 years of experience.

INTRODUCTION

Charing Cross Hospital is nationally and internationally recognised as a high quality flagship service for diagnostics and rehabilitation. Many thousands of satisfied patients have passed through our hands. The population we support includes:

- Hammersmith & Fulham;
- Kensington & Chelsea;
- Westminster; and parts of
- Ealing & Hounslow.

Total adult population for the above areas: 1,013,000 and growing.

The comprehensive Audiology services we commit to in our Service Level Agreement include:

- Direct Access Hearing Assessments.
- Hearing Therapy.
- Diagnostic Testing (both Vestibular and Electrophysiological).
- Paediatric Audiology Services.
- Paediatric Habilitation.

We are a leading Training Centre and Mentor site for Audiologists from across the country.

Since May 2004 well over 4,000 of our patients are today benefiting from their new digital hearing aids. This number will continue to rise as the elderly population increases, people become more aware of their hearing-loss and patients already fitted require their hearing aid prescription to be updated. We are very keen to maintain and expand this important service and have made sure the necessary foundations are firmly in place.

Our work also encompasses the newly implemented Neonatal Hearing Screening programme. This essential service identified children under the age of three months from the serious impact that unrecognised hearing problems can have on their all-important early speech and understanding.

In 2006 we were proud to host a meeting for the All Parliamentary Group on Deafness on behalf of the RNID.

NHS Audiology services have never been so good, we now have:

- Fantastically improved modernised service.
- Highly skilled, educated and trained Audiologists.
- Commitment to deliver the highest quality of care and service.

We implore the government and the PCT commissioners to maintain and further invest in our recently modernised services rather than redirect funding elsewhere as a quick fix for waiting times.

Our answers to the five questions raised are included, in summary plus supporting detail based on real experience.

Are accurate data on waiting times for audiology services available?

1. No comparable data at all is available on Audiology services in the private sector. There is ample accurate data available on all aspects of treating patients at Charing Cross Hospital. We continue to assist in improving the quality of the data at national level.

2. Accurate data for local NHS Audiology services have always been available. The national collection of data has been on going via the RNID since the implementation of MHAS (Modernising Hearing Aid Services). Nationally the Department of Health diagnostic waiting time's data collection is in its infancy with regards to definitions and collection of transparent data. Data requirements have already been amended twice and are still very open to interpretation. Further improvements to the current data have been suggested as national data collection guidelines are still ambiguous.

3. Patients do not want a trade-off between poor quality outcomes (eg a hearing aid that's poorly prescribed and fitted) as the price for shorter waiting times. On balance many prefer to "get it right" rather than just "get it fast". It is important that data is not just collected on waiting times but also that outcome measures and quality issues are monitored to ensure a high quality delivery of services is achieved for all patients in both sectors.

4. At present the data collection is staff hours intensive as it can require double entry of data. Therefore an improvement would be development and investment in a two way link between the specifically designed Audiology Patient Management System (PMS) (AuditBase/Practice Navigator) and the hospital PMS.

5. A way forward is to:

- Streamline this inefficient data duplication.
- Inform and train PCTs to recognise the valuable existing Audiology reporting system.
- Add real value for patients by making available a sophisticated bespoke range of reports across the entire end-to-end patient journey.

6. It is essential that any data collected from the independent sector is of a high quality and comparable with NHS information so that true outcomes can be monitored for the protection of patients, some of whom are very vulnerable.

7. In our experience of the Public Private Patients (PPP) Scheme, serious anomalies have arisen—in fact, even the transfer of basic, valuable and important existing patient information has been given low priority or in fact simply ignored as irrelevant.

Why do audiology services appear to lag behind other specialities in respect of waiting times and access and how this can be addressed?

8. The appearance of lagging is because the comparison is not like with like. An extra three significant stages are included for audiology which are not included for other disciplines.

9. The 15 diagnostic tests (in other disciplines) that Audiology has been grouped with are purely diagnostic tests. Audiology patient journeys cannot be compared with these figures as the wait times need to include not simply diagnostic testing but also assessment of patient's suitability for a hearing aid, pre assessment counselling, hearing aid selection, impression taking, fitting and verification of a hearing aid and a fine tune follow up or referral to ENT.

10. The whole patient journey for Audiology combines diagnostic and rehabilitation processes. The various sequential phases in the journey to a successful outcome for the patient are:

- Diagnosis.
- Assessment of patient success, pre assessment counselling, impression taking.

- Fitting an aid, Real Ear Measurement (REM).
- Fine tuning follow-up after patient early learning-curve.
- Verification of successful outcome.

11. A decision has to be considered (at the assessment phase) to refer to ENT in certain cases due the history and results of some diagnostic tests. The overall process has five major phases in it compared with other disciplines which are measured for one phase only.

12. Audiologists in the NHS have undergone a massive change implementing the modernisation process. The waiting lists are a result of many factors but mainly an increased number of patients wanting to access our services. As a workforce NHS audiologists have embraced these immense changes (eg MHAS) and in tackling the recent waiting lists are implementing many innovative solutions.

Does the NHS have the capacity to treat the numbers of patients waiting?

13. The short answer is yes. In most cases, both ability and volume requirements can already be satisfied. With Modernisation, State Registration, and a BSc in Audiology there is no doubt the ability is at an all-time high. The vast majority of hearing impaired patients in the UK are NHS patients. The expertise and experience gained in dealing with this volume cannot be matched although of course there is still a strong commitment to improvement.

14. The capacity of Audiology Services tends to vary nationally therefore capacity should be looked at a local level. The staffing levels of the Audiology department of Hammersmith Hospitals NHS Trust (HHNT) were reduced due to cost improvement savings, introduced by the Trust due to rectify financial deficit. This situation is now resolving, new posts are being filled and waiting times reduced enabling us to expand our service to fully utilise out capacity.

15. The capacity can further increase by changes in working practice such as:

- Flexible working/opening hours—maximising the use of clinical equipment and rooms.
- One stop clinics utilising the open fit technologies now available.
- Telephone follow ups.
- Appointment reminders (red DNA's).
- Increase in clinical expertise BSc State Registration.
- Fine tuned skill mix.
- Building on links with GPs and health centres delivering in community.
- Home visits/reducing timely transport issues.
- Walk in clinics for repairs and batteries.
- Do once and Share.
- Choose and Book.

16. The maximum capacity can be achieved by utilising all possible sites for service delivery thus bringing our services to patient's doorstep in the community. This could include utilising space in Health Care Centres and as in current practice, Care Homes, Day Centres, and in the patient's home.

17. Capacity can also be increased by ensuring a proper skill mix across Audiology services including the use of Assistants and Associate Audiologists and ensuring efficient utilisation of highly skilled staff.

18. As the elderly population increases the demand on Audiology Services will follow. Insightful forward planning in conjunction with the GP's will enable more accurate strategic planning for efficient delivery of services.

Are enough new audiologists being trained?

19. Again the answer is yes. Four fallow years are about to end with the first cohort of BSc Audiologists joining the workforce from nine universities this summer.

20. The four year BSc Audiology degree is about to deliver its first cohort of graduates. The last four years concurrently with MHAS implementation has impacted heavily in the levels of qualified staff available for employment by the NHS. This situation will improve now that the first cohort of students are graduating. As the BSc course is funded by the NHS, there should be a commitment from graduates to serve a length of time for the NHS.

21. The development of Access courses and Foundation degree (starting 2007) will enable part time routes to the BSc. This will open up routes into audiology as a profession, enabling retention and recruitment. Attention given to development of recruitment strategies given changing nature of entry into the NHS.

How great a role should the private sector play in providing audiology services?

22. Their role should be strictly limited, based only on a proven track record, and only if managed by clinically competent staff. Experience from PPP has highlighted grave concerns with regard to all aspects of the service delivery. Including hidden expenses such as:

- rent-free use of NHS treatment rooms (contractual issue);
- NHS support services;
- inadequately trained staff;
- quality control issues (referrals into NHS as PPP performance unsatisfactory); and
- NHS utilities.

23. A contractual approach that endorses cherry-picking of very simple cases turns out in practice to be both wasteful and damaging to patients. Any private sector role should continue to be as a supplier to the local NHS to meet local needs. A proven track record and well-established quality and patient service must be the primary criteria for short term contractual agreements with the private sector, eg a short sharp sock to reduce this “Bump” in demand.

24. Vulnerable patients should not be at the mercy of management decisions giving priority to maximising profit to the detriment of patient outcomes. It is essential that thorough consultation with highly skilled and experienced audiologists should take place prior to contracts being awarded.

25. Hearing aid dispensing is only one aspect of Audiology, and it is argued that this cannot be fully achieved without a sound clinical understanding of the individual patient diagnosis and physiological ramifications of the diagnosis.

26. As the hearing aid council (HAC) is disbanding, an area of great concern is the lack of checks and balances in place with the private sector. A roll-out of revised codes of practice are to commence April 2007 until 2008 (see HAC website www.thehearingaidcouncil.org.uk). Starting the implementation of ISTC (audiology) is untimely, with patient safety, quality of service, and accountability all areas of concern during this transition process.

27. Whilst these codes of practices are being implemented, NHS Audiologists should be given the chance to prove how they can handle and implement change, with effective skill mixing of staff the majority of departments can significantly reduce waiting times.

28. BSc (NHS funded) student audiologists on clinical placements are able to gain a breadth and depth of training consolidated into one audiology department in the NHS. The future workforce is dependent on this quality driven service. Private sector training is not uniform and required qualifications to work as a dispenser are far inferior to the essential BSc Audiology required to practise in the NHS.

29. During the PPP contracts the companies delivering Patient Journey services experienced recruitment and retention issues. The work was very repetitive because only very simple straightforward direct referral patients were offered this route. Company staff turnover was very high because of low job interest. This led to poor continuity of care for the patients (and incidentally, the NHS organisations working in partnership).

30. Private sector coverage is patchy. In one example a PPP supplier was unable to obtain premises from which to work because retail outlets in the area were too expensive.

31. In an attempt to protect vulnerable patients, PPP staff were provided with rent-free space and services within NHS audiology facilities. Because of contract restrictions, PPP staff were not allowed to contribute towards waiting time improvements when any particular PPP patient DNA. In a similar situation, an NHS staff member would have been re-allocated dynamically to contribute in other ways. An extra NHS audiologist in-house would have been a much more efficient use of space and money.

32. Historically smaller digital in the ear hearing aids were solely offered by the private sector. Due to local negotiations these hearing aids are now available to suitable NHS patients.

- We can offer this product and service to patients within budget.
- Compared with private sector charges where costs to the patient would be in excess of £2,000 per hearing aid.

This proves we can be efficient, meet local demand and most importantly provide a caring patient focused expert service.

Julie Wilkins

Head of Audiology Services

Ruth Thomsen

Audiology Services Manager

Deirdre Moir

Audiology Services Manager

Charing Cross Hospital

8 February 2007

Supplementary written evidence from Ruth Thomsen (AUDIO 21A)

This is further value-adding material to assist the Health Select Committee in making its recommendations to clear the backlog for Audiology and to keep it clear.

An important Resource.

At least 80 BSc Audiology graduates will become readily available Summer 2007.

An important Question is where will they contribute best value for money in reducing backlogs most effectively? The answer is no doubt they will contribute faster and give best value for money if they are all employed in NHS Audiology Departments as rapidly as they become available.

Why is this so?

1. The graduates will *hit the ground running* when they join NHS departments because their work placements in Year 3 have included working in these departments.

2. Only the NHS is really in a position to commit to early job offers to enable the *earliest starting date and hence contribute soonest* to reducing the waiting list.

3. 80 graduates can contribute nearly 5,500 patient journeys every month, so *every month lost in recruitment means 5,500 patients still in the queue* who could have been helped.

4. Because they will have very little experience of working in whichever private sector employer eventually decides to offer them a job, an induction period will mean working at perhaps 50% productivity for at least a month or maybe longer. That means *a further 2,750 patients still in the queue*.

So time will be lost before confirmed recruitment and lost again in getting up to speed in an unfamiliar environment, and patients will be paying the price.

5. Value for money is dramatically better when these graduates are used in an NHS Audiology service which has already been modernised.

Calculations (using NHS band 5) lead to an *NHS cost per journey of £24*,¹² this compares extremely favourably with *PPP cost per journey of £200*.¹³

The icing on the cake is that this is 88% cheaper than the PPP route.

So what's the obvious next step?

As soon as possible we should do as originally planned and bring these 80+ graduates into the NHS to start adding value immediately, using the modernised infrastructure already in place and clearing the backlogs.

Ruth Thomsen

Audiologist, Charing Cross Hospital

March 2007

Further supplementary written evidence from Ruth Thomsen (AUDIO 21B)

Keeping the backlog under control is different to clearing it. To achieve a successful local dynamic balance between demand and supply use of accurate data is important. Quality control is of course very important for the patient but also contributes to controlling the backlog because unnecessary repeat visits are not generated.

Some important aspects are listed here, not just to aim at sustainable solutions but also to identify false solutions.

1. HOW IMPORTANT IS PROCESS INFORMATION?

Process information has many aspects. But data which is accurate, relevant and timely is vital for understanding the process and then improving it sustainable.

Lots of real-time data is readily available at local level and doesn't necessarily need to be aggregated across the whole of the NHS before it can be used. The essential information needed at this point is:

- Diagnostic to fitting wait times.
- Value for money in ISTC/PPP.
- Quality assurance of both pathways.

¹² £24 based on hourly rate of £9.80 Average patient journey = Direct referral (1 hour), fitting (1 hour), and follow up (1/2 hours) excluding hearing aid.

¹³ PT journey payment without hearing aid excluding hearing aid.

As the process improves, less data is needed because flexibility and responsiveness are built in at local level. The whole philosophy of “lean” thinking has a major contribution to make here, as it has already done in many other parts of the NHS.

2. LOOKING AHEAD ON SKILL MIX

If we invest in training graduates (or earn + learn associate grades) we should make sure that such valuable resources are rapidly put to work as soon as they can contribute.

In the longer term the investment will continue to return value if career paths which give good job satisfaction are clear, and dead-end production line approaches—leading to high levels of early drop-out—are avoided. (As experienced during PPP)

Associate grades are a key missing link in the skill mix, although urgent commitment is required to encourage more than the current small number of Universities offering limited places on the Foundation Degree courses. With the first courses starting in summer 2007, the earliest graduates will not be contributing full time until 2009.

For PPP to add any capacity worth considering they need to be trained to state registration level via a minimum of foundation.

Clear NHS commitment to use those who make the grade is the single biggest contributor to getting the supply line rolling for the benefit of both the NHS and PPP.

3. MAINTAINING AND IMPROVING QUALITY FOR PATIENTS

Digital hearing aids are complex and sophisticated. Skills of a much higher order are needed to ensure they contribute to the full in the patient's interest. Alongside that, there are many other factors in the patient's environment and behaviour which can impede true improvement.

The Hearing Aid Council has made clear the challenges to be faced to ensure that Hearing Aid Audiologists are genuinely fit for purpose and are protecting patients' best interests. These challenges are real and won't go away just because the Council is phasing out.

Strategic workforce planning that follows through the remit of training a workforce for the future needs to stay the course and deliver not only on education but in career pathways provision and remodelling of the recruitment process especially.

Any PPP or ISTC should be audited for quality and value for money.

4. LEARNING FROM ABROAD (REF EUROPEAN FEDERATION AUDIOLOGY SOCIETIES www.efas.ws)

The main lesson to learn from abroad is that they expect and respect solid professional training in dealing with a complex technical and human problems such as required for an audiology patient journey.

The digital hearing aid sits at the intersection of the technical and the human aspects and the voucher system works there because the audiologists have the full range of training and skills required to handle that joint complexity.

A voucher system assumes that Pure Tone Audiometry results are prescriptive. No two hearing losses are the same—even if they do appear identical on an audiogram. So many other factors need to be considered. Essentially, hearing aid fitting and hearing rehabilitation is a holistic treatment that would be unlikely to respond well to a prescription or voucher system. It is not comparable to the provision of eye care, spectacles and contact lenses.

Hearing aid fittings require access simultaneously to a sophisticated piece of digital equipment plus a properly qualified and trained specialist. The two go together. Software alone is no substitute for specialist skills. Far from deskilling the audiologist's role, in fact it calls for more demanding skills to achieve the much higher potential improvements possible.

5. LOCATION, LOCATION . . .

The Hidden Hearing written evidence cites the use of local health centres and GP surgeries. This lesson could be developed and implemented more efficiently in the NHS.

A very noisy shopping centre or high street can definitely compromise the quality of the testing and hearing aid verification which is at the heart of the process. Adequate sound proofing is costly and awkward to install correctly and would require massive capital investment. Not a financially attractive option when truly costing services on multiple sites.

Mobile units sound attractive for a one-off need but some patients often the ones with the highest need may require regular appointments.

Ruth Thomsen
Audiologist, Charing Cross Hospital
March 2007

Evidence submitted by Jacquie Connolly (AUDIO 29)

AUDIOLOGY DATA

1. It is unlikely that accurate data is available as not all Trusts are reporting on the same waiting times (as confirmed by verbal, informal enquiry in the local area).
2. Clear clarification is needed as to what should be reported as a pure tone audiogram (PTA) is not the same as a hearing aid assessment (although a PTA forms part of the initial assessment).

AUDIOLOGY SERVICE PROVISION

3. Diagnostic Audiometry is only a small part of the service provided by Audiology Departments.
4. Audiology services are, in the majority, a rehabilitative service providing treatment for, and advising on, a life long condition (as distinct from other diagnostic services where the department's responsibility ceases after testing).

CAPACITY AND THE PRIVATE SECTOR

5. There is currently a huge capacity gap between the numbers of patients being referred and the capacity available.
6. The gap (and the backlog) was being addressed by previous capacity initiatives such as extra funding for overtime and the Public Private Partnership (PPP)—with the withdrawal of the additional funding the gaps soon became apparent.
7. The PPP scheme provided “joined up” private sector provision. It was most successful when effectively managed by the NHS department and when IT issues were resolved. It provided a seamless increase in capacity and increased patient choice whilst being assured of robust clinical governance and parity of service.

Jacquie Connolly
February 2007

Evidence submitted by John Day, Maelor Hospital, Wrexham (AUDIO 43)

EXECUTIVE SUMMARY

There has been no use of the private sector in this area of NHS healthcare in Wales and consequently no distractions for service commissioners and NHS Audiologists. The Welsh Assembly Health Department have set relevant waiting time targets and there are growing signs that these are helping drive resources towards Audiology services at a local level without the need for dedicated national level funding. In Wales it has been left to local NHS professionals to manage capacity and deliver against targets unburdened by constraints or uncertainty. This is allowing NHS professionals to focus on the task in hand—delivery of high quality services that are accessible to our patients. It is interesting to note that with the correct targets and professional advisory structures there has been no need for a national Audiology action plan in Wales.

INTRODUCTION

I write this memorandum as a Head of an Audiology service at an NHS Trust in Wales where we face similar challenges to our colleagues in England. However, there are some differences in approach taken in the delivery of NHS services between England and Wales providing the opportunity to make some useful comparisons. I believe that this is true of Audiology services and that comparisons may be helpful in deliberations on the future of Audiology services in England. On this basis I will provide responses to the questions posed.

Whether accurate data on waiting times for audiology services are available?

1. In Wales waiting time figures for first fitting of hearing aids have been published by the Assembly Government on a monthly basis since April 2006.¹⁴ Crucially, the definition of waiting time was developed with the help of Audiologists on the Welsh Assembly Standing Specialist Advisory Group in Audiology. As a consequence the measure is robust and relevant. The chosen measure for Audiology relates to hearing aid fitting which is a key outcome/treatment following referral by GP and is clearly recognisable by patients. I understand that in England the focus is on diagnostic tests such as audiometry which is in itself not a health treatment or outcome and I would question its value.

Why audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed?

2. In Wales the first waiting times targets for first fitting of hearing aids has been set at 36 weeks and is to be achieved by end March 2007. It is very likely that we will see the number of long waiters decline significantly in the coming weeks. By 2009 the target maximum waiting time for first fitting of a hearing aid in Wales will be 13 weeks, including those patients referred directly from their GP to Audiologist. The key benefit of targets for our patients at a national and local level is that NHS Trust general management are highly motivated to reduce Audiology waiting times. Conversely, in the absence of relevant waiting times targets for hearing aid fitting (eg as in the case in England) it could be anticipated that it will prove challenging for Audiology services to secure resources in competition against those services that do have associated waiting time targets.

Whether the NHS has the capacity to treat the numbers of patients waiting?

3. With relevant measures (see above) the introduction of Audiology targets that are progressively more challenging over a period of three years should allow time for Trusts to manage demand and direct resources accordingly. However, an environment of uncertainty might be expected to hinder the acquisition and deployment of resources to match demand. In Wales the challenge has been clearly given to NHS services to deliver to target, there is no uncertainty over who is delivering services (private *versus* public providers) and the increase in NHS capacity can be achieved by marginal increases over existing NHS resources so allowing for a prompt and a potentially more efficient response (see below).

Whether enough new audiologists are being trained?

4. I have no specific information on this matter. However, the potential strength of the NHS Audiology service lies in a mix of professionals and skills being available to efficiently manage the variety of needs of patients presenting to the NHS. Currently the career pathway to provide for such a mix of skills is incomplete—the Healthcare science career pathway is under development. In particular there is a need for training/education to support greater numbers of Associate Audiologists and very senior professional staff. Such additions would complement the new graduate Audiologists that are entering the workforce, provide for career development, improved staff retention and sustainable services.

How great a role the private sector should play in providing audiology services?

5. I assume the motive for this question relates to providing for increased capacity to deliver Audiology services. In recent months I have received flyers from private healthcare companies (participating in the English NHS independent sector procurement programme) seeking to recruit from amongst NHS Audiologists. It is difficult to understand how this approach will increase capacity within the NHS, a case of robbing Peter to pay Paul.

One obvious approach to increase capacity would be through an increase in NHS in-house capacity. The rationale is that such increases would be marginal (given that many overheads would remain unchanged through use of existing facilities and management) and therefore costs would be marginal (and modest). For the sake of ensuring efficient use of tax payers money I would assume that such comparative cost analysis of the alternative models would be performed prior to any use of the private sector, but has this been the case? Of course access (waiting) time is not the only measure of service quality and it is imperative that other quality assurance issues feature in the procurement of services (whether public or private providers) and that the same standards are applied to all providers.

RECOMMENDATIONS FOR ACTION

- Adopt national waiting time targets for first fitting of hearing aids.

¹⁴ Welsh Assembly Government Statistics—Diagnostic and Therapy Services Waiting Times.
<http://www.statswales.wales.gov.uk/ReportFolders/ReportFolders.aspx>

- Before outsourcing to the private sector appraise the comparative costs of different routes to increasing capacity to meet demand—ie, outsourcing to private sector providers *versus* increasing capacity of existing NHS providers.
- Establishment of a standing multi-professional Audiology advisory group in England.
- Adoption of national quality standards (currently under development) for adult Audiology services. This would allow for consideration of quality issues additional to waiting times when procuring NHS Audiology services.
- Support for all elements of the Healthcare science career pathway to provide a mix of skills required to deliver NHS Audiology services.

John Day,
Head of Audiology, North East Wales NHS Trust
February 2007

**Evidence submitted by Jane Deans, The Great Western Hospital, Swindon and Marlborough NHS Trust
(AUDIO 14)**

BACKGROUND

20 years experience working in both adult and paediatric audiology, and national assessor for student practical examinations.

Whether accurate data on waiting times for audiology services are available?

1. I do not feel that all the data collected is accurate as different departments use different categories which therefore results in different data being collected—non uniform data collection.

Why audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed?

2. The introduction of digital hearing aids has changed so many patients lives for the better but the demand was not correctly estimated. In our department the waiting times only exist due to chronic under funding from the PCTs for digital hearing aids. This seems to be a historical problem, as it has occurred in other audiology departments I have worked in—but, it is more of a problem now with digital hearing aids being more expensive.

Whether the NHS has the capacity to treat the numbers of patients waiting?

3. I feel that the NHS has the capacity to treat the number of patients waiting if were funded properly. Funding has been given from PCTs but this has been to buy the hearing aids NOT to pay staff—implying that staff should work for free! Once patients have been transferred over to digital hearing aids that waiting list should, in theory, disappear.

Whether enough new audiologists are being trained?

4. Yes there are enough Audiologists being trained but the training now takes longer (ie BSc) so where as in the past students, whilst training, had clinical input this does now not happen until their third year of training.

How great a role the private sector should play in providing audiology services?

5. This should only be a temporary role, if at all, to help with the exchange to digital hearing aids. Once the patients have been exchanged they should have their care returned to the NHS. On talking to patients most do not want to be seen by the “private sector” as they have little faith in this system. We are significantly cheaper than the private sector (stated as being £300 + per patient without the cost of the aids) and already have our systems in place. Additionally, we have more experience of the “additional” problems patients experience (ie tinnitus, vestibular, general rehabilitation, support) so we infact do more than simply “fit” a hearing aid.

