NCHA
NATIONAL COMMUNITY HEARING ASSOCIATION

BSHAA
British Society of Hearing Aid Audiologists

2015-18 GUIDANCE

Clinical Commissioning Groups
Health and Wellbeing Boards
NHS Providers
Healthwatch

ADDITIONAL RESOURCES

ANNEX C:

5 Step Plan for Commissioners

NHS AUDIOLOGY - ADULT HEARING SERVICES

August 2015

ANNEX C – FIVE STEP PLAN FOR COMMISSIONERS

We set out below five recommended steps commissioners can take to improve outcomes, avoid waste and meet demand.

1. Plan services on the best available evidence and epidemiological data, not historical activity – *this will help meet growth in demand and stay within budget*

- Act now to meet the significant unmet need and avoid system failure in the next commissioning cycle

- Avoid using past activity as a predictor of future need for hearing care

Already 3.8 million people in England have unmet hearing needs[1]. CCGs are tasked with meeting this unmet need, meeting new demand from the ageing population, improving quality of services and remaining within budget.

Using past activity to commission hearing services is likely to underestimate the demand for adult hearing care and result in avoidable pressures on budgets and services. Instead CCGs should **work with public health experts and Health and Wellbeing Boards to estimate the level of local need**[i]. **This will result in cost-effective, responsive and high quality services being commissioned.**

In order to meet increased demand in a sustainable way, all commissioners should be aware of the following:

- evidence shows that referral criteria for hospital and community-based audiology for adult hearing loss are the same[2]. This means that the vast majority of people with adult hearing loss do not have to attend a hospital for their care and can be seen in a variety of settings, reducing the cost per case

- medical hearing loss is referred to ENT and audiological support for ENT will be reimbursed via the ENT tariff[3] - i.e. delivering adult hearing services out-of-hospital will not destabilise the hospital

- NHS England and the Department of Health's 2015 Action Plan on Hearing Loss confirms that hearing services for adults "*can be provided in a primary care setting*"[4].

This knowledge (transparency) should enable CCGs to better plan capacity and develop sustainable local hearing solutions. For example utilising capacity in primary, community and secondary care settings can improve access to NHS hearing services, improve quality, value for money and responsiveness. Evidence of this comes from Monitor's 2014/2015 review of NHS adult hearing services:

- "*The evidence we have reviewed suggests that most people accessing the service do need it and benefit from it. For example, most respondents surveyed said they were finding their hearing aids beneficial in terms of improving their lifestyle (92%)*"[5]

- "*…. the increase in patient numbers in areas where choice had been introduced is likely to reflect the presence of unmet demand and therefore should be considered in the context of commissioners meeting their objectives.*"[6]

[i] *See Annex B for estimated prevalence data.*

- *"….the introduction of choice has strengthened the opportunity for [NHS commissioners] to achieve better value for money. In areas with choice, commissioners have often put in place more robust or higher service specifications that raise expectations of providers."*[7]

- *"We estimate that the locally determined prices adopted by commissioners have been about 20% to 25% lower than the national non-mandated tariff. This can allow commissioners to treat more patients for the same spend and/or release additional funds that commissioners can spend on meeting other patients' needs"*[8]

Many CCGs have the potential to meet the hearing needs of the population within available resources by planning local services in an evidence-based way. The changes required are aligned with the growing consensus amongst health care experts - e.g. NHS England[9], Monitor[10] and WHO[11] – that states that reducing reliance on a hospital-based model of care is key to a sustainable health economy.

2. Procure at least three years of accountable care, not activity or opaque block contracts – *this will give commissioners the opportunity to improve outcomes for patients and achieve better value for money*

- Age-related hearing loss requires regular follow-up and aftercare for life

- Most of this care is straightforward and includes simple repairs, replacing batteries and re-tuning hearing aids

Value for Money

Commissioners should not pay more than the sector average for a simple aftercare/repair[ii]. Equally CCGs must ensure providers deliver comprehensive follow-up[iii]. This means demanding better outcomes for patients and value for taxpayers within available fees – i.e. doing more with less[iv].

Commissioning at least a three-year package of care will allow CCGs to share risk with providers and benefit from efficiency gains when it is done well[12]. For example Best Practice Guidance (BPG) sets out a package of care and prices that include aftercare and repairs for three years – buying the same package of care using the non-mandated tariff could cost 20-25% more per patient[13].

A guide to understanding prices and advice from Monitor are included in the checklist in Annex D to help commissioners obtain the best value for money in their local area.

[ii] **Initial follow-up should not be confused with ongoing aftercare.** The first follow-up appointment is to ensure patients are satisfied with their hearing aids. After this patients will need regular aftercare - including visiting a provider for hearing aid repairs. Aftercare (repair) is the main reason people with age-related hearing loss visit NHS audiology. For example in 2012/13 1.1 million repairs were reported by NHS hospitals. Shifting this activity out-of-hospital would therefore remove thousands of patient contacts from each hospital per year.