Jane Deans
Audiologist, The Great Western Hospital, Swindon & Marlborough NHS Trust
6 February 2007

Evidence submitted by Keith Dunmore, Terry Nunn, Pete Roberts and Julie Wilkins (AUDIO 34)

EXECUTIVE SUMMARY

This document is written by a group of NHS Audiologists representing the services in London.¹⁵

The advent of NHS digital hearing aids in London has produced a great initial demand from new and existing users, leading to long waiting times for the service. This initial rush is now reducing to a manageable level. Departments are still facing great difficulties due to vacant posts being frozen and funding diverted away to help with Trust deficits. Many departments have been involved with the Private Patient Partnership Scheme but this has proved unsatisfactory further adding to the Audiology workload. When future use of the independent sector is considered there should be input from NHS Audiologists in order to ensure quality care.

There is good communication between departments in the area and a willingness to work together looking at innovative ways of providing patient care. If the allotted resources reach the Audiology departments a high-class service can be provided to the customer with minimum delays.

The RNID has always recognised that London Audiology departments and Audiologists have unique problems particular to the area due its socio-economic diversity.

The authors all play a leading role in Audiology in the Region and volunteered at a recent Audiology Heads of Service meeting to represent Audiology in relation to recent developments such as the independent sector involvement within Audiology.

Below are our views relating to the question raised by the Health Committee.

Whether accurate data on waiting times for audiology services are available?

1. We have attended several meetings, both BAA National and Regional Meetings and London Heads of Department meetings where this point has been raised. There seems to be a great disparity between the interpretations of these figures. As such they cannot be compared across different Trusts. The wording is very ambiguous. To this extent the above people have been liaising with each other with the idea of standardising the data collection across the whole of London.

Why audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed?

REASON FOR WAITING TIMES

2. The advent of digital Hearing aids brought additional monies for increased staffing at each centre throughout the region under the MHAS program. The problem at that time was there were not enough qualified staff to fill these posts. This led many departments having to use expensive locum staff for short periods rather than permanent staff on a long-term basis.

3. Traditionally Audiology has been seen as a poor relation in many hospital Trusts and therefore not given priority or adequate funding. With the advent of MHAS this improved but demand on our service also increased. With continued funding Audiology Services could be innovative and push the profession forward.

4. There was much publicity surrounding the introduction of digital hearing aids. This led many people to apply for them as soon as they were available. A typical Audiology Department such as at Chase Farm Hospital had approximately 22,000 patients registered with it on the paper system at the time of change over. There is therefore a very high demand for the first few years. This initial rush is now calming down. Each month there is now a manageable amount of referrals for upgrading to digital hearing aids.

5. Because the new hearing aids are better at giving targeted support to individual hearing losses, patients who would have been unaidable, with analogue aids, are now able to benefit from the improved technology.

6. Centralised ring fenced funds available during the MHAS programme and brokered by the RNID successfully reached Audiology services. However, since completion of the MHAS programme, money to maintain modernised services are no longer ring fenced. PCTs in many areas have failed to commit appropriate funds beyond the ring-fenced allocation, which has caused increased Audiology waiting times.

7. During the MHAS programme three waiting list initiatives were made available in an attempt to control the spike in referral rates to Audiology services. These were the Private Public Partnership (PPP) Scheme which used Private Dispensers under the NHS PASA framework to provide Audiology patient journeys; overtime access, which funded staff within core NHS services to offer "out of hours" services to provide additional patient journeys and the Hearing Direct Scheme, providing a trained telephone operated

¹⁵ Keith Dunmore, Head of Audiology Barnet and Chase Farm Hospitals NHS Trust/ Chairman of the British Academy of Audiologists (BAA) London Group, Chair of the Audiology Sub Group of the London Workforce Development Confederation; Terry Nunn, Acting Head of Audiology, Guys and St Thomas' NHS Trust. BAA Audiology Supply Group, London Representative; Pete Roberts, Head of Audiology, Ealing PCT, BAA Communication & Publicity Committee member (Treasurer); and Julie Wilkins, Head of Audiology Charing Cross Hospital, BAA Board member.

follow-up service as part of the Hearing Aid patient pathway. Audiology services were able to bid for a proportion of the funds available. The RNID controlled the allocation funds to meet the UK patient need. However since completion of the MHAS programme, money to maintain a modernised service and continue to make use of waiting list initiatives is no longer ring fenced. PCTs in many areas have failed to commit appropriate funds beyond the ring-fenced allocation, which have caused increased Audiology waiting times.

HOW CAN THIS BE ADDRESSED?

8. The initial rush for digital hearing aids is calming down. This will mean that in the near future many departments will have reduced demand for the digital service and just have to maintain demand. It should be noted that this is expected to be higher than before due to the fact that many people who would have not bothered to apply for an analogue aid would apply for a digital one since a greater degree of help can be given.

9. Skill mix. Many centres are still using highly skilled Audiologists to do semi technical jobs or clerical work. An associate level practitioner should undertake these. The Modernisation agency did a lot of useful work looking at the role of the Associate Audiologist. A funded Foundation degree course in Audiology could help to train more people at this level.

10. Including the fitting of hearing aids in the 18 week targets would give Audiology a higher profile within the Hospital Trusts and PCTs. This would ensure that appropriate funding reached the departments and wasn't diverted elsewhere.

11. Giving ring fenced monies to Audiology departments. If this was done for the next few years it would enable departments to have adequate resources to deal with the backlog analogue to digital waiting lists.

Whether the NHS has the capacity to treat the numbers of patients waiting?

12. One of the problems many centres have experienced is having unfilled vacancies frozen or removed. This reduces that department's capacity and works against the MHAS program, which acknowledged that a digital service could not be delivered unless the staffing levels were increased.

13. The waiting list capacity initiatives supplied money to NHS Audiology to work extra hours and get paid per completed patient journey (At least three visits: Assessment, Hearing aid Fitting and Follow up). Many Audiologists took part in this scheme leading to an increase in capacity while maintaining the high MHAS standards. The cost per patient through this route was also significantly cheaper than through the PPP route. We believe that due to the success of this scheme it would be a worthwhile use of resources for it to continue rather than as a one off exercise.

Whether enough new audiologists are being trained?

14. As Chair of the Audiology sub group for the London Workforce Development Confederation Keith Dunmore has been looking into demand for Audiologists in London in relation to Audiologists being trained. As yet there are no definitive figures, but anecdotal evidence that Audiology departments are losing vacant posts due to their Trusts economic situation. This summer the first London graduates will be looking for positions and we will be monitoring their progress. A strong concern is that many of these young graduates will have to work in the independent sector fitting hearing aids. It should be noted that a qualified Audiologist role covers a wide range of duties including audio-vestibular diagnostics, balance rehabilitation, tinnitus assessment and management as well as paediatric diagnostics and rehabilitation. Most newly qualified Audiologists would not wish to work in the private sector due to very limited experience and workload that they would cover.

How great a role the private sector should play in providing Audiology services?

15. There is evidence that in London the PPP scheme was not a success. In March 2006 we gathered information from Audiologists in the region relating to their PPP schemes. These were presented to the All Parliamentary Group on Deafness. The main problem was that once the patient had been concluded their "journey", and obtained their hearing aid they very soon presented themselves at the NHS Audiology department as they were having problems. These often included very simple problems that should have been sorted at their initial PPP visit. Although the companies undertaking PPP agreed to work to MHAS standards most departments could provide evidence to the contrary. This was acknowledged by the companies who tried to solve the problems, but still led many patients to undergo a substandard experience.

16. Based on local experience only, the following observations have been made:

- PPP was unable to provide commercially based care in our area due to the high cost of rental space.
- A concerning lack of basic training was noted. Levels of training and education were not comparable with our existing NHS staff, and several near misses were identified which raised significant concerns regarding patient care.

- Diagnostics, complex rehabilitation cases and paediatrics could not be addressed by the PPP initiative.

17. If the independent sector is to have further involvement then it is vital that the contract is drawn up with the advice of Audiologists with safeguards in to protect quality of the patient journey.

RECOMMENDATIONS FOR ACTION

- Clarification/definition of Audiology waiting times.
- NHS Audiology departments should receive their allotted funding in order for them to work at capacity and reduce waiting times.
- Waiting lists for hearing aids should come under the 18week targets to ensure proper investment in the service from the PCTs.
- The continuation of short-term waiting list initiative while Audiology departments clear the initial rush for digital hearing aids.
- Pressure put on trusts to “unfreeze” Audiology vacancies.
- NHS Audiologists should have input into any independent sector contracts to insure quality of patient care.

CONCLUSION

18. If the above points are taken in to consideration we believe that NHS Audiology in London can welcome and meet the challenges of providing a high quality patient service within a set timescale. In fact London services could work together to help neighbouring hospitals whose waiting times are outside the targets. We could welcome the chance to meet with you and further discuss these issues.

Keith Dunmore

Head of Audiology, Barnet and Chase Farm Hospitals NHS Trust

Terry Num

Acting Head of Audiology, Guys and St Thomas' NHS Trust

Pete Roberts

Head of Audiology, Ealing PCT, and

Julie Wilkins

Head of Audiology, Charing Cross Hospital

7 February 2007

Evidence submitted by Jan Harling, North Manchester General Hospital (AUDIO 4)

Thank you for offering the opportunity to comment on audiology services—my comments are those of an experienced Head of Service.

1. The published data of high audiology waiting lists expressed in the media is that of a worst case scenario, mainly reflecting areas that have particular recruitment and retention issues and/or budgetary pressures. My own service has no waiting list either for diagnostic or rehabilitative audiology and has held this position for in excess of eighteen months. All patients referred into this department are contacted and offered appointments within days, and we have not, and do not, expect to have any problems meeting the 18 week diagnostic target. The majority of my colleagues in and around Greater Manchester also report minimal audiology waits—exception Stockport Acute Trust.

2. Waiting times in audiology are influenced by the historic requirements of the local ENT services and their target waiting list pressures. These audiology waits can be affected by changing audiology practice and allowing GP's to directly refer into the audiology departments for all ages and all hearing problems. This change in working and referring patterns having both positive benefits for the patient and practitioner, not to mention waiting lists. Audiologists, as a group, are keen to embrace change as proven by the modernisation of hearing aid services some seven years ago, and the majority would adopt changes in referral patterns and role in a very positive mode.

3. The NHS has the capacity to treat high numbers of audiology waits providing that commissioners look further than their local PCT boundaries, and by talking directly to the Audiology experts locally. By employing and utilising surplus capacity/good will in adjacent areas the NHS could manage the majority of these waits without any Independent Sector procurement.

4. Changes in workforce profiles, the results of Agenda for Change and the financial position that many Trusts find themselves in, suggests that the current employment of newly qualified audiologists is reaching saturation point. Resources should reflect the skill mix required by changing practice-skills for health and any new investments should also be in delivering training at the Associate Practitioner level.

5. As already stated, as a service without a waiting list, the role of the independent sector is currently redundant in this area, North Manchester. However for patient choice the employment of dually qualified audiologists and true partnership working (NHS and registered with the Hearing Aid Council) can only compliment an excellent service and offer income to stretched NHS budgets.

Mrs Jan Harling

Head of Audiology, North Manchester General Hospital

18 January 2007

Evidence submitted by The Hearing Aid Council (AUDIO 42)

BACKGROUND

The Hearing Aid Council is the statutory body that registers and regulates individuals and organisations involved in dispensing hearing aids. The Council was established by the Hearing Aid Council Act 1968 (as amended). The Act makes it a criminal offence for someone to dispense a hearing aid in the UK unless they are registered with the Council.¹⁶

The Council has a number of statutory functions, and is required to:

- maintain a Register of Hearing Aid Dispensers and a Register of Employers of Hearing Aid Dispensers;¹⁷
- define eligibility criteria for registration with the Council, through its approved Standard of Competence. This sets out the education and training requirements for practice as a hearing aid audiologist required before an individual may register as a hearing aid dispenser;
- set out a Code of trade Practice that governs how hearing aid dispensers should conduct themselves when dispensing hearing aids. The dispensing of hearing aids requires regulatory intervention for three reasons: because of the healthcare relation between dispenser and client, because of the asymmetry of knowledge between dispenser and client resulting from the highly technical nature of aids and because of the additional vulnerability of clients arising from their general old age and the practice of selling aids in the client's home. The Council's approved code of trade practice sets out standards and rules of conduct in relation to each of these three areas of regulatory need; and
- investigate whether registrants have breached the code of trade practice and take disciplinary action where appropriate. The Council has semi-judicial disciplinary functions, and has the power to admonish, fine or remove from the register those individuals and organisations found guilty of breaching its codes.

Unlike most healthcare regulators, the Council does not have fitness to practice powers.

SIZE AND NATURE OF REGULATED MARKET

1. There are currently c 1,350 Registered Hearing Aid Dispensers in the UK and c 200 registered employers of dispensers. Each year, around two hundred individuals register with the Council for the first time.

2. Five companies currently employ around two thirds of existing dispensers and 90% of newly registered dispensers. These five companies are collectively known as "national training companies". They provide work-based training for individuals working towards registration and practice as dispensers. While the Council does not collect information about volume of sales or turnover, it is understood that these five companies account for a large market share of both.

3. Of the five largest companies, four have been trading for a number of years and generally before the introduction of statutory regulation. In the past three years, aggressive market share development has been undertaken by a new entrant to the marketplace. By the end of this year, it is expected that this new entrant will be the largest company in terms of employees, turnover and volume of sales.

4. Dispensers not employed by one of these five companies are generally involved in small organisations: typically sole traders or organisations of less than five employees. Of those newly registered dispensers that were not trained by one of the national training companies, half (5% of the total) are audiologists working in the NHS who wish to dispense and half (5% of the total) are individuals trained by a small dispensing organisation.

¹⁶ Dispensing is a process that involves an individual conducting or seeks to conduct oral negotiations with a view to effecting the supply of a hearing aid, whether by him or another, to or for the use of a person with impaired hearing. It excludes aids provided via the NHS and some aids sold via the internet or direct mail.

¹⁷ The Council is one of a small number of professional regulators that has responsibility for employers as well as individual professionals. Similar regulators include the General Dentistry Council and the General Optical Council.

5. In March 2005, the Government announced its intention to abolish the Hearing Aid Council and transfer its regulatory functions to other bodies. The Council welcomed this proposal, and has taken the opportunity to make recommendations to Government about the future regulation all professionals involved in hearing aid audiology.

LINES OF INQUIRY

6. The Committee has stated that it is interested in five specific questions, namely:

- whether accurate data on waiting times for audiology services are available;
- why audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed;
- whether the NHS has the capacity to treat the numbers of patients waiting;
- whether enough new audiologists are being trained; and
- how great a role the private sector should play in providing audiology services.

7. The first three questions relate to the provision of audiology services within the NHS and the Hearing Aid Council does not have a view on these matters. The Council does have views on the final two questions, and these are set out below.

Are enough audiologists being trained?

8. Different standards of education and training operate in the independent and NHS sectors. There is no system of formal recognition of education and training across the two sectors. The Council believes that the lack of common education and training significant impacts on the operation of the audiology labour market to the detriment of hearing aid users.

9. As part of the work programme in preparation for the future regulation of all professionals involved in hearing aid audiology, the Council is working towards developing and implement a Foundation Degree qualification in audiology. It is intended that the Foundation Degree will be the threshold entry qualification for entry to the future statutory register for all hearing aid audiologists, including those working in the NHS and independent sectors. The Foundation Degree has been developed by the Hearing Aid Council with the three professional bodies covering hearing aid dispensers and audiologists, namely the British Academy of Audiology (BAA), the British Society of Hearing Aid Audiologists (BSHAA) and the Association of Independent Hearing Health Professionals (AIHHP). The Council anticipates that by the end of 2007–08, it will have approved six Foundation Degree courses and that the first output from these courses will be on the employment market by September 2008. The Council has kept the Department of Health informed of progress, and the department has supported this process through provision of external consultancy support.

How great a role the private sector should play in providing audiology services?

10. Whether, and to what extent, the private sector should play a role in providing audiology services is a matter for the Government, and the Council does not a specific view on this subject. The Council does, however, have specific views about how the private sector (and indeed all audiologists) should be regulated.

11. The current regulation of hearing aid audiologists is simply not fit for purpose and is not consistent with Government policy in relation to the regulation of health care professionals. Currently, different standards operate in the independent and NHS sectors. Standards in the independent sector are determined by the Hearing Aid Council, as a statutory body responsible for regulating the sale of hearing aids. In the NHS, there are a mixture of standards which are determined by professional bodies, local NHS trusts, voluntary registration bodies¹⁸ and the Health Professions Council.¹⁹ This means that hearing aid users cannot easily determine whether an audiologist is covered by a statutory regulation regime, and if so by which regulatory authority.

12. The Hearing Aid Council believes that the current position is not in the best interests of hearing aid users. Hearing aid users have a right to expect a common standard of professional conduct, regardless of how they access hearing aid services. The Council has therefore recommended to Government that all audiologists should be registered with and regulated by a statutory body to a single set out standards. The Council believes that the Health Professions Council (HPC) is the most appropriate regulator in this regard, and is working with the Department of Health and the HPC towards this end.

13. The impact and potential risks of this fragmented regulatory framework is apparent in the recent Private Public Partnerships (PPPs) covering hearing aid audiology services. A number of NHS trusts have contracted with private sector dispensing companies for the provision of hearing aids to NHS clients. These

¹⁸ For example, the Registration Council for Clinical Physiologists is a voluntary registration body for clinical physiologists, including those involved in the provision of hearing aids. The Health Professions Council has recently made a recommendation to the Secretary of State for Health pursuant to the provisions of the Health Act 1999 that Clinical Physiologists be covered by statutory registration and regulation.

¹⁹ The Health Professions Council regulates clinical scientists, including those involved in provision of hearing aids.

contracts are generally with one of the five national training companies mentioned above. However, as the hearing aid is not provided by way of retail sale, the provisions of the Hearing Aid Council Act 1968 (as amended) do not apply. Dispensers providing services via a PPP contract are generally not regulated either by the HPC or the Registration Council for Clinical Physiologists (RCCP). Nor are their employers or premises covered by the Healthcare Commission's Standards for Independent Healthcare Providers. Indeed, unless the procuring Trust specifies its own regulations and standards, the provision of hearing aids through PPPs is completely unregulated.

14. Over and above the lack of common standards across all hearing aid audiologists, the Council believes that the current statutory basis for regulating dispensers is outdated and not fit for purpose. Specifically, there are a number of gaps in the current legislative framework, including:

- no fitness to practice powers;
- no externalisation/separation of investigations and disciplinary functions;
- limited scope for disciplinary action;
- limited scope for risk-based regulation;
- limited inspection and direction powers;
- regulation focused on sale with oral negotiation, and may exclude internet and direct mail sales; and
- functions cover employers and individual professionals.

The small size of the regulated market limits the size and resources of the Hearing Aid Council. The Council does not believe the current regulatory framework is fit for purpose.

CONCLUSIONS

15. The Council believes that the current regulatory framework covering hearing aid audiologists is not fit for purpose. The fragmented and complex system of statutory and voluntary regulation and unregulated professionals, coupled with the lack of common standards of education, training and practice is detrimental to both hearing aid users and hearing aid professionals.

16. Such common standards should ensure that all hearing aid audiologists are trained and have the skills and experience to practice in a safe and effective manner, making appropriate clinical decisions and providing hearing aids that maximising a person's hearing gain. The Council wants to see common standards that apply to all hearing aid audiologists, allowing individuals to practice freely in both in the independent and NHS sectors.

17. The announcement by the Government of its intention to abolish the Hearing Aid Council and the acceptance by Ministers of the need for statutory regulation of clinical physiologists are an opportunity to ensure that all hearing aid audiologists are regulated on a statutory and single basis. Without such change, any re-structuring or re-balancing of the education and training of hearing aid audiologists practicing in the private sector, or any move to increase the provision of audiology services through the private sector (either as private healthcare or NHS care delivered by private providers) will create significant regulatory risk to hearing aid users.

Chris Hughes
Chairman, The Hearing Aid Council

12 February 2007

Evidence submitted by Help the Aged (AUDIO 24)

Help the Aged is delighted to have the opportunity to input to the Health Select Committee's inquiry into audiology services. Clearly we are not a specialist agency in the area of hearing impairment, however we know that hearing impairment is extremely common amongst older people, and they are often in the greatest need of audiology services.

Help the Aged is happy to support the recommendations outlined by the RNID in their submission to this inquiry. We support their view that waiting times for audiology services need to be closely monitored with the same targets applied as for consultant led clinics.

Help the Aged believes that the high level of unmet need for hearing aids is a serious cause for concern—some half a million people in England are still waiting for a hearing aid. Furthermore, an Audit Commission report, *Fully Equipped*, published in 2000, found that health authorities issued hearing aids to less than 20% of the population who needed them.

Provision of hearing aids is a key issue because older people who are unable to hear properly are at serious risk of becoming isolated, as they avoid social interactions. This is a particular problem for older people, as many are already affected by other risk factors for isolation such as low income, and decreased levels of mobility and independence.

Older people say that having social networks is a high priority for them, and their withdrawal from social interactions can lead to poor mental health, with loss of self esteem and depression. Failure to provide hearing aids can therefore have an extremely wide-ranging impact on older people's health and well-being.

Given the Government's stated policy of promoting independence and well-being amongst older people, we believe the failure to make adequate provision for hearing aids simply does not make sense.

NHS commissioners are required to plan services based on the needs and priorities of the local population. If only 20% of the population who need hearing aids are receiving them, then this is clearly not happening.

There is a pattern of services of primary importance to older people not being given priority by health commissioners: podiatry and foot care are another prime example. We believe that this indicates that age discrimination is impacting commissioning decisions.

I hope that this information is helpful. Please get in touch if we can be of any further assistance.

Kate Jopling
Help the Aged

February 2007

Evidence submitted by Mrs June Henriksen (AUDIO 2)

The Health Service Journal has an article saying the Health Committee is to undertake a short inquiry into audiology services in England.

I wondered whether you might note that my mother has had one preliminary appointment about a hearing aid, made through her GP. But she has been told that there is an 18 month wait for her to see the consultant and actually get a hearing aid in the Hexham area. She lives in Haydon Bridge. I have written to the PCT who admit there is no direct access clinic available in Tynedale for hearing aids. They have offered her an earlier appointment at North Tyneside Hospital, but she has more considerable health problems and does not feel up to the travelling or going to a completely unfamiliar place.

She has had a heart attack (mild) before Christmas and has been told she has quite severe stenosis of the aortic valve for which she has been offered treatment, because she is otherwise very fit and mentally alert. However, at 86 she feels the open heart surgery necessary would pose too many risks and she is currently declining this offer.

Having a hearing aid would mean she could hear consultants whom she must now see regularly without the difficulty she has at present. Her recent spell in hospital was the first time she has ever been in a hospital, and the first time she has ever taken drugs apart from a daily aspirin/consultants found it hard to believe.

She may not have 18 months to live. I hope very much she does have. But I do feel that an 18 month waiting list for an elderly person for a hearing aid is untenable. She would like to have a digital hearing aid, which I believe is what is now on offer. The Northumbria Healthcare Complaints Department, who took on board my comments to the PCT, and the Operational Services Manager are continuing to pursue the issue, I gather from correspondence, and hope to speak to the Clinical Director for ENT.

Mrs June Henriksen

January 2007

Evidence submitted by Hidden Hearing Ltd (AUDIO 25)

BACKGROUND

1. Hidden Hearing is a leading independent sector provider of digital hearing aid services with 60 hearing centres throughout Britain. We also assist over 60 GP practices in carrying out initial hearing assessments of patients in order to reduce pressure on GPs and audiology departments.

2. We welcome this inquiry and share the Committee's concern over long waiting times for audiology services and are grateful for the opportunity to make this submission.

3. An ageing population, increased quality of life aspirations and improved technology are generating unprecedented and rising demand for hearing healthcare. 55% of people over 60 are deaf or hard of hearing²⁰ but the problem is not confined to the elderly. In total, over four million people in the UK have a hearing difficulty that could be assisted through the use of properly prescribed hearing aids. Only around two million have such instruments.²¹

²⁰ RNID Fact sheet: Facts and Figures on Deafness and Tinnitus: Accessed 1 February 2007.

²¹ RNID Fact sheet: Facts and Figures on Deafness and Tinnitus: Accessed 1 February 2007.

4. People with a hearing difficulty would see their quality of life improve significantly if they could be fitted with digital hearing aids quickly and easily. In January 2006, *A Sure Start to Later Life*²² was published with the aim of tackling inequalities faced by older people. The report noted that in many cases “quality of life for older people can be significantly improved by the use of aids and adaptations such as hearing aids.”²³ The longer people have to wait, the greater the likelihood that their hearing will deteriorate as will their chances of successful rehabilitation with their new aids, when they are eventually fitted. Left untreated, hearing loss can lead to further health problems stemming from psychological withdrawal in social situations. This can result in feelings of isolation, lack of self-confidence and depression.

5. The Modernisation of Hearing Aid Services (MHAS) project, launched in January 2000, equipped all NHS audiology departments to deliver digital hearing aids. However it did not enhance NHS internal capacity. The launch of MHAS and greater public awareness of the benefits of digital hearing aids released latent demand which it has proved impossible to meet within existing NHS capacity.

6. MHAS did include a very limited Independent Sector involvement. Since October 2003, approximately 68,600 patients have been fitted with a hearing aid through a Public Private Partnership (PPP) involving only two companies.²⁴ There has been unanimous approval of the Independent Sector companies’ standard and ability to complement the work of the NHS in providing fitting and follow up service. Furthermore, this service can be provided to patients in a community setting.

7. Initially finance for the PPP was ring-fenced, but this ceased in April 2005. Subsequently there has been a severe reduction in PPP activity. The removal of ring-fenced funding not only reduced commissioning through the PPP but also saw anecdotal increases in monaural aid fitting by NHS departments when binaural (two aids) had been the aspirational “norm”.

8. For the last three years, the British Society of Hearing Aid Audiologists (BSHAA) has carried out a survey of local audiology waiting times. This included establishing the wait from GP referral to a first appointment for a hearing test as well as the wait between receiving a hearing test and having a hearing aid fitted. The latest survey in October last year showed average total waiting time in England had risen for the third year in succession, to between 45 and 48 weeks (compared with 43–47 weeks in 2005).²⁵

9. For the first time, BSHAA also surveyed waiting times for existing NHS analogue aid users to upgrade to digital. At the moment, priority is given to patients without any hearing aid. Only when their needs are met are those with an analogue aid, from which they may be receiving little benefit, considered for a digital aid. Results showed that in England such patients have to wait on average between 68 and 72 weeks for a digital instrument; this average hides some dramatic black spots.

Whether accurate data on waiting times for audiology services are available?

10. The short answer is “no”, for the following reasons.

11. Originally the Department of Health did not collect audiology waiting time data centrally. This led to BSHAA carrying out its first survey of audiology waiting times in 2004.

12. In January 2006, the Department of Health started collecting data measuring NHS audiology waiting times from referral to first assessment only. The results were published for the first time on 12 July 2006. The total number of people waiting in January 2006 was 119,285. Of these, 77,412 were waiting for more than 13 weeks and 53,941 were waiting for over 26 weeks.²⁶ Subsequent monthly reports have shown a continuing increase in the number of people waiting for assessment.

13. Asked at Health Questions on 18 July 2006 why the full wait from referral to treatment was not tracked, the Minister replied that “The Department does not collect waiting times for hearing aid fittings. We aim to deliver audiology diagnostic tests within 13 weeks by March 2007, and within six weeks by December 2008.”²⁷ Subsequently work started on measuring waiting times from referral to treatment but no indication was given on how the new targets would be met.

14. In October the definition of audiology tests was expanded to include a wider number of assessments.²⁸ The total number of people waiting in October for assessment that month stood at 169,385.²⁹ This compared to 127,280 in September.³⁰

15. The lack of published departmental data on the waiting time between the first assessment to the fitting of a hearing aid means that the Department of Health does not have a full picture of the extent of the waiting time problem. A full set of data would enable the Department to identify where bottlenecks exist.

²² *A Sure Start to Later Life*, Social Exclusion Unit report, 26 January 2006.

²³ *Ibid*, page 51.

²⁴ Written Statement, Health Minister Ivan Lewes MP, 18 July 2006.

²⁵ British Society of Hearing Aid Audiologists Survey, October 2006.

²⁶ Commissioner based monthly Diagnostics—Diagnostic Return, Department of Health, 12 July 2006.

²⁷ Ivan Lewis MP, Health Minister, *Hansard* Column 136, 18 July 2006.

²⁸ Diagnostic Waiting Times, Department of Health Statistical Press Notice, 13 December 2006.

²⁹ Commissioner based monthly Diagnostics—Diagnostic Return, Department of Health, 13 December 2006.

³⁰ Commissioner based monthly Diagnostics—Diagnostic Return, Department of Health, 15 November 2006.

16. For the purpose of assessing overall audiology waiting times, the patient journey should be measured from the initial GP consultation and referral and include the hearing assessment at the hospital audiology department (or in 20% of cases with a hospital consultant), and the diagnosis and fitting of appropriate hearing aid(s).

17. We have identified two major roadblocks: the length of wait between the GP referral and the hospital appointment; and the waiting time between the appointment and the fitting of the device. Current Department of Health statistics only reveal the extent of the former.

Why audiology services appear to lag behind other specialities in respect of waiting times and how this can be addressed?

18. Audiology suffers from the simple fact that hearing loss is an invisible condition, is not life threatening and affects the elderly in the majority of cases. A direct consequence of these facts is that commissioners having to make financial decisions between competing disciplines will always relegate hearing care and audiology to the bottom of their list of priorities. Given the reluctance of the Department of Health to ring fence funding, this situation is likely to continue.

19. Since the Modernisation of Hearing Aid Services (MHAS) was launched in January 2000, the Government has consistently under-estimated the demand for digital hearing aids. Furthermore, it has provided only limited ring fenced funding (now discontinued) and made too little use of the only source of extra capacity currently available—the independent sector.

20. As more people realise the improvement that a digital hearing aid can make on their daily lives, demand for the new technology is growing. The Government has acknowledged admitted that “Waiting times in audiology, including those for digital hearing aids, are likely to have increased in some areas because of the modernising hearing aid services (MHAS) project.”³¹

21. Demand on existing NHS audiology services far outstrips capacity and is still increasing. A report in *Society Guardian* stated that “In addition to existing hearing aid wearers, a further 250,000 people each year visit their doctor for the first time with a hearing problem, with 95% needing a hearing aid.”³²

22. Demand will continue to increase due to our ageing population. By 2015 nearly a quarter of the population will be over 60. In April 2006, the Department of Health published the priorities for the second phase of the government’s 10-year National Service Framework (NSF) for Older People. One of the key aims of the framework is: “To overcome barriers to active life for older people through giving attention to equipment, foot-care, oral health, continence care, low-vision and hearing services.”³³

23. MHAS provided the equipment for the NHS to supply and fit digital hearing aids but not the extra staff resources to meet demand. There is an urgent need for trained hearing aid dispensers who can carry out hearing assessments and fit hearing aids. The Government has responded to the lack of capacity by introducing an audiology honours degree course. However, precise numbers of students are unclear. The first students have only just graduated and indicative numbers suggest these courses do not begin to fill the gap between supply and demand. Furthermore, more qualified NHS audiologists alone are not the solution to the staff capacity issue.

24. Patients require assistance to fine-tune the new digital hearing aids and then continuous aftercare to help maintain them and ensure they continue to meet their needs. This is particularly the case with the over 60s who tend to need more help over a longer period of time. But pressure on NHS audiology departments to provide the new aids is reducing the time available for rehabilitation and aftercare. In an attempt to process more people, the NHS has introduced a new telephone follow up service, which reduces the patient journey time. However, if digital hearing aids are to be used to their full potential, ongoing personal face-to-face consultations are needed. For example, many patients also do not realise that digital hearing aids available on the NHS are fitted behind the ear and not in the ear as is routinely available from independent suppliers. This leads to disappointment and the increasing possibility of hearing aids not being used.

25. On 10 May 2006 the Department of Health published its “implementation framework” for achieving the 18 week referral to treatment target, the so-called patient pathway. Audiology was excluded from this target, ostensibly because “most audiology services are accessed directly from primary care” not by referral to hospital consultants.³⁴ In fact 20% of referrals for audiology do go via hospital consultants and the figure is rising, as GPs and patients seek a short cut to reduce waiting times by qualifying under the 18 week target.

26. Instead, audiology was highlighted as an area needing special attention due to long waiting times and a high volume of patients. It was recognised that in addition to existing waiting lists there is “a significant reservoir of unmet need that currently does not present for treatment”.³⁵ It was revealed that the Department

³¹ Dr Stephen Ladyman MP, Health Minister, *Hansard* Column 926W, 12 July 2004.

³² *Still waiting to hear*, *Society Guardian*, 17 January 2007.

³³ *A new ambition for old age: Next steps in implementing the National Service Framework for Older People*, Department of Health report, 20 April 2006 (page 16).

³⁴ *Tackling Hospital Waiting: The 18 week Patient Pathway*, Department of Health, 10 May 2006, (page 8).

³⁵ *18 Week Patient Pathway Delivery Resource Pack*, Department of Health, 10 May 2006, (page 31).

of Health intended to develop a separate action plan for audiology to deliver a “sustainable low wait solution”. A working party has been formed to formulate this and met for the first time in November. A report is awaited but could be Spring 2007.

27. Meantime on 25 July, Lord Warner announced an additional 300,000 patient journeys³⁶ per annum for the next five years, to be sourced from the Independent Sector. Early indications were that this would commence early 2007. It is now clear that it will start much later, thus calling into question the targets referred to above.

28. There are also doubts about the volume of patient journeys that will be delivered. Contrary to initial indications, it is now clear that funding for the additional 300,000 patient journeys will not be ring-fenced. Instead individual SHAs and PCTs will decide what priority should be given to the provision of digital hearing aids and how much funding to allocate.

29. This is not the first time that a lack of ring fenced funding has called into question the priority accorded to audiology services by local health economies. Prior to the announcement of the additional 300,000 patient journeys, the Government had also extended the existing PPP to enable 48,000 extra patient journeys to be procured using Independent Sector Treatment Centres. However, the delivery of these journeys has been delayed and in some cases cancelled due to a lack of ring-fenced funding to guarantee their delivery. The same thing is likely to happen with the 300,000 patient journeys.

30. An additional problem is that the Government stopped collecting reference costs for digital hearing aids. This has made it difficult to set an equitable tariff for additional patient pathways to be delivered by the independent sector. The lack of a National Tariff also means that audiology is excluded from initiatives such as Practice Based Commissioning and Payment by Results—thereby inhibiting the wider use of the sector by PCTs.

31. There is a question mark over whether future provision of some audiology services will be in a secondary or a primary care setting. Audiology services should be made more readily accessible to patients. A number of sites exist which are trialling new ways of accessing audiology services. These include eight physiological measurement sites, five “Care Closer to Home” Project demonstration sites,³⁷ as well as independent initiatives in GP surgeries. There is scope for increased delivery of audiology services in a community setting.

32. In summary, action on reducing waiting times seems to be in limbo. The 300,000 new patient pathways are unlikely to begin coming on stream before the latter part of this year and without ring-fencing the volumes provided are not predictable. Furthermore, work on the new audiology plan has only just started and a report is not expected before the spring.

Whether the NHS has the capacity to treat the number of patients waiting and whether enough new audiologists are being trained?

33. The Secretary of State for Health, Rt Hon Patricia Hewitt MP, has acknowledged that the only way the 18 week target would be met is with “a massive increase in capacity in both the NHS and the independent sector, all of it free at the point of need.”³⁸

34. The NHS has acknowledged that it needs help to meet demand for digital hearing aids. The fundamental problem in the current supply process is human resources. There is a national shortage of audiologists. The Department of Health through its Modernising Audiology Workforce Education and Training (MAWFET) group continues to investigate this issue. The recently introduced Audiology degree courses at Higher Education Institutes will make a contribution but only in the long-term and on such a scale that will not solve the problem. Indeed, none of the staff models produced have forecast anything other than future shortage.

35. However, additional NHS audiologists are not the only solution to boosting capacity. The provision of hearing care is not limited to the fitting of hearing aids and requires skills beyond the strictly technical. There is a need for a massive influx of trained dispensers so audiologists can focus on acute cases.

How great a role should the private sector play in providing audiology services?

36. There are approximately 1,400 Registered Hearing Aid Dispensers (RHADs) who are qualified and registered under the Hearing Aid Council (HAC) 1968. They are bound by the HAC Code of Practice, which requires that they maintain a high standard of ethical conduct in the operation of their practice. They deliver a quality assured service to hundreds of thousands of hearing impaired clients each year. This resource offers potential for contributing to the solution of the capacity problem.

³⁶ Lord Warner, Health Minister, *Hansard* Column 1642, 25 July 2006.

³⁷ Care Closer to Home Demonstration Project Update, Department of Health, 13 October 2006.

³⁸ Fabian Society Address, 20 July 2005.

37. There has been a reluctance to accept Independent Sector help in reducing audiology waiting lists. The PPP was a small step in this direction, but it only offered limited scope for Independent Sector involvement; only two companies were involved in service provision.

38. It is now accepted that additional independent sector capacity will be needed in the foreseeable future (It is estimated that the delivery of the 300,000 new patient pathways alone will require about a third of the annual capacity of the sector). However, lack of ring-fencing is fuelling fears among NHS audiology staff of “creeping privatisation” through erosion of their funding, at a time when public and private sectors need to work even more closely together if waiting times are to be reduced. The Department of Health will need to decide how this sensitive balance between the two sectors can be achieved.

39. The Independent Sector could assist with the current situation in two ways. Firstly, it can help reduce the number of onward referrals to NHS audiology departments by providing a hearing assessment filtering service in a primary care or community setting. Secondly, it can prescribe and fit hearing aids to the same high standard as NHS audiologists and provide an ongoing aftercare service. Such models are already successfully employed in other EU countries.

40. Hidden Hearing provides a free on-site hearing assessment service in over 60 GP surgeries across England. The service has been shown to reduce referrals to local NHS audiology departments by around 40%.³⁹

41. GP practices participating in the scheme receive a regular monthly visit from a RHAD who carries out a hearing assessment of patients who have been referred to the service by their GP. Following the assessment, patients are referred back to the GP who recommends appropriate action.

42. In some cases patients do not require a hearing aid and will benefit from simpler treatment by the GP. The remainder are referred on to the NHS audiology department for a hearing aid or more complex treatment. Some of these may, in the interim, decide to purchase an aid from the independent sector at their own expense.

43. The service benefits all patients by reducing their waiting time for a hearing test and ensuring that they receive the correct treatment as soon as possible. The patient is treated promptly in the community, the service is free at the point of need, and the care is overseen by the GP.

44. The NHS also benefits. Pressure is taken off the GP and the resources of audiology departments are used more efficiently as patients are pre-assessed rather than being referred automatically. Two case studies are attached as appendices to illustrate the success of this service.⁴⁰

45. The Independent Sector can also assist in reducing the delays between the referral from a GP, assessment by an audiologist and final fitting of the hearing aid. It can provide initial assessments, prescribing and fitting and aftercare services in a range of settings including high street branches, GP surgeries or people’s homes as well as in ENT or audiology units.

46. Independent companies can help make audiology services more accessible to patients since they are community based. Patients can have greater choice as to where they can access digital aids. The advantages could be significant. Patients requesting a hearing aid assessment in the high street are seen immediately. Patients referred to an independent sector clinic by a GP on average are seen within two weeks of requesting a hearing test. This compares to waiting times for an NHS ENT department assessment of up to 26 months.⁴¹ Furthermore, the commitment of the independent sector to aftercare is open-ended whereas the patient journey in the NHS is limited.

47. The re-introduction of reference costs for digital hearing aids and the development of a national tariff would provide an incentive for Primary Care Trusts and Practice based Commissioners to commission audiology services from the Independent Sector to help tackle lengthy waiting times and meet the 13 week target.

48. The longer term solution needs to be a coming together of state and Independent Sector provision to provide the skills and capacity necessary to provide a first class audiology service. This in turn requires a fusion of professional standards and training.

49. The independent sector also has ongoing difficulty in filling vacancies. Common factors affecting both sectors are lack of awareness and recognition of the audiology profession.

50. What is needed is an audiology profession of sufficient size to satisfy future demand for hearing services. Encouragement needs to be given for large numbers to enter the profession, which in turn will give education providers the confidence to create the requisite facilities. Once this is achieved, a virtuous circle will be created.

³⁹ Appendix 1 (not printed here).

⁴⁰ Appendix 2 (not printed here).

⁴¹ British Society of Hearing Aid Audiologists Survey, October 2006.

51. The optical profession is a model worth examining. State support of those requiring assistance with their sight has fostered a large-scale profession. Government policy may change but in essence its support for the individual encourages them to seek eye-care from a suitably qualified provider of their choice. This in turn encourages people to enter the profession and stimulates constant demand for training places.

52. It would be worth examining how the optical model could be adapted to hearing care to benefit the patient and provide for a long-term sustainable service.

53. The Department of Health published its review of General Ophthalmic Services on 17 January 2007.⁴² The Department concluded that the system of optical vouchers works well in terms of providing “far greater choice for patients, encouraging competition between providers and promoting high standards of quality and efficiency.”

54. We believe this blueprint is wholly compatible with the Government’s aim for improved delivery of audiology services. Furthermore it adheres to the principle that “patients should have the right to choose from any health care provider which meets the Healthcare Commission’s standards and can provide the care within the price the NHS will pay.” We should be happy to elaborate our thoughts on how this principle could be applied to audiology so as to secure the future of state funded hearing care in the UK.

CONCLUSION

55. It is becoming increasingly self-evident that because of raised expectations, demand on existing NHS audiology services for the new digital hearing aids far outstrips capacity, resulting in longer waiting lists and increased waiting times.

56. A hearing care service that is inherently inaccessible is unacceptable. New and innovative solutions are needed to ensure that the funds already invested in modernisation deliver a service of acceptable ‘quality’ in every sense.

57. As developments have shown, it is now accepted by Government that the independent sector has to be part of the solution to the problem of providing sufficient capacity to reduce waiting times for digital hearing aids. So far, however, little effective action has been taken to ensure that the financial resources are available to make this happen. Creating extra patient pathways without ring-fenced funding will have little effect on PCTs whose budgets are already strained to the limit.

58. There needs to be much closer cooperation between NHS and independent sector providers if the capacity shortages in audiology are to be permanently addressed. To date Department of Health terminology has always indicated that the use of the independent sector for audiology is a short term expedient only. The Department needs to acknowledge the fundamental difference between costing the use of available existing capacity and the provision of additional capacity and fully engage with the independent sector in meeting the demand placed upon it for high quality and accessible hearing health care. Only a long-term relationship will create the climate of re-investment required to encourage the ongoing training and resource allocation needed to achieve a lasting solution. This will require attitudinal as well as operational change and the Government will need to take the lead in breaking down the barriers between the two sectors.

59. An ageing population, greater awareness of the benefits of new technology digital hearing aids, coupled with chronic under-funding and under capacity in the audiology service mean that this is not an issue that can be solved with short-term “surges”. The whole of the resources available—both the NHS and independent—must be employed in harness if we are to raise the audiology service from its current “Cinderella” status.

60. Hidden Hearing has been following the issue very closely and contributing to the policy debate. We should be delighted to help the Committee further in its inquiry by providing further information and giving evidence as the Committee sees fit.

61. Hidden Hearing provides a free on-site hearing assessment service in over 60 GP surgeries across England. The service has successfully reduced onward referrals to local audiology departments by up to 40%, reducing pressure on waiting lists and putting patients’ minds at rest.

62. The Twyford Surgery, which is the focus of the case study attached as Appendix 1,⁴³ has been running the service for almost four years. Hidden Hearing is also working with the Whitstable Medical Centre. The practice has used the audiology hearing test service to make financial savings through Practice based Commissioning. The Improvement Foundation cites the case study within its publication *High Impact Changes for Practice Teams*, as an example of how to provide services closer to patients. This is attached as Appendix 2.⁴⁴

Alan Rudge

Director, Hidden Hearing

7 February 2007

⁴² General Ophthalmic Services Review, Department of Health, 17 January 2007.

⁴³ Not printed here.

⁴⁴ Not printed here.

Evidence submitted by Hidden Hearing (AUDIO 25A)

We have read the written and oral evidence presented to the above enquiry on 8 March. There are three particular points that require clarification and on which we offer some additional comments:

PRICE

At Q37 during the oral evidence session, the Committee briefly pursued the disparity between the NHS price for hearing aids and the price charged by the independent sector. The assumption was made that the comparable figures are £70 for NHS and £2,000 for private (these were the figures used in RNID publicity at the introduction to the NHS of digital hearing aids in 2000 and quoted by the Department of Health in its evidence to the Committee). Time did not allow for the issue to be discussed in detail. However, a number of additional factors need to be considered:

1. The NHS figure of £70 was the cost per digital hearing aid to the NHS of bulk purchasing from the manufacturer (ie the wholesale price). It did not include supply, fitting or follow up service to the patient.
2. The independent sector figure was the fully inclusive price of the complete Audiological service, including the cost of the digital hearing aid, pre and post fitting with ongoing lifetime rehabilitation and support.
3. At the time, the figure of £2,000 was challenged and even the RNID never claimed it to be usual or average but an isolated extreme. As Mr Murphy said in his evidence on 8 March, the average “all inclusive” independent sector price is now just over £1,000 (Q40).
4. Prior to the launch of NHS digital aids there was a National Reference Cost for the assessment, fitting and follow up in relation to NHS analogue hearing aids. The 2005 costs for these analogue aids were average £236/upper quartile £306. The manner of establishing the costs and overheads included in such figures has always been contentious as possibly underestimated.
5. However, since the launch of *digital* hearing aids no such reference costs have been available for the new devices. This makes any valid comparison between the two sectors even more questionable.
6. At a rough estimate, current costs of the NHS service, inclusive of one digital hearing aid, is about £400. The cost of the full independent sector service (including a superior device and lifetime care) is £1,000.
7. The official NHS patient pathway totals a fraction over two hours and, as the recent DOH document *Improving access to Audiology services* indicates, now includes aid fitting by assistants and follow up by a telephone call from a secretary (paragraph 28, page 9 and accompanying case study). In comparison, the price of an independent sector digital hearing aid includes full care and support for the lifetime of the device.
8. A major factor influencing cost is availability. The independent sector service is available, more or less, upon demand in the high street or even in the client’s home, compared with NHS hospital based service requiring an average wait of 45 weeks and in some instances in excess of four years. No independent sector service would dare offer such a service but if it did, its costs would be slashed.
9. The unique supply process in the UK results in massive volume through the state-funded NHS route, with minor activity through the independent sector. Consequently the latter operates at less than full potential, whilst being subject to all of those costs associated with larger volume activity. If the full potential of the independent sector was utilised, prices would reduce as economies of scale were realised.

In summary, the cost disparity for which justification was sought is completely invalid. Furthermore, the comparison is between a service with long waiting times at £400 and a premium service at £1,000.

It may also be worth pointing out that the NHS digital hearing aid currently available is an external device (ie “behind-the-ear”) whereas the independent sector offers a choice of digital hearing aids, including “in the ear” devices.

REGULATION AND TRAINING

At Q138 during oral evidence by the Minister, reference was made to the status of hearing aid audiologists. The Committee was clearly disturbed by the submission from the Hearing Aid Council (HAC) and Ronnie Campbell MP queried whether the HAC comments could be a case of “sour grapes” in the light of its pending abolition (Q138). This seems unfair and the following points might be pertinent to a deeper understanding of the issues addressed by the HAC:

1. The HAC written evidence clearly states that it wishes to see the strengthening of its current regulatory responsibilities and their transfer to the Health Professions Council.

2. The reference to “not fit for purpose” should also not be misconstrued. As paragraph 10 of its evidence makes clear, it refers to the structure of the current regulatory regime rather than to standards. The reference also refers to the regulation of all hearing aid audiologists—both NHS and independent sector—as do its later comments on the lack of common standards across the profession (paragraph 14).
3. In terms of independent sector hearing aid audiologists, the current training regime requires trainees to complete a written and practical examination, preparation for which demands a minimum period of six months intensive classroom education. The syllabus and examination are wholly managed by the HAC, which is a statutory not a trade body. However, the training provided is entirely funded by the independent sector and inevitably impacts on prices.
4. Until they pass their exams, trainees cannot see clients unless a qualified person is present. Following their exam success (the pass rate is around 60%), there is a further six months to complete a period of pre-registration dispensing under the supervision (some direct, some indirect) of a qualified person. Post qualification, compliance with a programme of continuing professional development is mandatory.
5. Both Registered Hearing Aid Dispensers and their employers are subject to a thorough and strict Code of Practice. This is fully under the control of the HAC together with its associated disciplinary powers which, in the Background to its evidence, the HAC describes as “semi-judicial”. There is consistent evidence of discipline being applied when appropriate.

PUBLIC PRIVATE PARTNERSHIP (PPP)

At Q139 the Committee asked whether the structure of the current regulatory regime could affect the running of the PPP. Again it is important not to misconstrue the evidence given by the HAC, which prompted this question, and the following additional points may be helpful:

1. The HAC evidence (paragraph 13) made the legal point that because hearing aids provided for the PPP were not by way of a retail sale, the regulatory and standards legislation did not apply. However, the PPP contracts established strict service specifications and Ms Helen McCarthy of the Purchasing and Supply Agency (PASA) in her evidence to the Committee confirmed that no negative feedback had been received about the PPP (Q139).
2. Ministers, the Department of Health and the RNID have all expressed satisfaction at the involvement of the independent sector in the PPP and the contribution made by the independent sector. In its report, “*Sustaining your modernised Audiology service*”, the RNID stated: “Patient experiences of the PPP were positive . . . Outcomes from the private sector are as good as, or better than, the NHS service” (page 4).

We hope these further comments will assist the Committee in drawing up its final report.

Hidden Hearing

20 March 2007

Evidence submitted by Mrs Margaret L Howard (AUDIO 36)

1. This memorandum gives a brief account of my experience of various Audiology departments and waiting times for obtaining the new NHS digital hearing aids, my experience of purchasing private digital hearing aids outside the NHS and some thoughts I have on the private sector, the training of hearing therapists as well as audiologists.

2. My name is Margaret Lilian Howard, I am aged 75, divorced (twice), retired and live alone, my daughter lives nearby and helps me. I have been a single parent raising four children, prior to that I was a Local Government Officer for 18 years in administration, including working in a Public Health department for six years prior to the 1974 Local Government Reform Act, I have also been a builder/developer (held a NHBC certificate in my own right). I suffer from Menieres Disease and I had my first dizzy attack in 1953, until then I had perfect hearing. Since that date I have had periods of remission in between attacks, but with each attack I have suffered a loss of hearing in both ears until now I have a severe hearing loss. I am heavily reliant upon hearing aids for contact with the outside world. My last audiogram showed a 90 decibel loss in my right ear with a 80 decibel loss in my left ear. I have been a patient with the Audiology departments at the following hospitals:

- Royal South Hampshire hospital, Southampton—Issued with one hearing aid 1965 (the old headphone type), followed by one “behind the ear” analogue hearing aid in 1975. I attended as a patient from 1975 to 1978, and again from 2000 to 2003.
- Derbyshire Royal Infirmary, Derby—issued with two analogue hearing aids in 1991.
- Chesterfield Royal Hospital—issued with two BE54 analogue hearing aids in 1998 which I still have. I was a patient here from 1993 to 2000 and again from 2003 to 2006.

- Queen Alexandra Hospital, Cosham, Portsmouth—Waiting for an appointment which I understand from my GP on 6 February will be a two year wait.

For a number of years I have been a member of both the Royal National Institute for the Deaf (RNID) and the Menieres Society and I have been kept informed up to date by both bodies regarding the provision of NHS digital hearing aids, also news of what Parliament was proposing for the provision of such aids to patients. I do not expect to take priority over anyone else but I would have thought with the severe loss of hearing that I have sustained that by now that I should have been provided with two digital hearing aids by the NHS. Alas no! There was a three year wait at Southampton, and I have been waiting since March 2005 at Chesterfield—the policy of that audiology department is that new patients only are issued with NHS digital hearing aids regardless of the degree of hearing loss of existing patients. In February, 2006 I was told I would have a six to eight months wait, I moved back to Hampshire for health reasons in January, 2007 I was still waiting! I've recently asked my Hampshire GP for an audiology department appointment, he apologised and told me that there is a two year wait at Queen Alexandra Hospital, Portsmouth, the only hospital he could send me to, so once more I am on a waiting list. Perhaps hopefully after a seven year plus wait I might finally be provided with some. Nearly every hearing aid wearer that you could question (once that they have experienced a digital hearing aid) would tell you that the NHS analogue hearing aids are useless, they pick up background noise, they distort noise etc. With one in seven of the population experiencing some form of deafness (quoted from RNID information) and one in 33,000 people suffering from Menieres Disease (Menieres Society) which eventually leads to deafness, a huge amount of money is wasted by the NHS on the supply of analogue hearing aids many of which are never worn. In desperation in March 2002 I searched on the internet for private hearing aid dispensers, also the price of various types of digital hearing aids. The cost of the same make of hearing aids varied considerably between firms, there appears to be huge profits in the private section of hearing aid dispensers. I finally settled on a local private dispenser, and negotiated a bank loan with my bank (where my house deeds were deposited for safe keeping), and purchased two digital hearing aids at a cost of £2,770.00. The difference in hearing was remarkable, there was just no comparison, they brought me back into the land of the living, not perfect hearing, but much, much better than I had ever experienced with analogue aids. Every person with a hearing loss should be able to be supplied with a digital hearing aid, I could ill-afford to buy my private digital hearing aids as apart from owning my own property (fortunately which I could borrow against), I have no savings and I am in receipt of Pension Credit and Disability Living Allowance. Incidentally my digital hearing aids have cost me a further £500.00 in repairs which I can ill-afford.

3. My personal view is that the NHS being the largest purchaser of hearing aids in the world, by bulk buying should be able to greatly reduce the cost of digital hearing aids—why do they cost such a lot much more than PCS? Why cannot the NHS bring in some form of financial assessment so that if people could afford to make a financial contribution towards the supply of a NHS digital aid, they could be charged on a sliding scale, which could then provide further finance to perhaps train more audiologists and thus reduce the waiting time for the provision of NHS digital hearing aids. All this could be attended to by properly trained people within the NHS and thus save elderly gullible deaf/hard of hearing people being ripped off by some of the private dispensing firms. Incidentally one of the firms that I dealt with was run by an employed audiologist in the NHS, and I am sure there are many more similar businesses. With the country's aging population and an increase of deaf/hard of hearing patients attending Audiology departments all over England I can only see the situation worsening and waiting lists getting longer. If the private sector becomes involved, a middleman is introduced, more money is expended by the NHS in paying his/her fee, which should be put instead towards the training of more audiologists and the supply of digital hearing aids. Furthermore a most important member of the audiology department is the hearing therapist, I don't believe much in therapy but I was greatly helped by a hearing therapist and I think more type of this staff should be trained. To really understand deafness one either has to suffer from it or live with someone who is deaf/hard of hearing, because it is an invisible disability the majority of the public have very little patience with people who are deaf/hard of hearing and that is the reason for me submitting a memorandum to your committee, not just for me, but for the many people who are suffering in silence, often on their own, and not knowing where to obtain help from.

Margaret L Howard

8 February 2007

Evidence submitted by the National Deaf Children's Society (AUDIO 18)

INTRODUCTION AND EXECUTIVE SUMMARY

1. The NDCS is the only national charity that is solely dedicated to the support of the UK's 35,000 deaf children and their families.

2. We welcome the Committee's inquiry into audiology services, which are of critical importance to deaf children and young people's ability to achieve their full potential in education and transition to adulthood.

3. The importance of early intervention following a diagnosis of deafness for children cannot be over-estimated. Time spent on waiting lists for children means time lost in development of crucial speech and language skills, with a knock-on impact for their ability to achieve at school.

4. This submission contends that while there has been significant and welcome investment in children's audiology services, much remains to be done. There are particular problems due to a lack of data to measure waiting times, the exclusion of audiology services from government schemes to support disabled children and a danger of children's services suffering a lack of available staff.

5. This submission recommends the following actions to be taken by Government:

- Introduction of a uniform system to record waiting times for children's audiology services, starting from GP referral and ending with hearing aid fitting.
- The inclusion of audiology services in Children's Trusts.
- To ensure bi-lateral cochlear implantation is made available where clinical advice and parental consent exists that the procedure is in the best interests of the child.
- Investment in training for audiologists who work with children and young people.
- An action plan to address the ageing demographic of doctors currently working with children and young people.
- Lift six month mandatory "watch and wait" times currently in place for some audiological interventions, for example grommet operations.

RESPONSE TO THE INQUIRY'S QUESTIONS

Whether accurate data on waiting times for audiology services are available?

6. No data exists to measure the wait between GP referral to fitting of a hearing aid. This is the full patient journey between diagnosis of a problem and the NHS response. Rather, the Department of Health only measures the time between GP referral and diagnostics (hearing test), which therefore presents a distorted picture unreflective of the actual patient experience.

7. This situation is exacerbated by a wide range of differing data recording practices throughout England, with some areas measuring waiting times from GP referral to hearing aid fitting but others only measuring GP referral to hearing assessment.⁴⁵

8. The situation is further complicated by hospital targets for meeting "new" patient referrals. This results in follow-up appointments needing to be made via another GP referral as opposed to directly with the audiology department in order that they might be classified as a new referral. This is a waste of NHS resources and, crucially, results in lost time for children who urgently require this support.⁴⁶

9. Therefore data is neither accurate nor easily understood. A uniform system of data recording for the full patient journey (GP referral to hearing aid fitting) is urgently required for the NHS as a whole, in order to measure waiting times that equate with the actual patient experience.

Why audiology services appear to lag behind other specialities in respect of waiting times and access and how this can be addressed?

10. The vital nature of audiology services for deaf children and young people is not widely appreciated; as a consequence they are not factored into multi-disciplinary programmes in place for disabled children.

11. This has an immediate impact on deaf children's life chances, and a long term impact on paediatric audiology services. It results in missed investment for audiology services and a resulting lag behind other specialities that do benefit from inclusion in joined-up programmes and the consequent investment involved.

12. The importance of audiology services to deaf children and young people cannot be overstated. Their quality and capacity literally determine life chances. Early identification and appropriate management will lessen the impact of deafness on the child, the child's family and on society.⁴⁷ Therefore their absence from programmes in place for disabled children is a critical gap which requires urgent action. This is particularly the case for Children's Trusts, the mechanism by which Local Authorities are obliged to provide minimum standards of service for disabled children, from which audiology services have been excluded.

⁴⁵ NHS Audiology, Building the Service, British Academy of Audiology, 2006 <http://www.baaudiology.org/new.htm>—accessed February 2007.

⁴⁶ NDCS communication with ENT consultants and service providers, February 2007.

⁴⁷ Markides, 1986; Meadow-Orlans, 1987; Ramkalawan & Davis, 1992; Kuhl *et al*, 1992; Yoshinga-Itano *et al*, 1998. Quality Standards in Paediatric Audiology; Guidelines for the early identification and audiological management of children with hearing loss, NDCS, 2000 www.ndcs.org.uk/information/professional_focus/professional_publications/health_professionals/quality_3.htm

13. The exclusion of audiology from the NHS 18-week wait target has also increased the gap between audiology services and other specialities in terms of waiting times and access. Indications are that many children are now on multiple waiting lists (for example ENT as well as audiology) as GPs attempt to get access to the service for their patients in the quickest possible way.⁴⁸

Whether the NHS has the capacity to treat the number of patients waiting?

14. Capacity is lacking in several critical areas of children's audiology services, with particular problems faced by children experiencing long waiting times for cochlear implants. During 2006 at least two specialist cochlear implant centres in London temporarily closed their doors to new referrals due to capacity issues.⁴⁹ Other children have been refused bilateral implants despite clinical and parental judgement that they are in the best interests of the child.

15. NDCS welcomed the MCHAS programme and believes that the introduction of digital hearing aid technology and associated good practice guidance transformed audiology services for children. However the practical reality is that the first fitting of digital hearing aids take longer than their analogue predecessors, and along with the surge in demand for adult hearing aid services has had a knock-on effect of lengthening childrens' waiting times.⁵⁰

16. Following the roll-out of the Newborn Hearing Screening Programme (NHSP) early diagnosis of deafness has dramatically improved but early years audiology services have struggled to keep pace.⁵¹ As a result many audiology services do not have the capacity to respond with sufficient speed or expertise in providing access to information, support and advice to parents about possible choices for early intervention.

17. There is a very limited pool of audiologists experienced in working with very young babies, children and their families. There has been no investment in training for audiologists who work with this client group.

18. The majority of doctors working with deaf children are in the latter stages of their careers, with very few young trainees entering the profession. This will result in serious consequences for capacity in the near future if left unaddressed.⁵²

19. A lack of capacity to treat patients waiting for audiological interventions requiring surgery is also indicated by blanket restrictions being applied by the NHS throughout England. Examples include grommet operations which are now subject to six month "watch and wait" times before the decision to proceed with surgery is taken.⁵³ The NDCS believes that while exercising caution before any surgery is advisable, applying blanket restrictions which add to the referral and waiting list time for the surgery itself and therefore delay a child's treatment for anything up to a year is excessive.

Whether enough new audiologists are being trained?

20. There are currently over 300 BSc (Audiology) degree students of a possible 800 places. The BSc is a new route into the profession, students following a four year training programme before becoming fully qualified. However there is already evidence that frozen posts and funding limitations across the NHS has resulted in difficulties securing work-based practical placements during training and newly qualified audiologists unable to secure jobs.⁵⁴

How great a role the private sector should play in providing audiology services?

21. The fitting of hearing aids and the expected outcomes are fundamentally different for adults and children. Young children who are born deaf or develop deafness early in life will not be able to develop speech and language skills without the use of the most appropriate hearing aids. These need to be fitted, evaluated and managed by fully trained staff in clinical, education and home environments.⁵⁵ Therefore NDCS believes that children's audiology services must remain within the NHS. We believe that those working with deaf children must be suitably qualified to MSc level with relevant practical experience.⁵⁶ Although training routes for Registered Hearing Aid Dispensers are likely to change significantly in the near

⁴⁸ NDCS communication with ENT consultants and service providers, February 2007.

⁴⁹ NDCS communication with families and teams affected.

⁵⁰ NHS Audiology—Building the Service, British Academy of Audiology, 2006 see www.baaudiology.org/new.htm

⁵¹ NHSP Annual Report 2005–06. See www.nhsp.info/cms.php?folder=97

⁵² Children's Audiology Services; A multi-professional review in partnership with the NHSU, Royal College of Paediatrics and Child Health, 2004 see www.rcpch.ac.uk/publications

⁵³ PCT low priority procedure lists.

⁵⁴ NDCS communication with university providers and on-line audiology discussion forum www.aud.org.uk

⁵⁵ Modernising Children's Hearing Aid Services (MCHAS) www.psych-sci.manchester.ac.uk/mchas/int

⁵⁶ Quality Standards in Paediatric Audiology; Guidelines for the early identification and audiological management of children with hearing loss, NDCS, 2000
www.ndcs.org.uk/information/professional_focus/professional_publications/health_professionals/quality_3.htm

future, existing personnel are not trained to provide audiology services to children and have no facilities suitable for testing young children. At the current time it is not appropriate or desirable for children to be referred to the private sector.

22. A large proportion (40%) of deaf children have additional or complex needs in addition to their deafness. A deaf child's needs are therefore best met by experienced multidisciplinary teams. Involvement of the private sector is not desirable and would run counter to the need for multi-agency working required for children for whom deafness is one of several factors requiring intervention.

Chris Underwood

The National Deaf Children's Society

7 February 2007

Evidence submitted by David Ormerod Hearing Centres (AUDIO 35)

EXECUTIVE SUMMARY

David Ormerod Hearing Centres (DOHC) was founded in 1961 and is one of the leading hearing aid dispensing companies in the UK with a growing market share (currently around 15%). The primary activities of the Company are testing of hearing and fitting of hearing aids to adults.

DOHC works with Boots plc and specifically Boots Opticians. DOHC services are operating in over 100 High Street Hearing Centres nationwide within Boots Opticians; with an additional 50 Hearing Centres operating in stand alone high street stores or from within NHS Audiology Departments. The Company also operates a nationwide domiciliary service through a second brand Advanced Hearing Services. The DOHC Group employs 170 Hearing Aid Audiologists.

DOHC also has a strategic partnership with Phonak who are the largest global hearing aid corporation and have a 30% worldwide market share.

The Audiology market in the UK is dominated by NHS provision and the penetration of hearing aids fitted per head of population in the UK is second only to Scandinavia; however the more useful benchmark is perhaps a measure of usage which in the UK is significantly lower. One of the key determinates here is public perception of anything that is deemed to be "free" and therefore perceived of little value.

The NHS fits around 700,000 units p.a. predicted to increase to 1,000,000 units p.a. by 2008. Statistical data produced by the Institute of Hearing Research indicates that early intervention in cases of hearing loss can significantly improve quality of life and can be preventative of medical conditions brought about by social exclusion. In contrast the independent market fitted approx 200,000 units commercially last year.

Whether accurate data on waiting times for audiology services are available?

1. There is no published data to indicate the true capacity and demand of NHS Audiology services. The British Society of Hearing Aid Audiologists commissioned a report *Suffering in Silence* 2006 which shows waiting times for a first hearing aid to be well over 12 months. "The South East remains the worst place . . . between 73 and 74 weeks (to obtain a hearing aid)".

Why audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed?

2. No comment to make in this area.

Whether the NHS has the capacity to treat the numbers of patients waiting?

3. There is plenty of anecdotal evidence that the NHS does not currently have the capacity to treat the numbers of patients in need of a hearing aid. Predicted demographic population changes will increase demand for what appears to be an already over stretched NHS Audiology service.

Whether enough new audiologists are being trained?

4. In May 2007 over 100 students will graduate with a BSc in Audiology and there is evidence that around 40% of these will look for a post in the private sector. DOHC has already started a database of students who have expressed an interest in working for the company on graduation.

5. The private sector is currently regulated by the Hearing Aid Council (HAC) which is primary legislation from 1968 amended in 1989. The HAC is part of the Hampton review and is likely to be abolished (there are currently approximately 1,400 Registered Hearing Aid Dispensers in the UK). Future and existing registrants are likely to come under the Health Professions Council (HPC) who will also be responsible for

NHS registered audiologists. The HAC is currently developing a Foundation Degree as the future entry point for Hearing Aid Audiologists. This clearly paves the way for harmonisation of qualifications for the NHS and private sector.

6. DOHC has already established links with the key Higher Education Institutions and will offer appropriate clinical supervision for students following this route to increase the number of Hearing Aid Audiologists employed by the company.

7. It is unlikely that existing numbers of Audiologists being trained will cope with the combined demand in the public and private sector going forward. The Department of Health have indicated that they expect the demand for NHS hearing aids to be at 1000,000 units by 2008 in addition to the 200,000 + units fitted annually in the private sector.

How great a role the private sector should play in providing audiology services?

8. Key questions for the current NHS delivery model are: increasing patient numbers, levels of appropriately qualified staff, cost and location of service delivery.

9. The private sector can offer simple but creative solutions to these issues.

10. DOHC was one of two companies in September 2003 awarded the National Framework Public Private Partnership (PPP) contract in England for providing adult hearing aid services. This contract has been extended to 31 March 2007. The company worked with 48 NHS Trusts and provided a service to a total number of 24,000 patients primarily through high street locations.

11. The company has a strategy in place which would allow ramp up to cater for significantly more patient journeys per year based on the standard Modernised Hearing Aid Services (MHAS) protocol, or any subsequent revised fitting protocol.

12. Current PPP funding is no longer ring fenced and therefore the existing PPP activity has declined significantly. Where local NHS Trusts or Primary Care Trusts have secured funding to purchase further services, DOHC has worked to establish or continue existing services to meet those demands.

13. Through the experience of PPP, DOHC has identified a number of areas where greater efficiencies could be introduced into the service model thus creating greater capacity and offering value for money without compromising quality.

14. DOHC has a track record of being able to react quickly to market forces providing a high quality service working to given protocols. The company is committed to offering a client centred hearing aid audiology service on the high street, close to where people live and shop. This is further supported by our partnership with Boots Opticians. We feel that the private sector should be working in partnership with the NHS to alleviate the overwhelming demand on audiology services nationwide.

David Ormerod

Chief Executive, David Ormerod Hearing Centres

8 February 2007

Supplementary evidence submitted by David Ormerod Hearing Centres (AUDIO 35A)

I was present at the Inquiry and felt I must write and record my input to the evidence regarding PPP from Ruth Thomsen representing Charing Cross Hospital.

My role at David Ormerod Hearing Centres is that of Relationship Manager. I am an Audiologist by profession and worked in the NHS for 20 years before moving to the Independent Sector. My last post within the NHS was that of Project Lead for the Audiology element of Action On ENT, a Department of Health Project aimed at improving organisational practice within NHS Audiology Departments. This gave me a national picture of Audiology and through interaction with a large number of Audiology services throughout England I gained insight into the challenges faced by many Audiology departments in meeting the needs of their local population.

At David Ormerod Hearing Centres, we have worked with 48 partner Trusts to deliver over 25,000 full patient journeys. During this time we have maintained excellent working relationships with NHS colleagues and provided a high quality and regularly audited patient service.

I was surprised and disappointed to read the Charing Cross submission and hear what Ruth Thomsen said about the partnership. I have addressed each of the points raised and I have sent a copy to Ruth Thomsen for information.

Experience from PPP has highlighted grave concerns with regard to all aspects of the service delivery. Including hidden expenses such as:

— *rent-free use of NHS treatment rooms (contractual issue)*

David Ormerod Hearing Centres were allocated Hammersmith Hospital (Charing Cross) and it was disclosed to the NHS Trust and to the RNID at the time of allocation that we had no spare facilities in which we could offer PPP service in West London (this was a London issue and not typical of other PPP centres). The initial concept of PPP was to use spare capacity in the private sector. The NHS Trust offered DOHC the use of St Mary Abbots Hearing Aid centre on days that it was not used by the NHS staff—thus increasing the usage of this room and improving the efficiency of the facility that was at that time under used.

— *NHS support services*

I am sure Ruth will agree that we had routine positive contact with the administration staff and the service ran very efficiently with little input from the NHS management or audiologists.

— *Inadequately trained staff*

The allocated Hearing Aid Audiologist was fully registered and had the same MHAS training as NHS colleagues. The Trust did not raise any issues about the standard of work carried out which was subject to a detailed audit process.

— *Quality control issues (referrals into NHS as PPP performance unsatisfactory)*

A defined process was followed that complied with the contractual obligations and observation of nationally accepted guidelines and local practice. No issues were identified.

All PPP patients were ultimately referred back to the Trust, the PPP journey was limited to hearing assessment, hearing aid fitting and follow-up. The on-going aftercare was not included in the PPP contract which meant that all patients would go back to the Trust for ongoing care.

In our experience of the Public Private Patients (PPP) Scheme, serious anomalies have arisen—in fact, even the transfer of basic, valuable and important existing patient information has been given low priority or in fact simply ignored as irrelevant.

The national roll out of the IT function for PPP governed the timeline for data transfer at Charing Cross. They chose to continue to sending us paper copies of all files. All data was returned at the conclusion of the contract on a CD and IT support was provided to assist in the integration of their main database. This contract ended on 25 October 2006 and there is no data outstanding.

5.5 During the PPP contracts the companies delivering Patient Journey services experienced recruitment and retention issues . . . Company staff turnover was very high because of low job interest. This led to poor continuity of care.

One Hearing Aid Audiologist worked on this contract from the start and up to the final months when she finished for maternity leave. At this point another HAA took over the coverage. Both of these ladies thoroughly enjoyed PPP and are both continuing to work in this field.

5.7 In an attempt to protect vulnerable patients, PPP staff were provided with rent-free space and services within NHS audiology facilities. Because of contract restrictions, PPP staff were not allowed to contribute towards waiting time improvements when any particular PPP patient DNA. In a similar situation, an NHS staff member would have been re-allocated dynamically to contribute in other ways. An extra NHS audiologist in-house would have been a much more efficient use of space and money.

This is purely a contractual and data protection access issue—it could be over come (and has been in other Trusts) with contract amendments. With regard to “rent free space”, I would re-iterate that we made it clear at the very beginning of the contract that we did not have a venue in the desired location and because of this, Charing Cross paid the lower of the two contract prices for each patient seen.

In conclusion I feel that PPP was a very successful project and I would have no hesitation in endorsing collaboration between the NHS and private sector.

Many thanks for taking the time to read these comments in relation to the Audiology inquiry.

Heather Pitchford
Relationship Manager, David Ormerod Hearing Centres

March 2007

Evidence submitted by Meenaxi Patel, Northwick Park Hospital (AUDIO 37)

I am Senior Audiologist at Northwick Park Hospital. My comments on the questions that the Health Committee Press are going to be looking into are:

Whether accurate data on waiting times for audiology services are available?

Our department has had a turn over of clerical staff.

Proper training was not given to the relevant employees who put these referrals onto the audit base.

Why audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed?

We already had a six-month waiting time for patients to be assessed for hearing aid fittings prior to going digital. Enough staff were not recruited to addresses the problem, which was highlighted through a project, carried out by the government, called "Access to Work".

There has been an increase of ENT clinics. Clear guidelines and written protocols were not introduced to all professionals.

Whether the NHS has the capacity to treat the numbers of patients waiting?

Yes there is capacity to treat the patients, if it is planned properly. Offering staff the same payment that PPP are charging or locum rate for weekend and evening clinics. Opening out the work to audiologists at other hospitals.

Whether enough new audiologists are being trained?

I do not know if there is enough audiologists trained however we have been training students (two) for the past two years as part of their degree course.

How great a role the private sector should play in providing audiology services?

We have been working with PPP and are at the tail end of the assigned work. Our experience has been not one of satisfaction. Some patients had been discharged when they had not had a follow up appointment. When some patients cancelled their follow appointments they were not offered another one. Patients would be visiting our department for modification to their moulds or fine-tuning within weeks of having received their hearing aids. On some occasions we have seen moulds with hard tubing. I would like our department to be responsible for monitoring the work PPP carried out on our patients to ensure that our protocols and are followed and a quality of service is delivered.

If PPP is something that is going to be part of the NHS hearing aid work then the patients that are being seen by them should be their sole responsibility, ie GP's refer patients directly to them.

Meenaxi Patel

Senior Audiologist, Northwick Park Hospital

[comments made as an individual]

8 February 2007

Evidence from Andrew Phillips, Royal Berkshire NHS Foundation Trust (AUDIO 15)

EXECUTIVE SUMMARY

The unacceptably long waiting times for audiology services would be resolved by financial flows resulting from publication of National Tariff for audiology in 2007–08. Audiology departments need to become more efficient and employ the audiology graduates now abundant. The current planning around independent sector provision is resulting in reducing NHS capacity and threatens long term care for hearing impaired adults and children.

INTRODUCTION

I am Andy Phillips, Consultant Clinical Scientist and Head of Audiology Services for West Berkshire. I have been involved in audiology research, management and service provision for over 20 years. I was recently presented with a National Award for Service Innovation by the Secretary of State for Health. I am providing this evidence in a personal context, but have been involved in national discussions on Audiology Services for many years.

Whether accurate data on waiting times for audiology services are available?

1. There is strong evidence that Audiology Services do not routinely collect data on numbers of patients waiting, consecutive number of days waited, referral rates or capacity. Data given by Trusts, therefore cannot accurately describe waiting times, and therefore the centrally collected data are inevitably inaccurate, a point conceded by DH on many occasions. With central planning blight, providers find it difficult to give patients an accurate estimate of their likely wait for a service. Recent application of targets has distorted service provision, for example, with services assessing patients within target waiting times, but patients having no possibility of being fitted with hearing aids since fitting is not associated with a target.

Why audiology services appear to lag behind other specialities in respect of waiting times and access and how this can be addressed?

2. (a) Audiology services are generally managed, led and provided by non-medical clinicians. Audiology services have in consequence, never been associated with waiting time targets. None of the National Service Frameworks mention hearing care. NHS managers are tasked with meeting targets and resources are, therefore, diverted away from audiology towards services that are associated with targets. Similarly, audiology is concerned with quality of life issues, rather than acute or chronic medical care, and the NHS is focused on life saving or prolonging treatments. In general, issues around care of the elderly receive disproportionately little funding.
- (b) Until recently, there was a global shortage of qualified audiologists and so when resources were available, in some areas of the country, it was difficult to recruit. This shortage has now been resolved by DH investment into BSc Audiology courses.
- (c) In common with much of the NHS, there is significant inefficiency and poor use of staff skills within NHS Audiology departments. Improvements are required, both in terms of quality and efficiency.

Whether the NHS has the capacity to treat the numbers waiting?

3. If audiology departments had adequate funding, they could recruit some of the excellent BSc audiology graduates into the workforce. With an average of an extra two wte new graduates employed per 500,000 population, together with wider use of Associate Practitioners, and efficiency improvements, the NHS would have the capacity to treat the numbers waiting. This issue would simply be resolved by changing the current "indicative" tariff for hearing aid episodes to "National Tariff" status. This would mandate Commissioners purchasing audiology care at an economic rate, which would allow NHS providers to recruit the small number of extra staff they need.

Whether enough new audiologists are being trained?

4. Currently, more than enough new audiologists are being trained. If MSc, PGDip and BSc graduates are included, there are around 300 new graduates produced at public expense per year. The issue is that audiology departments have not been able to secure the funding from their activity to allow recruitment of these new graduates.

How great a role the private sector should play in providing audiology services?

5. The concept of patient choice and plurality of provision should be welcomed as it should lead to better quality of patient experience. However, this is not currently being planned appropriately. For example, the ring-fenced funding of 300,000 patient journeys, together with phase 2 ISTC provision is having the consequence of reduced NHS capacity. This results from NHS Audiology departments not being able to bid for this work.

6. Commissioners have a large sum of money that must be spent outside the NHS and are choosing not to commission NHS Audiology services from their baseline allocations. Value for money can only be achieved if both NHS and private sector organisations can bid for commissions on an equal basis. The danger with the current situation is that private providers may sell expensive private hearing aids to elderly, vulnerable patients instead of providing the free NHS devices. In addition, it must be recognised that patients fitted with hearing aids require lifelong maintenance over 20, 30 or more years.

7. If NHS capacity disappears, these elderly, vulnerable, often house bound patients may be forced to pay thousands of pounds for private hearing aids in order that they can be maintained. The training of private hearing aid dispensers is currently, and intended in the future, inadequate to deal with complex issues of hearing impaired people.

Andrew Phillips

Royal Berkshire NHS Foundation Trust

[comments made as an individual]

4 February 2007

Evidence submitted by Paul Piper (AUDIO 3)

My view, for what it's worth is:

There is no point in treating an audiology patient the same as an x-ray or an MRI scan. In the latter case, you turn up, have the scan and go home. An audiology patient is not just for one hour, they are for the rest of their life.

This must be taken into account when farming out large numbers of patients to ATOS Origin et al. Who looks after these patients in the long term? Who have the skills to treat complicated cases? NHS audiologists do.

Think about the long term not just the short term, papering-over-the-cracks reactive approach. If you devoted the same amount of money that has been ploughed into PPP and this new approach to the private sector, we just might get somewhere with our waiting lists.

But then again, what do I know? I've only been working in audiology for 18 years.

Paul Piper

Adult Rehabilitation Lead, Audiology, Bournemouth and Poole Primary Care Trust
[comments made as an individual]

19 January 2007

Evidence submitted by Lesley Roberts (AUDIO 5)

As a recent audiology graduate from Manchester University I would like to comment as follows:

Whether the NHS has the capacity to treat the numbers of patients waiting?

1. I do believe the NHS has the capacity to treat the number of patients waiting if Audiology services are well-organised and well funded. I am recent graduate of the government-funded fast-track Postgraduate Audiology Diploma scheme brought in to increase the number of qualified audiologists and address the waiting list issue. After three months of job hunting however, like many other recently qualified NHS professionals, remain unemployed. Advertised positions are few and far between and certainly not available in the local area. My training was paid for by government resources in order to combat what was described as a national shortage of Audiologists throughout the county, and I was led to believe there would be plenty of options available to me upon graduation. In order to complete the training I left my full-time position (I was already working in an NHS Audiology Department as an assistant), so it turns out that I left my job to better my career and now find myself with no job at all! It has been my experience that positions are not being advertised due to financial constraints—departments are unable to advertise vacancies due to a recruitment freeze. This has led to a situation where positions that are advertised are often swamped with applications many of those willing to work are turned away.

Whether enough new audiologists are being trained?

2. I am one of the first of many new audiology students, the next band of whom will graduate in June this year. I think that the new University courses across the country are producing well-qualified and eager young health professionals and that the government should seek to ensure these graduates can find appropriate employment within the NHS (see point 1 above).

How great a role the private sector should play in providing audiology services?

3. I have now heard that NHS Audiology Services are being considered for transfer to private providers. I know that there are currently vast numbers of people waiting for hearing aid services, but I do not think that the contracting out of hearing aid work to the private sector is the solution. A well run NHS Audiology Service does far more than the provision of hearing aids, and I do not understand why work needs to be contracted out when there are many recently qualified audiologists like myself desperate to obtain work within the NHS. I am also concerned that patients with more complex needs, or requiring follow-up treatment, may not necessarily be adequately provided for if too much resource is diverted to private providers. I feel that current NHS Audiology services provide more comprehensive treatment and best serve patient interest. NHS Audiology services should be given equal opportunity to bid for service provision and that newly qualified staff should be employed to combat waiting lists. The government needs to ensure NHS services remain at the heart of Audiology provision and should be allocated funding appropriately.

Many thanks.

Mrs Lesley Roberts

[recently qualified Audiologist]

18 January 2007

Evidence submitted by the Royal College of Paediatrics and Child Health (AUDIO 39)

The Royal College of Paediatrics and Child Health welcomes the opportunity to submit comments to the Inquiry into Audiology. The College's response to the specific questions is set out below:

Whether accurate data on waiting times for audiology services are available?

1. As far as paediatric audiology is concerned, children are seen by different professionals, both medical and non-medical. Within medical paediatric audiology there are different grades of paediatrician, many working in the community where data is hard to come by. It is probable that only consultant waits are documented. Since the Department of Health started monthly waiting statistics about a year ago, this may be clearer for adults but not for children. Newborn Hearing Screening Quality Standards state a maximum wait of four weeks for babies failing the newborn hearing screen. New standards for paediatric audiology are in progress.

Why audiology services appear to lag behind other specialities in respect of waiting times and access and how this can be addressed?

2. This point is aimed towards adults, but the lag is due to services not being consultant led.

Whether the NHS has the capacity to treat the numbers of patients waiting?

3. There will be a shortage of doctors working in paediatric audiology in the next 5–10 years, as there is no formal training path at present and the old "community" structures are gone.

Whether enough new audiologists are being trained?

4. With the new degree courses there are now new (non-medical) audiologists graduating at Level 5. However, a non-medical audiologist should have Band 8 experience before embarking on work with children. Doctors will always need to be involved with children with deafness, because 40% of deaf children have other special or complex needs.

How great a role the private sector should play in providing audiology services?

5. This question again relates to adult services, but we consider that on no account should children's audiology be assigned to the private sector.

David Ennis

Director of Policy and Standards, Royal College of Paediatrics and Child Health

9 February 2007

Evidence submitted by the Royal College of Physicians (AUDIO 28)

1. We are pleased to submit evidence to the above Inquiry. The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 20,000 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

2. A recent RCP Working Party on hearing and balance disorders included practitioners from a wide range of specialties including primary care, neurology, geriatrics and paediatrics, as well as audiological medicine and a representative from the Department of Health. In addition, evidence was given by societies for the deaf, those who provide specific services, and a patient representative.

BACKGROUND INFORMATION

3. Audiovestibular Medicine is the medical discipline concerned with the investigation, diagnosis and management of disorders of hearing and balance, including tinnitus, in both children and adults. In addition, some specialists are concerned with overall communication and the management of speech and language disorders in children (phoniatrics). Indeed, in some European countries, audiovestibular medicine and phoniatrics are one specialty.

4. Hearing loss can affect all ages—from congenital hearing loss in the newborn to late onset hearing loss in older people. The condition impacts on learning and development, is socially isolating and in addition has economic consequences for those of working age who suffer hearing loss often accompanied by balance disorders (which need to be considered in their own right and not just as an add-on to hearing loss). Yet the conditions causing hearing and balance disorders often remain undiagnosed or inadequately managed because of inappropriate referrals and the non-availability of a medically supported audiological/vestibular service.

5. The World Health Organisation has identified deafness as a non-communicable disease that is “a cause of enormous human suffering and a threat to the economics of many countries” and that “constitutes a major contributor to the burden of avoidable risk and disease” that require to be addressed with surveillance, health care and long-term care measures (WHO May 2004) http://www.who.int/ncd/mip2000/documents/key_areas_en.pdf).

6. Disorders of the ear represent 24% of all disabilities in the adult population in the UK. Of the UK adult population aged 18–60 years, 17% suffer significant hearing loss and this figure rises steeply with age (80% by 80 years). One in 1,000 children are born with a permanent hearing loss and this figure rises to two in 1,000 for children 9–16 years of age. The Newborn Hearing Screening Programme has identified some 50% more infants with permanent childhood hearing impairment at a much younger age than were previously diagnosed. Some of these infants will have potentially treatable conditions.

7. Forty per cent of people aged over 40 years experience symptoms of dizziness and/or imbalance. These symptoms are the most common reason for visits to a doctor by patients over the age of 65 years.

8. Demographic changes in the population will increase the medical need in hearing and balance disorders, as has been outlined in the *National Service Frameworks (NSF) for Long-Term Conditions and for Older People* (2001).

ROLE OF THE AUDIOVESTIBULAR PHYSICIAN

9. Consultant audiovestibular physicians form an integral part of the Multi Disciplinary Team, which aims to provide prompt, accurate, resource efficient and effective care to patients with audiological and vestibular disorders. The unique role of the audiovestibular physician is two fold:

- (a) generically, as a consultant physician supervising the holistic care of the patient; and
- (b) specifically, in the prevention and/or amelioration of pathology, aetiological diagnosis, interpretation of investigations in the context of medical care and medical treatment/management/rehabilitation.

10. This is particularly important with respect to the translation of basic neuroscience research advances in pathological mechanisms, neurochemistry and pharmacology into the clinical domain.

SERVICE PROVISION

11. Despite the prevalence of hearing and balance disorders (set out above), the provision of medical care has remained a relatively low priority for the NHS. There are inadequate numbers of medical and non-medical personnel, limited availability of test facilities and poor access nationally to the range of treatment and rehabilitation options. Thus in 2006 there was one audiovestibular physician per million population in UK. In Denmark the ratio is 1: 125,000 and Sweden 1:135,000. There is marked geographical inequality in service provision, with clustering of audiovestibular physicians/ paediatricians in specialist centres (London and Manchester) with no provision in the majority of the country (see figure 1).

12. Hearing and balance services have developed piecemeal across the UK dependent upon local expertise and resources. Only a handful of services provide complex audiological investigations/rehabilitation, for example for auditory neuropathy or auditory processing disorders and full vestibular investigation and rehabilitation. Specific deficits in the service are listed below:

- here are no national audit figures as provision is fragmented, provided in diverse settings, and historically “audiology” has been seen as a low priority healthcare need;
- here is a paucity of dedicated audiology, tinnitus or vestibular clinics, with limited access to an integrated multidisciplinary team (MDT) comprised of the relevant complement of professional skills;
- despite the majority of patients suffering from conditions which are not surgically remediable, nor caused by central nervous system pathology, referrals are primarily directed to specialties recognised to be overburdened by the Department of Health (ie, ENT and neurology);⁵⁷
- here is no clear evidence to ensure appropriate medical as opposed to non-medical provision, and optimal use of available manpower and resources;

⁵⁷ RCP Working Party Report on Audiovestibular Medicine (2007).

- appropriate medical expertise may not be available to patients presenting with audiovestibular symptoms in a non-medical audiology service, leading to limited diagnosis and treatment of relevant medical conditions;
- with the loss of community medical officers, there is a shortfall in provision of community medical/paediatric audiological services;
- with the reorganisation of services, audiological experience amongst community medical officers is low; and
- here has been inadequate medical and non-medical workforce planning for future hearing and balance services.

Figure 1

National distribution of Audiovestibular Physicians: from the RCP Working Party Report on Audiovestibular Medicine (2007)



ECONOMIC CONSEQUENCES OF HEARING LOSS AND BALANCE DISORDERS

13. The public health and socioeconomic costs of auditory and vestibular disorders have not been recorded. However, the cost benefit of early identification and habilitation of infants with profound hearing loss, facilitating integration into education, society and a full range of occupations is well recognised.⁵⁸

14. Adult auditory rehabilitation programmes are also recognised to be cost effective in enabling adults to continue functioning both in the workplace and socially with consequent effects on psychological wellbeing.⁵⁹

15. Community based studies in England and Scotland have suggested that 20–25% of the population experience symptoms of dizziness/vertigo, with one quarter losing time from work in one study and one half reporting some disability in a second study.⁶⁰

16. According to the US National Institutes of Health, the mean number of physicians a patient with peripheral vestibular pathology visits before receiving a correct diagnosis is 4.5. A similar finding is reported from specialist balance centres in the UK.⁶¹ Frequently such referrals are associated with non-contributory expensive investigations such as MRI. The cost of delay in diagnosing the most common vestibular syndrome in older patients (BPPV) has been estimated at 253.62 Euros/patient.

NEW AUDIOVESTIBULAR PHYSICIANS AND TRAINING

17. The shortcomings of the audiovestibular service can be partly accounted for by the lack of training opportunities. Specifically:

- here is virtually no training in audiovestibular medicine (the investigation, diagnosis and management of hearing and balance disorders and labyrinthine involvement in systemic disease) at the undergraduate level, in general practice training programmes or specialist training for physicians and paediatricians;
- Neurologists, ENT surgeons and audiologists receive minimum training in the physiology and pathology of eye movement disorders, which are key to diagnostic vestibular assessment;
- here is no overlap in training programmes between the professional groups leading to variability in standards of knowledge and competencies; and
- here is only one academic unit of audiovestibular medicine in the country with a paucity of junior academic training posts.

NHS PROVISION

18. MDT working is essential in the future. Within this model, the focus of the work of the Audiovestibular Physician is directed at supporting and integrating with the skills of all members of the MDT. To meet the NHS targets of rapid, easy access to medical care, a three tier multidisciplinary managed network of care for hearing and balance disorders is proposed. A healthcare scientist/GP led primary care service will be developed and have access to and support from hospital centres, with audiovestibular physicians as part of the MDT. These centres, in turn, will be linked to tertiary centres with state-of-the-art facilities and medical and non-medical staff with subspecialty expertise. This will enable rapid, high quality care close to the patient's home for the large number of routine cases, with seamless, prompt and direct access to super-specialist care for complex cases, as required by current NHS directives.

RECOMMENDATIONS

Service provision

- Clinical and academic audiovestibular physicians and paediatricians together with senior clinical and academic audiologists with a subspecialty interest and expertise, eg neuro-otology, electrophysiology, cochlear implantation should be based at the university/regional centres which have particular responsibility for teaching and research to both the medical and healthcare professions.
- Consultant audiovestibular physicians and paediatricians together with audiologists as part of a MDT should provide a broad service across the discipline and be based in specialist centres serving 250,000 per consultant physician.

⁵⁸ Barton G R, Stacey P C, Fortnum H M, Summerfield A Q. *Hearing-impaired children in the United Kingdom, II: Cochlear implantation and the cost of compulsory education*. Ear Hear. 2006 April; 27 (2): 187–207.

⁵⁹ Joore M A, Van Der Stel H, Peters H J, Boas G M, Anteneunis L J. *The cost-effectiveness of hearing-aid fitting in the Netherlands Arch Otolaryngol Head Neck Surg*. 2003 March; 129 (3): 297–304.

⁶⁰ Yardley L, Owen O, Nazareth I and Luxon L M (1998), *Prevalence and presentation of dizziness in a general practice community sample of working age people*. British Journal of General Practice. 48, 1131–1135.

⁶¹ Personal communication: St George's Hospital London Audit, Dr Snashall and Dr Raglan.

- Audiologists should provide diagnostic auditory and vestibular services within the primary care/ community service, while GPs, with additional training should continue to provide medical care of the patient within this service.
- Given the current lack of training and knowledge in primary care, an audiovestibular service should initially be led in a top down manner with consultant audiologists and audiovestibular physicians training and supporting those working at the community/primary care level who will ultimately lead the service. It follows that there would need to be an increase in the number of consultant audiovestibular physicians and senior audiologists at every level of the network.
- A national network of balance centres should be formed to address the current limited access to such services.

Training and Resources

- We recommend that 10 new consultant audiovestibular physicians should be appointed over the next two years, in hospitals without medical support for audiovestibular services to lead the appropriate medical training and provide medical input to MDT. This figure takes account of the estimated 50% retirement of the current consultant workforce in next seven years.⁶²
- Five new funded training numbers at ST3 level should be allocated each year for next five years. This would lead to approximately 200 audiovestibular consultants in 2016 ie approx 1:300,000 population.
- Dialogue with RCPCH should continue to ensure appropriate training of specialists providing paediatric service, and the development of integrated core modules of knowledge common to all healthcare professionals working in the field.
- Audiovestibular training programmes and workshops should be developed for GPs (who it is envisaged will ultimately lead the service).
- The development of additional academic departments to lead training and research should be supported.
- Basic training in audiovestibular medicine should be introduced at both the under- and post-graduate medical levels, including foundation training, and in relevant healthcare *curricula*.
- Basic principles of audiovestibular medicine should be included in the *curricula* for MRCP and MRCPPH examinations.
- The development of common assessment of competencies for core skills should be provided by a professional working in the field.

We hope you find this information useful to your inquiry. The RCP would be pleased to provide oral evidence as part of the next stage of this inquiry.

Lucy Widenka

Royal College of Physicians

8 February 2007

Evidence submitted by the Royal National Institute for Deaf People (AUDIO 23)

EXECUTIVE SUMMARY

1. A transformation has taken place in NHS audiology services in the last seven years. In early 2000 every NHS audiology department was routinely providing adult patients with hearing aids based on technology that had not changed since the early 1970s. One third of aids were infrequently or never used by patients. Over five years the NHS audiology service was completely modernised by RNID working in partnership with the Department of Health. Since March 2005 every audiology department has routinely been providing high quality digital hearing aids. Yet, set against such a transformation there has been no real change in the capacity of the NHS audiology service to meet local needs. The absence of any central targets for waiting times has meant that the service has been starved of adequate funding by the majority of Primary Care Trusts. The failure to tackle the issue of capacity has meant that lengthy waiting times have been a long standing and escalating problem in many areas of the country.

⁶² RCP Working Party Report on Audiovestibular Medicine (2007).

INTRODUCTION

2. RNID is the largest charity representing the nine million deaf and hard of hearing people in the UK. As a membership charity, we aim to achieve a radically better quality of life for deaf and hard of hearing people. We do this by campaigning and lobbying vigorously, by raising awareness of deafness and hearing loss, by providing services and through social and medical research.

3. Until 2000 the NHS audiology service was routinely providing out of date (analogue technology) hearing aids to adults. The difference in benefit between the analogue hearing aids available on the NHS at that time and the advanced digital hearing aids available only on the high street, at a cost of over £2,000, was almost certainly the biggest example of health inequality between public and private sector provision in the UK. This view was reiterated by the Audit Commission in their report *Fully Equipped* (March 2000). The report stated: “Nowhere is the cost versus quality debate in public service delivery better exemplified than in the provision of hearing aids. Millions of people could benefit from reduced waiting times and the provision of better hearing aids”.

4. Waiting times have been a significant problem for many years. In May 1999, before the modernisation of audiology services started, RNID published a report titled *Waiting to hear*. The information about waiting times was based on a survey of audiology services undertaken by RNID and revealed that the average time from direct GP referral to obtaining a hearing aid was then about five months, with waits of over a year in some parts of the country. The report highlighted the inadequate capacity and poor accessibility of the service and commented: “The low priority given to audiological services within the NHS is having a serious impact on quality of life, especially for older people.”

5. Working with the NHS purchasing team RNID led the procurement process for digital hearing aids at the outset of the modernisation, fully exploiting the power of the NHS as the largest volume purchaser of hearing aids in the world. Following negotiations with multinational hearing aid manufacturers an agreement was reached that ensured a dramatic drop in the price of advanced digital aids for the NHS. RNID subsequently managed the Modernising Hearing Aid Services programme in partnership with the Department of Health from 2000–05, introducing the provision of cutting edge digital hearing aids in a phased roll-out across the country. This programme also included the provision of equipment for programming digital hearing aids, training of staff in the new techniques and improved service delivery protocols at every audiology department in England. This was the first example of a charity delivering a major Government programme of modernisation within the NHS.

6. The Medical Research Council’s Institute of Hearing Research evaluated the effectiveness of a modernised hearing aid service. Its evaluation of the first 20 modernised audiology departments found that patients fitted in a modernised service with digital aids were reporting a 41% overall improvement in hearing benefit compared to patients with an analogue aid. There was also evidence of patients wearing their digital hearing aids for significantly longer each day.

7. It is estimated that since 2000 over a million people have received digital hearing aids from the NHS. While a significant achievement, there are nonetheless about half a million people in England who are in the system and still waiting for a modern digital hearing aid.

8. RNID is committed to changing attitudes towards hearing loss. Our vision is a world where wearing a hearing aid is considered no more surprising than wearing glasses. We are seeking to challenge the widespread misunderstanding and often stigma that relates to hearing loss. In particular we actively encourage more people to take an interest in their own hearing. In December 2005 RNID launched a nationwide campaign called *Breaking the Sound Barrier*. An integral part of this campaign was a telephone based hearing check (0845 600 5555) which has already been taken by well over 300,000 people.

Whether accurate data on waiting times for audiology services are available?

9. Comprehensive accurate data is not available. Since the beginning of 2006 the Department of Health have been collecting and publishing monthly data on waiting times for a range of 15 key diagnostic tests and procedures, including hearing tests (audiology assessments).

10. In relation to audiology services we understand that some PCTs have not submitted audiology returns. There has also been a lack of clarity as to how the data should be collected, with the result that even the partially collected data is unreliable. In particular the exclusion of people waiting for repeat tests has led to hearing reassessments not being included in returns from some PCTs. For people waiting to have their hearing reassessed, it is often many years since they were last fitted with a hearing aid and their hearing may have changed considerably. The waiting times for reassessments currently tend to be much longer than for people getting hearing aids for the first time.

11. Most fundamentally, there is total lack of data collection on the subsequent wait for having a hearing aid fitted after patients have had their hearing tested.

12. However, while there are no centrally held figures for the total wait between GP referral and actual fitting of hearing aids for new patients, or the time that people with hearing aids are waiting for reassessments, there is nonetheless extensive information from numerous surveys which have consistently

revealed the existence of lengthy waiting times. Most recently the Freedom of Information requests made by the Grant Shapps MP have confirmed this situation. His survey of nearly 100 NHS Trusts revealed an average time from referral to fitting of 40 weeks and 64 weeks for reassessments.

Why audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed?

13. Over many years health economies have not invested adequately in audiology services. Historically audiology services have had a low profile and have been neglected and marginalised in many hospitals. Evidence of such neglect is clearly demonstrated in RNID's report *Waiting to hear* and also the Audit Commission report *Fully Equipped*, published in March 2000. The Audit Commission report stated "There is a two-fold variation in the number of hearing aids issued per head of the hearing impaired population between regions, and an even greater variation between individual health authorities within regions for audiology services. In 1996-97, 22 health authorities issued hearing aids to less than 20% of the population who needed them, and the amount of money allocated by health authorities to these services appears to be unrelated to need or explicit local priorities."

14. The success of the modernisation project was partly related to the special funding arrangements, where the funding was in practice ring-fenced. Commenting on this the Audit Commission stated: "While little of the new money for community equipment services reached frontline services, most of the new funding allocated to audiology services in England is being spent as intended. This is because it is allocated directly to trusts by a project manager at the Royal National Institute for Deaf People (RNID)."

15. Despite the inadequate funding of the audiology services it is the case that hearing aids are a relatively straightforward intervention with proven effectiveness, resulting in huge benefit in quality of life, social inclusion and employment opportunities. These benefits come at a very small cost per patient. Indeed, it is very difficult to think of any other form of expenditure in the health service where the benefits to individuals and society are so great, per pound spent.

16. The low priority given to audiology services has been reflected in the lack of any national targets. The absence of such targets has contributed to audiology services being a low priority for funding. Frozen posts and insufficient funds have meant departments have often been unable to properly meet the needs of their local populations. RNID has found that few commissioners are able to even identify how much they spend on audiology services, especially as audiology is often buried within blocks contracts for ENT and associated services. The limited national initiatives that have taken place to increase capacity have been very short term. There have also been inconsistent Department of Health policies in relation to audiology workforce and training.

17. In relation to the target 18-week pathway from referral to treatment it should be stressed this only applies to consultant-led services. Most people with age-related hearing loss are referred by their GP directly to the audiology department, avoiding the need for an ENT appointment first and therefore simplifying the pathway for these people. Only those who require further medical investigation are referred to ENT. Typically, around 80% of referrals are direct and around 95% of people referred directly to audiology need hearing aids. However, it is a bizarre consequence of the restriction of the 18-week target to consultant-led services that the 20% of people who are referred via ENT will get their hearing aids fitted within 18 weeks while the majority of people needing hearing aids are typically waiting a year or more.

18. In addressing the issue of waiting times it must be stressed that the centrally funded modernisation of the NHS audiology services from 2000 to 2005 was limited to improvements in technology and service delivery. Although it provided some modest funding for short-term capacity initiatives, while the changes were being implemented, it did not attempt to address in any fundamental way the issue of capacity.

Whether the NHS has the capacity to treat the numbers of patients waiting?

19. Until a full assessment of current and likely future demand has been undertaken, together with an analysis of workforce utilisation and skill mix, it would be misguided to make a judgement as to whether the NHS has sufficient capacity.

20. Many people who have a hearing loss actually wait many years before first raising their hearing loss with their GP, who are the gatekeepers to accessing NHS audiology services. Waiting lists for audiology services therefore only provide a partial picture of the number of people who would benefit from audiology services.

21. RNID understands that the Department of Health has never fully investigated the potential demand for audiology services. In producing the Action Plan for Audiology services it would appear that no consideration is being given to undertaking a rigorous analysis of the expected demand for audiology services.

22. The NHS could increase its capacity to see significantly more patients if staff vacancies and freezes in employment were ended. For example, 2006 saw the first graduates of the four-year BSc degree course in audiology. It is our understanding that about 40% have not yet found employment in the NHS. About 180 audiology BSc graduates are expected each year.

23. RNID does recognise there are limits to how quickly the NHS can expand its capacity and therefore accepts the need for some role for the private sector.

Whether enough new audiologists are being trained?

24. A proper assessment of staffing needs can only be made when a full assessment is first made of the actual demand for audiology services. Even the scant information that is available on waiting times reveals severe problems in many parts of the country, especially for people waiting for reassessments. However, there is also a great deal of further unmet need. Research from the Medical Research Council shows that there is typically a 15-year gap between the onset of hearing loss and patients taking the first step of raising the issue with their GP. At present around two million people in the UK have a hearing aid, but it is estimated that a further four million people could benefit from one. As a change in attitudes towards hearing loss takes place it is RNID's hope that many more people will present earlier for assessment.

25. Evidence of staff vacancies does exist. In answer to a written parliamentary question (24 July 2006) it was stated that there were 70 vacancies for audiologists remaining unfilled after three months or more in England (based on the March 2005 vacancy survey). This was a vacancy rate of 4.8%. While it is welcome that the vacancy rate has fallen to 50 in 2006, it should be stressed that a vacancy rate of 3.2% is still one of the highest vacancy rates for any medical profession.

26. RNID very much welcomes the agreement on the foundation degree being the basis for assistant audiology staff in the NHS as well as the independent sector, provided that both foundation and BSc degree course qualifications enable registration under the specific titles by the Health Professionals Council. However, it is disappointing that there has been lack of effective national workforce planning. For example staffing problems have been magnified by the decision to suddenly stop the BTec audiology qualification before students had completed the BSc degree course, leading to a gap in newly qualified staff.

How great a role the private sector should play in providing audiology services?

27. There is already experience of the private sector being involved in the delivery of NHS audiology services. During the modernisation programme, RNID worked with the NHS purchasing team to set up a National Framework Agreement with two national hearing aid dispensing companies for a Public Private Partnership (PPP). Central funding was available for this scheme and in total 50% of NHS Trusts took part, enabling capacity to be obtained in a short period of time. In some locations the local health economies also contributed to the PPP as well. Now that PCTs have to exclusively fund extra capacity themselves, PPP activity has dwindled to a very low level. Evaluation of the use of the private sector has largely been positive. Professor Adrian Davis of the Medical Research Council (MRC) who has evaluated PPP has stated "Our research concluded that judicious, quality assured use of private sector hearing aid dispensers has substantial promise in delivering a major boost to capacity."

28. RNID has welcomed the announcement by Lord Warner in July 2006:

"I am pleased to announce today that as part of the second phase of the procurement of diagnostics from the independent sector, I have decided that an additional 300,000 patient pathways will be procured. That will start to produce services in the form of assessments, fitting and follow-up for people with hearing difficulties from the early part of 2007."⁶³

29. RNID wishes to see the NHS directly increase its own capacity. However, we recognize that achieving a significant step increase in NHS provision will require involvement of the independent sector. In general we do not believe it is important where a patient is seen subject to the provision of digital hearing aids being free at the point of delivery and the service conducted by appropriately qualified staff working to nationally agreed service specification and standard protocols. It is vital that clinical governance is clearly defined and that a robust quality assurance mechanism is in place.

30. Any expansion in the use of the private sector by the NHS must include comprehensive safeguards for service users, many of whom are vulnerable people. It is vital that patients are not persuaded to buy products they do not need. Unlike with spectacles for correcting common visual defects, it can be difficult for people with hearing loss to identify if they are gaining optimal benefit with hearing aids. Choices are not purely aesthetic and pricing of features is not transparent or standardised.

31. NHS patients that are sent to the independent sector must be fully informed of what they are entitled to, what quality of service they can expect and how to complain if any problems arise.

⁶³ HL Debs, 25 July 2006, Cols 1641–1642.

RECOMMENDATIONS

32. Audiology services should be brought within the 18-week target for service delivery. The target should apply from the time between GP referral to final fitting of a hearing aid, or aids. The target should also apply to the length of time people wait from a request for reassessment to fitting of a new aid, or aids. A specific timescale should be set for reaching such a target, which should be no more than two years.

33. A full assessment should be made of the actual demand for audiology services and thorough workforce planning carried out to ensure that demand will be met in a reasonable timeframe.

34. Department of Health planning for audiology services should give greater consideration to the ongoing needs of hearing aid users in terms of continuing care.

35. The Department of Health should implement the Ministerial commitment, made in July 2006, to procure an additional 300,000 patient pathways.

36. The Department of Health's action plan to reduce waiting times should be published. The plan should include detailed proposals to ensure that in the longer term audiology services become more community based and accessible. The plan should further include rehabilitation and support that should be available for those living with tinnitus.

Royal National Institute for Deaf People

January 2007

Supplementary evidence submitted by the Royal National Institute for Deaf People (AUDIO 23A)

We are grateful to the Health Select Committee for giving the issue of unacceptable waiting times for hearing aids—and the underlying shortfall in service capacity—the thorough attention it deserves.

The Department of Health published its report “Improving access to audiology services in England” since we submitted our written evidence, and several questions and issues were raised in the evidence session on 8 March relating to this report, on which we should like to offer further comments to the Committee.

COLLECTION OF DATA ON WAITING TIMES

The Department of Health collects and publishes waiting time data for hearing assessment, but appeared reluctant to commit to collecting and publishing data on the subsequent wait that people experience between hearing assessment and actually having their hearing aids fitted. We can see no reason why provision of this data should create any greater difficulty for service providers and commissioners than the collection of waits for assessment. We consider that if the Department of Health is unwilling to collect and publish this data, it undermines the credibility of their stated intention to radically reduce waiting for hearing aids.

MILESTONES AND TARGETS FOR NHS DIAGNOSIS AND TREATMENT

In the absence of additional capacity, the Department of Health's direction that people should have their hearing assessed within the six-week diagnostic milestone (by next year)—while setting no explicit target for the fitting of hearing aids—is likely to mean that people will wait even longer after having their hearing assessed before actually obtaining their hearing aids. If this wait is longer than three months, they will need to be assessed again because their hearing may have deteriorated. This will clearly be wasteful of the already-stretched NHS capacity.

NEW TECHNOLOGY AND THE POTENTIAL FOR INCREASING SERVICE EFFICIENCY

In his evidence to the Committee, the Minister placed heavy reliance on the use of new “open ear fitting” technology as a major means of releasing substantial capacity in the NHS and reducing waits, since it enables one-stop assessment and fitting of hearing aids on the same day. This technology is well known to us and we have followed the progress of the pilot studies using open ear fittings with interest. Our understanding is that the final evidence from the pilots is not available yet. Only when the analysis of the outcomes for individuals at follow-up interview has been completed, and the final report is published, will we know the proportion of patients for whom this technique is actually appropriate. It is certainly premature to claim that it will be suitable (let alone optimal) for the majority and, even if this proves to be the case, it is not clear how much capacity could thereby be released in practice. Much longer appointments will be needed for the one-stop approach and—even if it proves possible to establish in advance of the patient's visit the general likelihood of this being suitable for them—there will be some wastage of time in cases where it is found that after all they need a traditional fitting, which will involve curtailing the visit and booking a further appointment.

The claim that this new technology will provide a key solution to the waiting time problem is premature in our view and clearly flouts the principles of peer-reviewed, evidence-based healthcare.

We welcome the incorporation of open ear fittings into service protocols because of the benefits in terms of hearing, comfort and handling that they offer to individuals for whom they are an appropriate solution. However, we cannot judge their potential contribution to service efficiency until the evidence is available.

INDEPENDENT SECTOR PROCUREMENT

We maintain that the increase in capacity required in order to meet increasing demand and achieve a radical reduction in waiting times will require involvement of the independent sector. Although some NHS audiology services have been successful in securing resources for local capacity initiatives from their PCTs and have reduced waiting times substantially, people needing hearing aids for the first time still face waits of well over a year in many areas and over two years in worst cases.

Our judgement is that if a commitment to a national contract to procure well over 100,000 patient journeys from the independent sector has not been made by the time that the Health Select Committee reports on its inquiry, it is inevitable that the Department of Health's strategy for improving access to services will fail.

We thank the Committee for its work and look forward to the report on its inquiry.

Royal National Institute for Deaf People

March 2007

Evidence submitted by Sense (AUDIO 41)

1. Sense is a national charity that supports and campaigns for children and adults who are deafblind. We provide specialist information, advice and services to deafblind people, their families, carers and the professionals who work with them. In addition, we support people who have sensory impairments with additional disabilities.

2. Sense welcomes the opportunity to submit evidence to the Health Committee short inquiry into audiology services in England. All NHS audiology departments in England have now reformed their hearing aid services through the Modernising Hearing Aid Services (MHAS) programme, and are fitting digital hearing aids and this is therefore a very timely enquiry.

RESPONSES TO THE COMMITTEE'S QUESTIONS

Whether accurate data on waiting times for audiology services are available?

3. The Government has excluded digital hearing aids from the 18 week patient pathway from GP referral to the start of treatment. Information on waiting times for hearing aid fittings and local funding for provision of digital hearing aids is therefore not collected nationally.

4. The Government has said that it aims to deliver audiology diagnostic tests within 13 weeks by March 2007, and within six weeks by December 2008. However, this target applies to diagnostic tests, not the fitting of hearing aids. The decision to exclude direct referrals from the 18 week target, while including referrals made through ENT consultants, creates an incentive for patients who know the system to ask to be referred to a consultant in order to receive a hearing aid within 18 weeks. Sense recommends that direct referrals for digital hearing aids should be brought within the 18 week target.

Why audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed?

5. Hearing aids improve people's quality of life, and this is particularly true for people with dual sensory impairments. However, not being able to see or hear clearly is not life-threatening, and this may be one reason why audiology services have lagged behind other specialties.

6. However, Sense believes that quality of life issues should be given priority by the health service, not least because of the impact they have on patients' wellbeing and ultimately on their overall health. For example, deaf, deafened and hard of hearing people are vulnerable to isolation and depression, and access to a digital hearing aid can help to overcome isolation.

7. For people with a dual sensory impairment, access to a digital hearing aid can also make an enormous amount of difference to their independence—this can be as simple as enabling them to cross the road in safety. Maintaining a person's mobility and continued integration with the community will benefit both their physical and mental health. A long delay will make reintegration very difficult for an older person, leading to reduced independence and greater potential cost to health and/or social services.

Whether the NHS has the capacity to treat the numbers of patients waiting

8. It is difficult to make a judgment as to whether the NHS has sufficient capacity because there has been no investigation of the potential demand for audiology services. Sense recommends that any assessment of the potential demand for audiology services should take account of the needs of the ageing population, especially as the most common cause of sensory impairment is old age (55% of people over 60 are deaf or hard of hearing).

How great a role the private sector should play in providing audiology services

9. The important thing for people receiving audiology services is that they get the service they need, including follow-up appointments to tune the hearing aid to their requirements. So it is vital that if services are commissioned from the private sector, customer satisfaction is carefully monitored, as well as throughput.

10. Any private sector organisations providing audiology services on contract to the health service must have appropriately qualified and experienced staff, and the service must comply with nationally agreed standards and be subject to external quality checks. There must also be an effective complaints procedure, and the availability of this needs to be advertised.

ADDITIONAL ISSUES

Priority for digital hearing aids

11. There have been no changes to the national guidelines for fitting digital hearing aids since digital hearing aids first became available free on the health service in September 2000. There are guidelines issued by the Modernising Hearing Aid Services (MHAS) programme, but the use of these is subject to local clinical discretion. Under the MHAS eligibility guidelines, patients who receive a war pension, are registered blind or are considered to have special clinical needs are given priority.

12. Many PCTs also prioritise people with visual impairments, not just those who are registered blind. For example, Sedgefield PCT's policy is that "vulnerable patient groups, such as the registered partially sighted, war pensioners and terminally ill, are fast tracked".

13. Sense recommends that there should be national guidance for priority for digital hearing aids. This should state that anyone who has a visual impairment in addition to their hearing impairment should be prioritised. At the same time, we would like to see urgent measures to reduce waiting times overall, so that the need for prioritisation of some groups above others becomes less.

SUMMARY OF RECOMMENDATIONS

- Digital hearing aids should be brought within the 18 week patient pathway target.
- Any assessment of the potential demand for audiology services should take account of the needs of the ageing population.
- National guidance on priority for digital hearing aids should state that anyone with a visual impairment, not just those who are registered blind, should be prioritised.

Katie Hanson
Sense

9 February 2007

Evidence submitted by Grant Shapps MP (AUDIO 30)

I have recently carried out research into audiology provision, in particular the waiting times for fitting of hearing aids, which was an issue brought up by some of my constituents. With around two million people using or needing the use of hearing aids this is a very important issue as far as health services are concerned.

I noticed the Health Committee is carrying out a short inquiry into audiology services, I hope this information is of some use to you.

Grant Shapps MP

8 February 2007

Table 1

Digital Hearing Aid Waiting Times (weeks)

	<i>First-fit Hearing Aid</i>		
	<i>2004–05</i>	<i>2005–06</i>	<i>Current</i>
Average waiting time	35.3	37.6	41.1

	<i>Reassessment</i>		
	<i>2004–05</i>	<i>2005–06</i>	<i>Current</i>
Average waiting time	45.6	52.3	64.4

Table 2a

Digital Hearing Aids Waiting Times for First Fitting (weeks)

<i>Trust</i>	<i>First Fitting Hearing Aid</i>		
	<i>2004–05</i>	<i>2005–06</i>	<i>Current</i>
University Hospitals of Leicester	25	22	*
Airedale	40	58	*
Bromley Hospitals	52	104	112
Plymouth Hospitals	78	108	108
Mid Staffordshire General Hospitals	*	*	104
Weston Area Hospital	*	68	100
East Kent Hospitals	*	95	100
Stockport	36	72	88
East Surrey	105	84	88
The Mid Yorkshire Hospitals	48	74	74
Warwickshire	*	*	73
Blackpool, Fylde and Wyre Hospitals	*	*	72
City Hospitals Sunderland	80	64	68
St Mary's	*	*	68
Wirral Hospital	38	52	68
Bradford Teaching Hospitals	*	*	68
Gloucestershire Hospitals	40	52	64
Guy's and St Thomas'	35	44	63
Ipswich Hospital	*	62	62
Harrogate and District	12	24	61
Essex Rivers Healthcare	64	64	60
Shrewsbury and Telford Hospital	65	60	60
County Durham & Darlington	28	47	59
Mayday Healthcare	121	65	58
Southampton Hospitals	51	63	57
Bedford Hospital	10	40	56
Queen Mary's Sidcup	78	56	56
Wrightington, Wigan and Leigh	34	42	56
South Warwickshire General Hospitals	*	*	54
Peterborough & Stamford	50	68	53
Royal United Hospital Bath	49	51	53
Sandwell & West Birmingham Hospitals	*	*	53
Heart of England	48	48	52
University Hospitals	52	36	52
North Bristol	30	40	52
North Hampshire Hospitals	*	*	52
United Lincolnshire Hospitals	18	32	49
Epsom and St Helier University Hospitals	32	48	48
Northern Devon Healthcare	64	52	48
Hull and East Yorkshire Hospitals	20	37	48
Oxford Radcliffe Hospitals	26	56	48
Burton Hospitals	*	45	47
University Hospitals of Morecambe Bay	44	44	46
Luton and Dunstable Hospital	30	30	46
University Hospital Birmingham	56	56	46
Mid Cheshire Hospitals	48	55	44
Royal Wolverhampton Hospitals	64	60	40

<i>Trust</i>	<i>First Fitting Hearing Aid</i>		
	<i>2004–05</i>	<i>2005–06</i>	<i>Current</i>
Aintree University Hospital	28	17	40
South Devon Healthcare	52	44	40
Barking, Havering & Redbridge Hospitals	12	24	40
Sheffield Teaching Hospitals	48	26	39
Calderdale and Huddersfield	13	23	38
York Hospitals	64	52	38
Mid Essex Hospital Services	26	33	37
Royal Cornwall Hospitals	21	31	34
North Cumbria Acute Hospitals	20	32	32
North West London Hospitals	76	38	30
Healthcare	52	30	30
University Hospital North Tees	27	29	29
Newham PCT	26	28	28
Barts and The London	29	38	26
East Lancashire Hospitals	20	20	24
Hillingdon Hospital	26	25	24
Buckinghamshire Hospitals	44	22	22
The Hammersmith Hospitals	10	12	20
Southend University Hospital	27	32	20
Trafford Healthcare	13	23	20
Walsall Hospitals	*	18	18
United Bristol Healthcare	38	23	18
Southport and Ormskirk Hospital	26.3	20.7	17
Derby Hospitals	14	14	16
West Suffolk Hospital	18	16	16
Royal Free Hampstead	33	21	16
South Manchester University Hospitals	4	12	16
Bolton Hospitals	3	4	16
Gateshead Health	9	12	15
Nottingham University Hospitals	30	42	14
Frimley Park	*	*	13
Freeman Hospital	7	13	12
North Tyneside Hospital	4	12	12
Children's University Hospitals	42	15	12
Royal Berkshire	12	12	12
Taunton and Somerset	45	12	12
The Rotherham	24.5	21.5	12
Whittington Hospital	52	52	12
St George's Healthcare	10	9	11
Sherwood Forest Hospitals	7	6	8
Milton Keynes General	52	60	8
Birmingham Children's Hospital	6	6	6
Barnsley Hospital	10	8	6
Royal Liverpool Children's	3	3	3
Great Ormand Street Hospital for Children	3	3	3
Salford Hospital (children's hearing aids)	4	1	1
Average	35.0	37.8	41.2

Table 2b

Digital Hearing Aids Waiting Times for Reassessment (weeks)

<i>Trust</i>	<i>Reassessment</i>		
	<i>2004–05</i>	<i>2005–06</i>	<i>Current</i>
University Hospitals of Leicester	24	27	*
Freeman Hospital	*	*	*
North Tyneside Hospital	*	*	*
Salford Hospital (children's hearing aids)	*	*	*
Northern Devon Healthcare	52	32	*
Airedale	20	58	*
Birmingham Children's Hospital	*	*	*
Blackpool, Fylde and Wyre Hospitals	*	*	260
Wirral Hospital	163	169	169
Derby Hospitals	*	*	156

<i>Trust</i>	<i>Reassessment</i>		
	<i>2004–05</i>	<i>2005–06</i>	<i>Current</i>
Mid Staffordshire General Hospitals	*	*	156
Plymouth Hospitals	78	112	156
Bromley Hospitals	*	*	156
Harrogate and District	26	52	156
Hull and East Yorkshire Hospitals	78	156	156
Sheffield Teaching Hospitals	124	150	130
North Hampshire Hospitals	*	*	128
Mid Cheshire Hospitals	92	110	128
North West London Hospitals	84	96	126
Barking, Havering & Redbridge Hospitals	12	24	124
Gloucestershire Hospitals	72	104	120
Calderdale and Huddersfield	50	65	115
Stockport	36	72	114
Hillingdon Hospital	33	114	114
Royal Wolverhampton Hospitals	112	114	110
South Warwickshire General Hospitals	*	*	110
The Mid Yorkshire Hospitals	53	96	110
Epsom and St Helier University Hospitals	40	76	104
Ipswich Hospital	*	70	104
North Cumbria Acute Hospitals	72	104	104
Heart of England	*	*	102
Weston Area Hospital	*	68	100
Essex Rivers Healthcare	78	100	100
East Kent Hospitals	*	95	100
Sandwell & West Birmingham Hospitals	*	*	96
Burton Hospitals	*	84	90
United Lincolnshire Hospitals	22	51	88
East Surrey	105	84	88
East Lancashire Hospitals	24	40	84
Newham PCT	50	52	78
Wrightington, Wigan and Leigh	30	52	78
Southport and Ormskirk Hospital	64.7	84.3	73
Shrewsbury and Telford Hospital	80	65	70
City Hospitals Sunderland	80	64	68
St Mary's	*	*	68
Walsall Hospitals	*	70	65
Bradford Teaching Hospitals	*	*	64
Royal Cornwall Hospitals	76	61	63
Luton and Dunstable Hospital	12	20	60
County Durham & Darlington	28	47	59
Mayday Healthcare	121	65	58
Bedford Hospital	10	40	56
Peterborough & Stamford	50	68	53
Royal United Hospital Bath	49	51	53
Barts and The London	44	40	52
Guy's and St Thomas'	25	36	52
University Hospitals	49	36	52
Queen Mary's Sidcup	112	56	52
Healthcare	78	52	52
Oxford Radcliffe Hospitals	26	56	48
University Hospitals of Morecambe Bay	44	44	46
The Hammersmith Hospitals	20	20	40
North Bristol	12	28	40
South Devon Healthcare	52	44	40
Mid Essex Hospital Services	26	35	38
York Hospitals	78	52	38
Taunton and Somerset	47	45	37
University Hospital North Tees	27	27	34
University Hospitals Coventry and Warwickshire	*	*	30
Aintree University Hospital	22	17	30
Southampton Hospitals	28	37	28
St George's Healthcare	*	*	24
Buckinghamshire Hospitals	52	22	22
University Hospital Birmingham	20	20	18
United Bristol Healthcare	32	23	18

<i>Trust</i>	<i>Reassessment</i>		
	<i>2004–05</i>	<i>2005–06</i>	<i>Current</i>
Nottingham University Hospitals	35	52	17
Bolton Hospitals	78	30	17
West Suffolk Hospital	20	17	16
South Manchester University Hospitals	12	24	16
Gateshead Health	9	12	15
Trafford Healthcare	47	16	15
Frimley Park	*	*	14
Southend University Hospital	33	52	14
Children's University Hospitals	36	20	13
The Rotherham	24.5	21.5	13
Royal Berkshire	12	12	12
Royal Free Hampstead	33	15	10
Milton Keynes General	52	60	8
Barnsley Hospital	10	8	8
Sherwood Forest Hospitals	6	7	6
Great Ormond Street Hospital for Children	6	6	6
Whittington Hospital	52	52	4
Royal Liverpool Children's	*	*	0
Average	48.0	55.4	68.8

TOP TEN WORST OFFENDERS

Table 3a

First Hearing Aid—Top Ten Worst Offenders

<i>Position</i>	<i>Trust</i>	<i>Waiting Time (Weeks)</i>
1	Bromley Hospitals	112
2	Plymouth Hospitals	108
3	Mid Staffordshire General Hospitals	104
4 =	Weston Area Hospital	100
	East Kent Hospitals	100
6 =	Stockport	88
	East Surrey	88
8	The Mid Yorkshire Hospitals	74
9	University Hospitals Coventry and Warwickshire	73
10	Blackpool, Fylde and Wyre Hospitals	72

Table 3b

Reassessment—Top Ten Worst Offenders

<i>Position</i>	<i>Trust</i>	<i>Waiting Time (Weeks)</i>
1	Blackpool Fylde and Wyre Hospitals	260
2	Wirral Hospital	169
3 =	Derby Hospitals	156
	Mid Staffordshire General Hospitals	156
	Plymouth Hospitals	156
	Bromley Hospitals	156
	Harrogate and District	156
	Hull and East Yorkshire Hospitals	156
9	Sheffield Teaching Hospitals	130
10 =	North Hampshire Hospitals	128
	Mid Cheshire Hospitals	128

Evidence submitted by Liza Smeeton, Barnsley Hospital NHS Foundation Trust (AUDIO 9)

I am writing in response to your request for information about audiology services. I am Head of Audiology at Barnsley Hospital NHS Foundation Trust.

Whether accurate data on waiting times for audiology services are available?

1. I feel that data, when mentioned in the press is averaged out across the country which paints a black picture for departments like mine where we have low waiting times. My waits are 6–8 weeks for all new referrals and a further 6–8 weeks for fitting of a hearing aid. Waits vary, even across regions and between neighbouring Trust's.

Why audiology services appear to lag behind other specialities in respect of waiting times and access and how this can be addressed?

2. I agree that this is an issue in many areas. I feel that access can be improved through audiology being part of direct access and Choose & Book. I also strongly believe that referral pathways need tightening so that patients who simply need a hearing aid do not end up being referred to ENT, where they clog up their clinics, but are always referred directly to audiology. Under MHAS and Action on ENT a lot of good work into these areas was done. When these initiatives stopped so did the improvements.

Whether the NHS has the capacity to treat the numbers of patients waiting?

3. We need to look at our processes to increase capacity and use lower bands of staff to do certain parts of the patient journey, eg repairs and simple adjustments of aids. In Barnsley we continually look at our appointment lengths to see if they can be reduced to create additional capacity. Reducing steps for the patients can also lead to a more efficient service.

Whether enough new audiologists are being trained?

4. Yes, but I wonder if, with the changes under Agenda for Change, we need to be training staff at a Band 4 level and increasing this element of our workforce. That is the plan for my department as staff leave. Having a changed skill mix, as nurses do, would provide a more effective and cost-competitive workforce.

How great a role the private sector should play in providing audiology services?

5. The “hidden” wait in all audiology departments are the number of patients currently on the older type analogue hearing aids who are waiting to be changed over to digital aids. My department is no exception. The private sector could, under a model similar to the PPP model used under MHAS, be the solution to this. Once we are over this “hump” I feel in most areas there would be sufficient staff to provide a quality service.

I hope this information is of use. I look forward to hearing the outcome of this enquiry.

Liza Smeeton

Head of Audiology, Barnsley Hospital NHS Foundation Trust

1 February 2007

Evidence submitted by Michael Snee (AUDIO 31)

1. We in Calderdale have a waiting list of 104 weeks for the above services when the audiologist before Christmas 2006 were just starting on waiting list that went back to April 2004. The PCT in a letter to me indicated a 90 week waiting list.

2. Its not the fault of the PCTs and the Audiologists. One has to go back to Alan Milburn in, I think, 2002 making a statement to the world and his wife that everybody in the country who was deaf and hard of hearing would have a new digital hearing aid by 2003, £115 million was allocated to NHS to achieve this. This is when the problem started for nobody knows how many people are deaf and hard of hearing in the UK. The RNID claim six million and they could be close to the truth.

3. If one looks at the return by local authority social services on the total number of deaf and hard of hearing in their locality the figures that are returned are ridiculous. In Calderdale we have a guesstimated total of 25,000 people deaf and hard of hearing. The majority of them are over 65 and many will be dead before they hear again, but the three year return by the local authority to the Department of Health indicates a total of about 800 people.

4. The local authority only returns the number of people who are registered, for to register is a voluntary act and the majority of people do not bother the Department of Health when they received the returns. Look at the figures. I think on memory the total for England is about 220,000 consider it to be of low value do a multiplication of sorts and then allocate monies to PCTs for audiology which is never enough.

5. You must get people to register and make it mandatory for local authorities to produce an accurate return. The next one is due in March 2007.

6. You will find that most forums in the UK have highlighted this problem to their MPs and without the Forums this would have gone unnoticed, and people would be dead before they get a hearing aid. This is just one small item in the agendas of the PPI Forums that have brought to light health inequalities but sadly this will disappear when LINKs appears next year.

Michael Snee

Chair, Calderdale PPI Forum

9 February 2007

Evidence submitted by Specsavers Hearcare (AUDIO 17)

EXECUTIVE SUMMARY

Our proven retail model of providing high quality, community-based hearing care at low prices clearly demonstrates that it would be possible for the independent sector to deliver a professional, cost-effective hearing service on behalf of the NHS. Specsavers believe we could deliver such a service, including the entire patient journey and the supply of digital hearing aids themselves, for a total inclusive cost of *circa* £350–£400 per patient journey for a monaural fitting⁶⁴ and £500–£550 for a binaural⁶⁵ fitting, with hearing tests and hearing aid fittings being completed within two to four weeks of referral.

A “prescription” based model (see paras 28–34) would fully engage spare independent sector capacity, could halve current NHS waiting lists within a year and reduce the total cost of public sector hearing provision.

75% of hearing aids dispensed in the UK are funded and fitted by the NHS (500,000 + units pa). The independent sector currently fits some 170,000 units pa but has the capacity to fit up to 200,000 pa more. The independent sector has the skills, the capacity and much of the infrastructure already in place to assist the NHS in both reducing current waiting times and improving overall value for money for public hearing provision.

The most effective mechanism for service delivery would be a “prescription” based system similar to that already in use in the UK optical market and as used for hearing care provision in a number of European countries. In effect, the patient is entitled to a sum of money that would be used for full payment of an agreed specification of hearing aid or which could be used at the patients’ discretion as part-payment towards a higher specification of hearing system with patient themselves making up the extra cost.

The “hearing prescription” would also cover the cost of the hearing test, dispense and fitting process and an agreed level of aftercare support. If necessary, entitlement to the prescription or the face value of the prescription would be dependent on the severity of the hearing loss with patient entitlement being limited to being able to claim every four to five years.

The adoption of such a system would be seen as equitable and would encourage the maximum participation of all independent sector hearing aid dispensers. Other proposed models of supply being considered by the NHS [such as commissioning or local partnership agreements] would engage only a small proportion of the independent sector and consequently would not be able to deliver sufficiently increased capacity to make the desired impact on current waiting lists or provide the value the NHS are seeking.

The introduction of a “prescription” system would allow the NHS rapid access to an additional, qualified resource capacity equivalent to up to 200,000 patient journeys a year, suggesting that existing waiting lists could be almost halved within the first year. Independent sector capacity would also further increase over the following years as independent sector businesses geared up to invest more heavily in staff training and providing greater physical testing capacity.

The “prescription” model is fair and equitable for practitioners inasmuch as it allows ALL hearing aid dispensers to “compete” equally for NHS business and more importantly, it empowers the patient/consumer to take control of their own well-being and gives them the freedom to choose the provider, location and specification of hearing care that best meets their needs. This is a major step forward from the current “one size fits all”, hospital-based approach to public hearing provision which in reality does not suit the majority of patients at all and which is failing to deliver the choice or speed of delivery to which the patient is both entitled and increasingly demanding.

⁶⁴ Monaural = hearing aid for one ear only.

⁶⁵ Binaural = hearing aids for both ears.

The following document discusses briefly some of the issues that would need to be addressed in detail in the short-medium term to allow the NHS to implement such a “prescription” system to take maximum advantage of the independent sector capacity and expertise. We would be pleased to supply more information on request.

ABOUT SPECSAVERS

1. Founded in 1984, Specsavers is now a multinational company providing services in the UK, Republic of Ireland, Netherlands, Denmark, Sweden, Norway and Spain. The Group has over 800 practices in total (560 in the UK) and over 15 million customers.

2. The Company is still privately [family] owned and family run; it is the UK’s largest optical retailer accounting for one in four sight tests and one in three spectacle dispenses in the UK and is by far the largest provider of sight tests and spectacle dispenses to the NHS.

3. Specsavers business model is built around a joint-venture structure incorporating over 1,000 community-based healthcare specialists across the country, including hearing aid dispensers and opticians, who each own their own practices in partnership with the Group.

4. Each Specsavers Hearcare practice is owned by a Registered Hearing Aid Dispenser [RHAD] on a joint-venture basis. This assures the full commitment and sustained focus on giving excellent customer service and customer care. Specsavers customer satisfaction/hearing aid acceptance rate is over 95% with over 90% of customers choosing binaural fittings, compared to the rest of the independent sector where average satisfaction/acceptance rates are less than 80%⁶⁶ with only 30% binaural fitting.

5. Specsavers diversified into hearing services in 2003 through the acquisition of Hearcare Limited. Over the past three years, Specsavers has invested heavily in hearing care and has expanded its store network to encompass over 220 stores (100 “dedicated” hearing services and 120 “day centres”) with plans to open in a further 150 locations during 2007–08.

6. By 2010, it is anticipated Specsavers will be providing hearing care from ALL of its optical stores in the UK, Republic of Ireland and the Netherlands.

7. Specsavers Hearcare is now the largest independent dispenser of digital hearing aids in the UK, dispensing some 5,000 units per month with an estimated volume market share of 18% of customer transactions and 23% of hearing aid dispenses. Only the NHS fit more than we do.

8. Specsavers Hearcare has been nominated for the third year running in the prestigious Retail Week Awards for retail excellence in the “Emerging Retailer of the Year” category.

CURRENT SYSTEM OF HEARING PROVISION

9. RNID figures indicate one in seven people (16%) of the UK population have some form of hearing loss yet, according to the Government’s “Living in Britain General Household Survey 2002”, only 4% of all men and 3% of all women wear hearing aids.

10. 75% of all hearing tests carried out and hearing aids dispensed in the UK (an estimated 500,000+ units per annum) are dispensed via the NHS at a total cost [ie including staff and premises] of over £500 per hearing aid dispensed.

11. While everyone is effectively entitled to free hearing aids under the NHS, 25% of people already choose to pay privately to source their hearing care citing better product choice, wider choice of hearing aid styles⁶⁷ and speed of service as the main reasons for choosing the independent sector over public hearing provision.

12. The NHS tends to dispense a single hearing aid for most patients [we assume due to cost/ budget constraints] despite the medical evidence and best advice from the Hearing Aid Council [HAC] that a hearing aid in each ear gives a better overall result and greatly assists the wearer in most situations through providing a more balanced, near-normal hearing experience.

13. The relevance of this being that despite all of the recent media attention regarding long waiting times for NHS hearing provision, there is growing evidence that increasing speed of NHS provision is not necessarily going to provide the complete solution to giving people what they actually want.

14. There is growing anecdotal evidence also that many people are put off applying for an NHS hearing aid because the NHS service is delivered from hospitals in most instances. In our experience, people with hearing problems do not perceive themselves as being “ill” and would prefer to be able to source their hearing care from the “high street” or within their local community [GP practices, health centre] rather than have to visit a hospital—much in the same way they are already able to do for NHS funded sight tests or spectacles.

⁶⁶ Hearing aid manufacturers figures as measured by customer-cancelled orders.

⁶⁷ Typically, only the traditional “behind the ear” [BTE] models are dispensed by the NHS despite consumers preferring the more discrete “in the ear/canal” [ITE, ITC and CIC] styles which are deemed more cosmetically attractive for many.

15. And while there is concern over increasing waiting terms now, the population is ageing and demand for hearing services is projected to increase significantly over the next 10–15 years suggesting that the current waiting problems will get substantially worse unless there is a fundamental change in the way hearing provision is delivered.

INDEPENDENT SECTOR CAPACITY

16. The NHS and consumers alike want to see waiting lists for hearing services reduce significantly. Consumers would also prefer to be able to choose their hearing provider from the “high street”. Although it would take time for the independent sector to gear up to be able to take all of the NHS demand, there is significant spare capacity already available which could “immediately” take on up to 200,000 patient journeys per annum. By way of explanation, there are currently only *circa* 1,000 practising RHADs⁶⁸ dispensing hearing aids in the UK independent sector, limiting current independent sector capacity to an estimated 350,000 dispenses/patient journeys per annum. Private dispenses currently account for c 150,000–170,000 units per annum suggesting there is existing “spare capacity” of up to 200,000 patient journeys per annum.

17. However, there a number of structural and regulatory issues, identified below, which would need to be addressed/removed to make such independent sector involvement possible:

People and regulations

18. The HAC currently regulates UK independent hearing provision and different regulations apply in the independent sector from those governing public hearing provision—not least in terms of the recognised qualifications for public and independent sector staff.

19. The lack of a commonly recognised qualification, which allows someone to practise in both the independent and public sector, makes it almost impossible for the independent sector to source suitably qualified staff quickly to gear up to meet NHS demand. The “additionality” clauses in existing public/private sector contracts prevent independent companies from actively recruiting NHS staff and restrict any short-term transfer of skills between the sectors.

20. This skill shortage is being addressed in the medium term by providing more training capacity via Higher Education Institutes but consideration should also be given in the short-term to reviewing the current HAC insistence on trained NHS audiology staff still having to acquire the HAC Registered Hearing Aid Dispenser qualification and complete the six months pre-registration period before they can work unsupervised in the independent sector. Within the NHS staff with different levels of training are already permitted to handle parts of the patient’s hearing test, dispense and aftercare journey yet this is not permitted to the same extent in the independent sector. Reviewing this restriction would significantly help increase capacity as new staff could be trained and introduced into the independent sector within months to undertake the more basic procedures which then would free up much needed RHAD time for the more specialist areas of the test and dispense process.

Premises

21. While Specsavers operates from a retail based “high street” model, many independent sector hearing practitioners trade from a variety of premises using calibrated, portable equipment. Domiciliary visits (ie providing the service in the customers own home) currently account for *circa* 50% of all UK private hearing aid dispenses while the remainder are provided from a mix of “dedicated” hearing centres and “day centres”—the latter being where the RHAD conducts the hearing service from “borrowed” premises such as optical testing rooms in local opticians stores, health centres and even hotel rooms.

22. In contrast, the NHS tends to provide hearing tests using soundproof booths in hospital consulting rooms. The use of such soundproof booths is not standard practice in the independent sector yet there is no evidence to suggest that an independent sector test and dispense is in any way less effective than that provided by the NHS. Determining whether independent sector providers have to provide sound-proof testing conditions will have a major impact on physical capability as well as the cost of service delivery. Specsavers is one of a minority of the national companies that actually fit soundproof booths in our 100 hearing centres but even we don’t yet have them in our 120 “day centre” stores. Providing the regulations focus on ensuring that test rooms meet suitable noise standards (ie ambient noise less than 35 dBA), then most independent hearing providers would be able to provide suitable testing conditions almost immediately. If the requirement for soundproof booths remains, the investment costs and physical space constraints would significantly restrict the speed that many companies could and would make more physical testing space available to take on NHS patients. (For information, the cost of soundproof booths is between £4,000–£6,000 per unit.)

⁶⁸ There are some 1,400 RHADs registered with the HAC but it is believed only *circa* 1,000 actively practice on a full-time basis.

PRICING AND SERVICE DELIVERY

Private sector

23. The independent sector is often seen (with justification in some cases) as providing hearing aids and hearing services at high, if not extortionate prices; a situation not helped by the remuneration model used by many companies based on paying dispensing staff a % commission of the retail sales value. Given the relatively low volume of private customers and lack of transparency in private hearing aid pricing, this model has become self-perpetuating in many companies with no apparent incentive for dispensers to drop prices. However, Specsavers entry into the independent hearing market in 2002, trading on a no-commission, value-for-money platform and our rapid growth subsequently, has shown it is possible for independent companies to make a fair return on investment by driving high volumes at much reduced prices. Our transparent approach to pricing has now started to force greater price competition across the independent sector resulting in better services at lower retail prices for consumers.

24. By way of example, the estimated average retail price per digital hearing aid dispensed across the independent sector is believed to be in the region of *circa* £1,200, whereas Specsavers average dispense value per digital hearing aid dispensed is *circa* £550. Being able to also provide services to NHS patients within an appropriate “prescription” based model would allow us to improve efficiency even reduce costs even further.

NHS pricing

25. A balance needs to be struck that gives the independent sector a fair return on resources deployed, gives the NHS the same (and ideally, better) value for money for public sector provision and guarantees consumers, who choose the NHS option, the same [or higher] level of patient care that they currently receive from the NHS. It is Specsavers view that a fee of *circa* £350–£400 for a monaural fitting and £500–£550 for a binaural fitting would be required for the independent sector to be able to cost-effectively take on this work and cover the required increased investment in staff, equipment and premises necessary to take on the increased patient volumes. These figures include the cost of the digital hearing aid(s) and all professional testing, fitting and aftercare.

26. The influx of NHS business would obviously grow the independent sector and should make all hearing businesses more efficient overall. Nonetheless, it remains a fact that most independent sector companies would need to subsidise what is, in reality, the necessary low-cost provision required by the NHS through offering private sales to those customers who wanted to “trade up” to a higher specification of product or who chose to pay for a cosmetically more attractive option. This situation mirrors the UK spectacle market whereby most opticians similarly subsidise NHS optical services by offering a wide range of frame and lens options for those customers who want something over and above their NHS-funded entitlement and are who prepared to pay for that difference themselves.

27. It is Specsavers considered opinion that only the following “prescription” based model would create the necessary environment to guarantee maximum independent sector engagement:

The “prescription”/managed care model

28. The underlying basis of this model is that the NHS would provide/fund a “hearing prescription” for each patient to cover the cost of hearing tests and a digital hearing aid to an agreed level of specification and value.

29. Costs per patient could be controlled/capped as required by limiting the issue of prescriptions based on need (defined by the severity of hearing loss) and/or via a time limit—ie patients would only be able to claim a monaural or binaural prescription depending on the degree of hearing loss in each ear with their prescription only “renewed” once in a four or five year period.

30. The “prescriptions” could be issued by the patient’s GP—although the existing General Ophthalmic Service provides an alternative model (which is both established and proven)—here it is the optometrist who issues the “optical voucher and prescription statement” at the point of service delivery. This “GOS type” model would ultimately be most cost-effective.

31. All “routine” hearing tests and hearing aid dispenses would be carried out by the independent sector, freeing up NHS resources to concentrate on the more complex audiological procedures.

32. Experience in other countries (eg Netherlands, Republic of Ireland etc) already shows such mechanisms work very effectively, with the additional benefit of encouraging greater competition between independent sector providers so raising the overall standards of choice and patient care and bringing down prices. This system has been in use in the optical sector for many years and there is no reason why it would not be equally as effective in the provision of hearing care.

33. The key benefits of such a system is that it would both:

- (a) engage the whole of the independent sector, allowing all companies/dispensers to participate equally, and making hearing services more accessible and more convenient across the UK; and

- (b) give the consumer the freedom to choose their preferred supplier of hearing services and to give them the opportunity to trade up to buy a different hearing aid if they so required.

34. The cost of service to the NHS per patient journey would be capped under the prescription system at a given agreed amount, giving an immediate saving per patient. Nonetheless NHS spending would have to increase in the short term in line with the increased numbers of patients being treated as waiting lists are reduced. Longer term however this model would reduce the total cost of public hearing provision via the savings achieved from engaging the independent sector and from freeing up NHS staff and physical resources for use in the provision of other, more acute patient care.

Governance and “gatekeeping”

35. It is obviously essential that costs are properly controlled and the NHS has an appropriate audit mechanism to validate claims as required and to control the aftercare entitlement for the patient. In the Netherlands the “KNO” consultant [equivalent of a UK ENT consultant] or designated audiology centre carries out the first hearing test to determine the patient’s initial need and generates the patients audiogram⁶⁹ for them to take to the independent sector for dispensing. Thereafter all regular hearing tests, hearing aid fittings and patient aftercare are carried out directly by the independent sector.

36. It may be desirable for the patient’s GP to play a similar “gatekeeper” role by authorising the initial need for a hearing test, to receive notification of the level of hearing loss determined during the test and confirmation that any appliance dispensed was both necessary and has been performed to the appropriate standard.

37. The HAC Code of Practice already requires the hearing aid dispenser to sign and keep a physical copy of the patient’s audiogram and it is proposed that this document could be submitted [either with every claim or on demand] to substantiate claims for “prescription” reimbursement from the NHS.

38. The Dutch system also includes a mandatory period of one month’s trial for the patient to wear the hearing aid and determine that it is correctly fitted and programmed before the provider’s claim for reimbursement of the “prescription” is paid.

OTHER POSSIBLE MODELS

39. We understand the NHS is looking at a variety of possible business models to allow the engagement of the independent hearing sector, including commissioning and local partnership agreements. While we understand that these might seem potentially attractive solutions, both have severe drawbacks and will not allow the NHS to fully maximise the independent sector opportunity. Furthermore, both have been tried and largely discredited in trying to engage the independent sector to take on public dental provision and, given the similarities between the professions, we see no reason why either would be any more successful in providing hearing care.

Commissioning

40. Asking independent sector providers to tender for public hearing provision meets one NHS requirement of driving value for money but would not meet the need to sufficiently increase capacity to reduce waiting lists. Our understanding is the commissioning process will only award business to the lowest tender; by definition therefore and irrespective of whether such commissioning is actioned on a national, regional or local scale, only one company can win a tender and therefore all the other possible suppliers would be excluded. Even if the largest independent employer of RHADs in the UK won all tenders, this would still only provide some 30% of potential independent sector capacity with the subsequent 70% excluded from the provision of public care.

41. In our view, it is highly unlikely in any event that any one company would be able to secure the necessary resources in terms of staffing or suitable premises to be able to meet the demand, either nationally or regionally. A “single provider” solution, whilst expedient for the commissioner, does not offer genuine patient choice.

Local partnership agreements

42. One model we know is already on trial in some parts of the NHS would enable the independent sector and NHS, probably on a regional SHA or local PCT basis, working together on a “partnership” basis. The underlying thesis of such a model is that independent sector expertise is used to manage the service dispensing both public and private sector hearing aids from community based premises, and with a proportion of the profits from the enterprise being reinvested to further extend hearing services in the community.

⁶⁹ Effectively the customers prescription which details the level of hearing loss in both ears at specific sound frequencies.

43. Audiology staff are effectively seconded to work in the new partnership but retain their existing NHS employment benefits. The SHA/PCT provide facilities at existing community-based premises (health centres, community centres) for the establishment of full-time hearing centres or “day centres”. The independent sector company would run the service for an agreed fee or a share of the resulting profits.

44. This model may have attractions for the NHS but also has constraints inasmuch as it would again only engage a small proportion of the independent sector and would be unlikely to generate any significantly increased capacity in the short-term to help reduce waiting lists. It would also be subject to legal challenge under UK and European Law if it were seen to unfairly prejudice other independent sector companies from being able to compete on equal terms for the NHS element of the service being provided. This model also suffers from only providing limited patient choice.

CONCLUSIONS

45. It is Specsavers conclusion that only the “prescription” model would engage the greatest possible support, capacity and cost-savings from the independent sector and while regulation and codes of conduct would be necessary to ensure the consistency of clinical excellence and consumer protection, this model also gives the patient the greatest choice and involvement in how and from where their hearing care is delivered. This solution offers the public the best combination of access, choice and quality.

46. The “prescription” model would enable the NHS to make the most rapid progress in both reducing waiting times and reducing the total overall, long-term cost of public hearing provision.

47. Costs per patient could be controlled/capped as required by limiting the issue of prescriptions based on the severity of hearing loss and/or via a time limit, giving the NHS greater budgetary control overall.

48. Experience in other countries (eg Netherlands) clearly demonstrates that increased level of competition generated by the “prescription” system has a positive effect in improving the quality of patient care, improving speed and range of service delivery, increasing choice and driving down prices. It is a proven model, popular with patients and allows the greatest utilisation of audiological resources across the country. It is our contention that such a model would work effectively in the UK also.

Keith Willis

Director, Specsavers Hearcare Group Limited

29 January 2007

Evidence submitted by East Sussex Health Overview and Scrutiny Committee (AUDIO 8)

East Sussex Health Overview and Scrutiny Committee (HOSC) is the statutory body responsible for scrutinising health services and health issues affecting residents of East Sussex. The HOSC’s membership comprises County Councillors, Borough and District Councillors and representatives from the local voluntary sector. This evidence is submitted on behalf of the committee by its Chairman, Cllr Bob Lacey.

BACKGROUND

HOSC members had identified various examples of patients waiting considerable lengths of time for diagnosis and treatment in Audiology, suggesting that there could be a significant problem for local people in terms of access to these services.

The HOSC made contact with the two local Primary Care Trusts (PCTs), East Sussex Downs and Weald PCT and Hastings and Rother PCT, in October 2006 to determine the actual situation with regard to waiting times. HOSC has also carried out some initial research into the issue.

Waiting times data for Audiology—accuracy

1. Enquiries to the PCTs revealed that in Hastings and Rother, waiting times at the Conquest and Bexhill hospitals are:

- New patients: 16–20 weeks (215 patients).
- Reassessment/upgrade: up to 58 weeks (327 patients).

In East Sussex Downs and Weald, waiting times at Eastbourne District General Hospital are:

- New patients: 10 months (616 patients).
- Reassessment/upgrade: 6–8 months (692 patients).

2. These figures suggest that waiting times data is routinely collected in relation to both new patients and those waiting for reassessment/upgrade. However, anecdotal reports suggest that some patients are waiting longer than the official figures suggest, casting some doubt over the accuracy of the data.

3. East Sussex residents also use services provided in Brighton and Hove. Anecdotal evidence suggests that waiting times there are also lengthy.

Reasons for lengthy audiology waits and how this can be addressed

4. The PCTs have indicated that they are concerned about the disparity in waiting times between the different hospital sites and regard the wait of over a year for reassessment/upgrade at the Conquest and Bexhill hospitals as unacceptable.

5. East Sussex HOSC understands that there is a national problem with lengthy waiting times in audiology. This appears to be caused by the advent of new technology and an ageing population generating additional demand, coupled with a lack of NHS audiologists to meet this demand. There is also a question over whether sufficient funding has been put into addressing the issue and whether alternative service models have been adequately investigated.

6. For example, HOSC research identified a GP Practice in Kent which has obtained the services of a private sector audiologist at no charge to see a proportion of the practice's Audiology referrals within the surgery. This has been achieved under practice based commissioning arrangements and has reduced waits, saved money, and enabled patients to be seen closer to home. It would seem to be a model worth further exploration.

7. The PCTs in East Sussex have identified allocations for patients to be seen by independent sector providers during 2007–08 which they expect to reduce waiting times significantly. HOSC will be following up with the PCTs to determine how quickly and by how much such an approach will reduce waiting times for patients.

Whether the NHS has the capacity to treat the numbers of patients waiting

8. East Sussex HOSC can confirm that the PCTs in East Sussex intend to source additional capacity from the independent sector in 2007–08 to reduce waiting times. This implies that the NHS locally does not have sufficient capacity to treat the numbers of patients waiting.

CONCLUSION

9. East Sussex HOSC can confirm that this is an issue of concern to local people and that evidence provided by the PCTs confirms anecdotal reports of lengthy waits for audiology services.

10. East Sussex HOSC welcomes this national enquiry into audiology services. HOSC members remain concerned that such lengthy delays in patients accessing audiology services can be detrimental to their wider health and quality of life.

Cllr Bob Lacey OBE

Chairman, East Sussex Health Overview and Scrutiny Committee

1 February 2007

Evidence submitted by Dinah Taylor, King's College Hospital NHS Foundation Trust (AUDIO 22)

The following comments are based on experience and observations of Audiologists and in no way necessarily reflect the views of Kings College Hospital NHS Foundation Trust.

Whether accurate waiting times for audiology services are available?

1. Accurate information is available at some departments. It is likely that the format in which it is held may differ from place to place.

Why audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed?

2. Increased waiting times at this hospital have resulted from:

- increased number of new referrals;
- the need to see all new referrals within 13 weeks as the expense of other appointments;

- reduced staffing levels over several years and particularly with the withdrawal at end March 2006 of additional DoH funding as part of the MHAS project; and
 - the need for longer appointment slots to fit and follow up DSP hearing aids compared with analogue aids, hence reducing throughput.
3. The difficulties could be addressed by:
- funding audiology services as a separate discipline rather than as part of ENT;
 - investing in adequate staffing establishment to cope with the workload;
 - ensuring that test and auditory rehabilitation facilities meet minimum standards; and
 - invest in adequate equipment to cope with workload.

Whether the NHS has the capacity to treat the numbers of patients waiting?

4. The NHS does not currently have the capacity to treat all the patients; this is not only lack of staffing establishment, but also inadequate facilities, varying between departments.

Whether enough new audiologists are being trained?

5. There are qualified Audiologists, both recently trained in the UK and foreign trained, who are unable find employment. This is not because there is not work available, but because there are inadequate posts for the workload.

How great a role the private sector should play in providing audiology services?

- It is likely that farming out work to private sector as proposed, and as is happening already in some areas, will be more expensive than properly funding existing Audiology departments.
- Provision of services via mobile units is unsatisfactory as patients are very unlikely to have immediate access for follow up or if they experience problems, unlike services provided by the NHS where an appointment can be offered on request.
- If patients are unable to obtain an immediate appointment via the private sector they are likely to visit their local NHS department. Audiologists will be unable to help them as they have already been seen by an alternative so called “service provider”. Only after a further GP referral to the NHS will a patient be seen in their local clinic when the Audiologists will be obliged to duplicate work, obviating the need for the original referral to the private sector.
- There is a danger of missed diagnoses if patients are assessed in the private sector; they may have other Audiological or ENT problems which will not be identified.
- For private sector involvement to be successful it is imperative that all patient data is passed to the local NHS department, but it seems that the costs significantly outweigh the benefits.

Dinah Taylor

Audiologist, Kings College Hospital NHS Foundation Trust

[comments made as an individual]

8 February 2007

Evidence from the UK Federation of Professionals in Hearing and Balance (AUDIO 12)

The National Committee of Professionals in Audiology (NCPA) has changed its name to United Kingdom Federation of Professionals in Hearing and Balance (UKFPHB) with effect from April 2006.

The NCPA was set up in 1990 as an independent committee representing the interests of the entire range of professional groups active in the field of Audiology. Thus it has a unique status in that it can be said to be a voice for the whole Audiology profession. Each of the member organisations is represented by a single committee member who acts as link between the UKFPHB and their own professional organisation and provides a briefing about the activities of their own professional group at each meeting.

The United Kingdom Federation of Professionals in Hearing and Balance is thus unusual in that it is very broad-based, consisting of representatives from the field of education as well as healthcare, from charities as well as professional bodies, from the private as well as the public sector.

The primary aims of the UKFPHB are to provide a national forum for debate of professional issues, for the sharing of information and as a sounding board for new ideas. As UKFPHB represents all the associations it is able to view audiological issues from a wider perspective than may be possible in totally profession based organisations. It is therefore in a very good position to act as a channel of access between professional associations and the relevant government departments.

UKFPHB will also, via working parties, produce position statements, guidelines and statements of best practice on a very wide range of issues, for example UNHS, lost/damaged hearing aids, classroom acoustics and service provision.

BELOW ARE THE UKFPHB RESPONSES TO YOUR INQUIRY

Whether accurate data on waiting times for audiology services are available?

1. No. In the field of audiology there have been great concerns and no clarification as to what exactly audiology needs to report on for the DH. Data is therefore inaccurate and there is missing data. Not all Trusts are submitting data and some are making monthly entries and others bi-annual census. Trusts may know how many patients and how long they are waiting but this information is not standardised across the country. There is a lack of clarity as to what is to be current in regards to assessments. Waiting time lists may be available but it is not known whether they are correct with regard to clarity. What is perceived by “audiology service” ie is it a patient coming with a hearing problem; paediatric; adult; balance; internal referral?

Why audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed?

2. Audiology, historically, has had a low profile and is chronically under funded and demand always exceeds capacity. There is a lack of appreciation of the long process of a diagnostic work-up and rehabilitation of the audio-vestibular patients, by the managers and referrers alike, and scanty knowledge about the existing audio-vestibular services among the referrers.

3. If a patient’s waiting time is to do with time from referral to time of hearing aid fitment that will have so many stages along the way that it will not be time of referral to time of first appointment. There is also a question of capacity in terms of equipment (including sound proofing which is costly) and audiologists. There is also a gap between first appointment and hearing aid fitting when a child may need to be recalled two or three times to get definitive results before a hearing aid is prescribed. The nature of audiology work necessitates an initial appointment which sets off a string of activities which requires a first assessment and lots of tests either aetiological or instrumental.

4. The management of a particular case could be medical or rehabilitative. If it is rehabilitative management, this could take quite a long time. There would also be several follow up appointments so the care pathways may be longer than in other specialties.

5. A lot of audiology cases are chronic in both audiology and balance and for both adults and paediatric hence there are a large number of follow-ups. An audiology department has to deal with, not only new patients but also, a huge amount of follow-ups. Hearing aid patients remain under the care of Hearing Aid Department for the rest of their lives as there is nowhere else for them to go.

6. There is also the situation that audiology cases may need to tap into other departments such as ENT and Medical Physics and feedback is required from audiology from these other departments. This has an impact on waiting lists and times.

7. It is also understood that according to new arrangements audiology departments may be split between the central site and community work. This would mean that audiology staff may have to travel between the various sites and will therefore have less time to see patients. This could make the situation of waiting times worse.

8. If everything is put together within one audiology department it would make training, teaching, research, etc easier. The audiology service has been modernised which has meant that demand is higher. There are larger numbers of existing patients coming forward and a small increase in the number of new patients. The volume of patients sent to audiology is much higher than, say, ultrasound, echo-cardiography, endoscopy, etc.

9. There seems to be a lack of detailed information at a local level to enable intelligent service delivery and commissioning. One way of addressing these issues is by audiology coming into tariff and being unbundled from ENT so that departments get paid for the services they provide.

Whether the NHS has the capacity to treat the numbers of patients waiting?

10. In some areas—no. What is meant by “treat” and to what standards? Whether they are following the guidelines, protocol and complete care pathways or just a click and fit service. The NHS would have the capacity only if the service structure is changed and more staff employed with an appropriate level of skill and competencies.

Whether enough new audiologists are being trained?

11. There are nine universities in the UK currently undertaking the BSc course in Audiology, seven of these are in England. The University of Manchester has been running the course for five years. Each university has 20 to 30 students per year but there is a large dropout rate. Around 190 students will complete the course and about 60% are getting jobs.

12. There is also a financial aspect in that there is a lack of money to enable Trusts to employ staff. A lot of Trusts have job freezes and posts have been lost. There is a lack of money for career development. There are not enough medically trained staff with appropriate levels of skills and competencies and a lack of training positions for junior medical staff.

13. There is only one postgraduate course in audiovestibular medicine in the UK, the MSc at the Institute of Child Health, UCL. There is no training in audiovestibular medicine at the medical undergraduate or postgraduate levels.

How great a role the private sector should play in providing audiology services?

14. This needs to be discussed with the local services. Sometimes Trusts do not want an audiology department within their acute sector hospital so the audiology services go to an outside provider with an unknown specification. There is a role for audiology in the independent sector which should be regulated and quality assured. In terms of the independent sector within the NHS market this is up to the local health department to say how that partnership should work.

15. In Australia there is a system where all information is on a central database. It is difficult to beat in terms of quality assurance and knowing exactly what everybody in the service is doing.

16. There needs to be unified governance for how audiology is directed at the moment. There are different needs in the different audiology services that are provided.

Pauline Beesley

Chairman, UK Federation of Professionals in Hearing and Balance

5 February 2007

Annex

THE FOLLOWING ORGANISATIONS HAVE A SEAT ON THE UKFPHB COMMITTEE

BAA—British Academy of Audiology www.baaudiology.org

BAAP—British Association of Audiological Physicians www.baap.org.uk

BACDA—British Association of Community Doctors in Audiology www.bacda.org.uk

BAEA—British Association of Educational Audiologists www.educational-audiologists.org.uk

BAO-HNS—British Association of Otolaryngologists—Head & Neck Surgeons www.entuk.org

BATOD—British Association of Teachers of the Deaf www.batod.org.uk

BSHAA—British Society of Hearing Aid Audiologists www.bshaa.com

RCSLT—Royal College of Speech and Language Therapists www.rcslt.org.uk

BSA—British Society of Audiology

IN ADDITION TO THE ABOVE, FOUR OBSERVER ORGANISATIONS SIT ON THE COMMITTEE

DOH—Department of Health

NDCS—National Deaf Children's Society www.ndcs.org.uk

PASA—NHS Purchasing and Supply Agency www.pasa.nhs.uk

RNID—Royal National Institute for Deaf People www.rnid.org.uk

Evidence submitted by the Wirral Health Forum (AUDIO 44)

1. The Wirral Health Forum (PPI) have been very concerned about the excessively long waiting times those patients requiring hearing aids (either as a new user or those needing a replacement of their older analogy aid with a new superior digital aid) have to suffer—up to two years—and the following evidence is based on our findings over the past 12 months.

2. The Forum believes that the current NHS waiting lists do not represent true numbers, because some people are “put off” seeking a new style aid because of the long waiting lists and because some patients have chosen to spend their own money on buying a privately provided (inferior) aid.

3. Audiology services should, in future, be included in the Health Service Targets as their current exclusion from these statistics is a major reason why these services waiting lists are excessive compared to other medical services.

4. Currently the NHS does have the capacity to meet the patients needs because of a large and temporary increase in the number of patients (ie those seeking to have their analogy aid replaced with a superior digital one) and because staffing levels are inadequate as there is a national shortage of qualified audiologists and under funding.

5. Not enough new audiologists are being trained and it takes too long (up to four years) to fully train individuals. The Forum would suggest that the Committee request that the training bodies be asked to consider reducing the length of training and seek to introduce a new level of operative—at a technician level—who could undertake the more routine procedures.

6. As the NHS cannot meet current needs. As much of this is temporary (ie caused because patients are requiring a “one off” replacement digital aid) it would seem sensible to engage private sector assistance as a temporary measure.

7. Additional funding could be used to reduce the burden of administrative duties on audiologists (ie to employ clerical staff in order to release the time of qualified personnel), to improve communications between doctors and service providers, up-grade telephone services, open centres in evenings and at weekends (by paying overtime), replace staff reporting sick though pressure of work and to ensure that any cancelled appointments are always recycled.

Robin Eley Jones

Chairman—Wirral Health Forum (PPI)

March 2007

Evidence submitted by Kath Woolley, Bury Primary Care Trust (AUDIO 7)

My points are as follows:

Whether accurate data on waiting times for audiology services are available?

1. With the Modernising Hearing Aid Services (MHAS) programme and the provision of hardware and software, the data collection for activity has never been more comprehensive.

Why audiology services appear to lag behind other specialties in respect of waiting times and access and how this can be addressed?

2. The Diagnostic Waiting Times and Activity template, introduced in January 2006, for collection of pure tone audiometry was non-sensical with unhelpful guidance notes. This led to inaccuracies in figures between Trusts with variations in interpretation. However, the template has now been updated successfully and it is now comprehensible, sensible and meaningful.

3. It would be helpful if Siemans could produce software that would enable the effective collation of the required bracketed waiting times ie 1–2 weeks, 2–3 weeks etc as this is not easily calculated by hand and is time consuming. The system currently counts patients waiting 0–13 weeks/13–26 weeks and 26 plus weeks.

4. The waiting times in Bury at the end of December 2006 were less than 11 weeks for all diagnostic tests and hearing aid work.

Whether enough new audiologists are being trained?

5. The NHS is supporting the students undertaking the four year BSc(Hons) in Audiology. We continually have two students on six-month placement and this week have had an additional student on a two-week placement. These commitments, in a small department, affect our output as the students, observe, practice under supervision and are assessed for their competencies. This investment towards the future workforce should be recognised.

Kath Woolley

Service Director, Audiology, Bury PCT

22 January 2007

Evidence submitted jointly by The Hearing Company, Specsavers, Hidden Hearing, Ultravox and David Omerod (AUDIO 47)

We write following the HSC hearing on 8 March and with particular reference to the written evidence submitted by the Hearing Aid Council (HAC). Together, our companies employ and train almost 100% of the new entrants to the profession and feel compelled to correct some of the misconceptions that could arise from the HAC submission.

EDUCATION AND TRAINING

In its submission HAC describe the training provided to new entrants as “work based”. Clearly, the submission must be brief but such brevity is grossly misleading. The comment implies on the job training is the extent of the training provided, this could not be further from the truth. An initial period of intense classroom training, approaching six months, prepares the trainee for a written examination of which the syllabus, question preparation and marking procedures are the total responsibility of HAC. This is followed by a practical examination also wholly in control of HAC and now in conjunction with Anglia Ruskin University. Success is not a foregone conclusion with a success rate in recent years of around 60%. Not until a trainee has been successful in both parts of the exam may he/she attend a client without the direct supervision of a Registered Dispenser. Exam success is followed by a further minimum of six month period of pre-registration under the direct and indirect supervision of a qualified Dispenser; duly evidenced by a ‘log book’ the criteria for which is stipulated by HAC. Only after this second period may the trainee apply for the status of Registered Hearing Aid Dispenser.

REGULATION

In the context of “regulation”, the HAC submission used the phrase “not fit for purpose” and it could be concluded that it was their opinion that the regulation of private sector Dispensers was inadequate and ineffective. We believe such a conclusion would be incorrect.

Subsequent to admission to the HAC register, Dispensers must follow the HAC programme for Continuous Professional Development and adhere to the comprehensive HAC Code of Trade Practice.

There is ample evidence that the HAC Code and their associated investigating and disciplinary procedures are applied robustly.

Inevitably, regulation has moved on since the 1968 Act and the proposed new framework will undoubtedly better fit the 21st Century’s perception of regulation; however, we trust the Committee will conclude from the above that the private sector is currently subject to appropriate regulation.

PUBLIC PRIVATE PARTNERSHIP

It would be easy to conclude from the HAC comments that the recent PPP in Audiology was evidence of inadequate regulation. What was, in fact, being pointed out was that current HAC jurisdiction covers only retail transactions and does not extend to NHS audiology. Consequently within PPP there was the potential for a regulatory gap; the HAC’s point regarding the limits of their jurisdiction is valid. However, under PPP each PCT established a precise professional service specification together with a formal process to ensure full patient protection. Hence, in practice, there was no void in regulation or “consumer” protection. Further, Patients, PCTs and RNID expressed satisfaction with the standards delivered by the private sector and certainly no suggestion of consumer risk or harm.

We trust that this additional clarification is helpful, should we be able to be of any further assistance we shall be pleased to hear from you.

Mark Georgevic, The Hearing Company

Peter Ince, Specsavers

Graham Lane, Hidden Hearing

Jeff Murphy, Ultravox

Peter Ormerod, David Ormerod Hearing Centres

30 April 2007

Supplementary letter from the Department of Health (AUDIO 1A)

AUDIOLOGY SERVICES IN ENGLAND

During my appearance at the Committee's oral evidence session on 8 March, I undertook to write to you on a number of points.

DEVELOPMENT SITES AND OPEN-FIT HEARING AID TECHNOLOGY

We discussed changing the way services are provided in order to address the waiting times issue. The Department is working with eight development sites to identify the efficiencies to be gained through improved waiting list management, better skill mix, streamlined referrals and new technology. Open-fit technology, which enables assessment and fitting to take place during the same appointment, is also being trialled at a further four sites. A list of all the NHS sites currently trialling the open-fit hearing aid technology is at Annex A.

PUBLIC PRIVATE PARTNERSHIP (PPP)

The Committee raised two queries in relation to the PPP. Firstly, whether either the Department or the NHS Purchasing and Supply Agency (PASA) encouraged the NHS to work with private providers outside the PPP contract. The PPP was specifically developed as part of the MHAS programme to provide the NHS with a framework with which to work with the private sector. The PPP was open to all NHS trusts who had modernised and were routinely fitting digital hearing aids. Those trusts were free to decide locally whether to use the PPP.

As part of the modernisation programme, RNID provided support to encourage the use of the PPP in areas where waiting times were relatively high. Given the availability of the PPP across the NHS and the focus that had gone in to negotiating an effective contract, there was no reason for either the Department or PASA to encourage the NHS to work with the private sector outside the contract. However, in the same way that the NHS locally was free to make use of the PPP, it was equally free to engage with private providers outside the contract, and we recognise that this did occur with some services.

Secondly, the Committee raised a point in relation to evidence given by Charing Cross Hospital Audiology Service relating to concerns that services provided through the PPP did not present value for money. The PPP included a number of contract terms to ensure that contractors provided services of appropriate quality to NHS patients. As part of this process, it was the responsibility of the local trust and the private provider to discuss and agree the specifics of what would be provided, and for the head of audiology within each trust to manage the contract at a local level. Any issues that were unable to be resolved locally, could be escalated to PASA.

Quality Assurance was a key part of the national framework agreement and both companies involved in the PPP demonstrated their commitment to meeting the contract standards. They invested resources in equipment, IT and staff training. The intention of the PPP was to enable capacity to be provided outside acute hospital settings, and local discussions between trusts and providers would have agreed where these services would be provided.

I would of course be happy to share with the Committee the comprehensive package of the PPP contract's full terms and conditions if this would be of interest.

PATHWAY COSTS

As we indicated to the Committee, the cost of procuring a pathway through the independent sector is broadly comparable with the cost in the NHS.

The cost of the patient pathway as part of the PPP independent sector contract was between £150 and £185. These figures do not include the cost of the digital hearing aid which would increase the cost of the pathway by between £67 to £195 dependent on the specification of the aid.

Modelling using 2004–05 Reference Cost data on stages of treatment and 2005–06 PASA data on the cost of hearing aids suggest that in 2005–06 the cost of an assessment, fitting of two aids and follow up in the NHS was £334. If one aid was fitted it was £253.

I referred to the figure of £270 at the Health Select Committee, which is between these costs. It should be noted that this analysis draws heavily on the cost of hearing pathways that have been referred via ENT and that we do not collect data on the cost of pathways that are referred directly to audiology departments. The cost also does not reflect the efficiency that can be gained through implementing the innovative solutions set out in *Improving Access to Audiology Services in England*.

I hope this is helpful. I look forward to reading the Committee's findings and recommendations from this inquiry.

Ivan Lewis MP

Parliamentary Under Secretary of State for Care Services
Department of Health

30 April 2007

Annex A

OPEN-FIT HEARING AID TECHNOLOGY TRIAL SITES

Royal South Hants Hospital, Southampton.

Leeds Teaching Hospital, Leeds.

Selly Oak Hospital, Birmingham.

Princess of Wales Hospital, Bridgend, South Wales.

Royal Devon and Exeter Hospital, Exeter.

Leicester Royal Infirmary, Leicester.

Basildon Hospital, Essex.

University Hospital (Audiology Central Outpatients), North Staffordshire.

North Manchester General Hospital.

Withington Community Hospital.

Norfolk and Norwich University Hospital.

Royal Bolton Hospital, Bolton.