[iii] Research has shown 68% of NHS patients that are offered a follow-up appointment report being very satisfied with their hearing aids compared to 46% that are not offered a follow-up appointment. See footnote 107 here

[iv] The economic regulator in England has reported the NHS can procure hearing care for up to 25% less per patient whilst also improving accountability and transparency, see pages 31-34 of the report - available here

Improving Outcomes

For decades there have been gaps in follow-up care for people fitted with hearing aids and this contributes to people not using hearing aids[14]. Excuses for not delivering ongoing care should no longer be tolerated. Failing to deliver continued care for this long-term condition fails to offset the negative consequences of unsupported hearing loss and wastes scarce NHS resources. CCGs can use this information to ensure providers deliver quality outcomes for patients and therefore avoid NHS England intervening locally[15].

In order to guarantee that follow-up care is delivered and NHS resources are not wasted, CCGs should commission at least a three-year package of inclusive care and hold providers to account for delivering ongoing support – i.e. if a provider fails to deliver ongoing support they should be appropriately penalised (e.g. withholding CQUIN payments and funding another provider to offer follow-up) and, if they fail to respond to warnings, the service should be decommissioned and re-commissioned from other providers. For example Monitor has noted that

- in areas with choice *"[p]roviders are required to report their service outcomes to commissioners, who can levy penalties for underperformance. Commissioners can use the service outcome data to drive further improvements in services"* making *"services more transparent"* and in contrast
- *"in areas without choice, adult hearing services are often provided as part of a block contract without service outcome reporting requirements, so it can be difficult for commissioners to tell how good services are, or even how many people are being treated and at what cost."*[16]

Where there is a choice of provider, Monitor notes that it is important to ensure patients have access to reliable information so that they can make an informed choice, and that they are offered a choice because research shows that patients value this[17].

3. Set access and outcomes standards and hold providers to account if they fail to deliver – *this will help meet the duty to commission services with a view to continuous quality improvement*

- It is important that providers deliver on contractual obligations and do not default on their responsibilities to patients, taxpayers and CCGs

- To avoid intervention from NHS England's Local Area Teams CCGs need to utilise data submitted by providers as part of contractual agreements[18]

- Waiting lists in isolation are not good proxies for quality in hearing care as there is a strong incentive to artificially hold down waiting times for initial assessments at the price of restricting follow-up care

During 2012-2015 not all CCGs utilised datasets submitted to them by providers[19]. This means in the upcoming commissioning cycle some CCGs run the risk of driving out high quality providers.

Commissioners should commission services from the highest quality providers on the best value terms. If capacity is to be decommissioned it should be from those providers which have delivered the least cost-effective service – e.g. those failing to deliver quality at the agreed (fixed) tariff price.

We recommend that commissioners refer to BPG – available here – for KPIs and quality standards approved by hearing care experts and implemented in many parts of England already. This will allow CCGs to benchmark services and meet their duties[20]. It will also ensure CCGs are ready for the updated NHS Constitution that is likely to give all patients the legal *"right to transparent, accessible and comparable data on the quality of local healthcare providers, as compared to others nationally"*[21].

4. Do more out-of-hospital and ensure there is a level playing field so that outdated models of care are not protected to the detriment of patients and the taxpayer – *this will help CCGs meet the goals set out in the Five Year Forward View*

- Commissioners should engage with their local population about where they would like to access hearing care
- 70% of people with hearing loss want and benefit from having a choice[22]. To facilitate choice commissioners can follow the *Five Year Forward View* and commission more care out-of-hospital
- This will also deliver the cross party vision for the adult hearing service to be delivered closer to home[23]

It is especially important to avoid mistakes made in the current commissioning cycle when significant NHS resource was wasted e.g. by operating block and activity-based contracts simultaneously, which resulted in total costs increasing at a faster rate than necessary without the equivalent health benefits for the local population.

Monitor advises on how to ensure there is a level playing field and instructs commissioners to ensure all providers deliver services to the same prices and standards:

- *"Align service specifications and prices for all providers of adult hearing services in a given area. Where commissioners have inherited contracts that include adult hearing services, decisions need to be made on how those contracts will be migrated to the new service specifications and prices, and over what timeframe. These arrangements should be made clear to existing providers ahead of the qualification stage. They should set out proposed treatment of VAT from the outset so that providers can take it into account when building their business cases"*[24]

Most visits to audiology over a patient's lifetime will be for new batteries, hearing aid repairs and simple follow-ups – e.g. over 1.1 million hearing aid repairs are reported by hospitals each year. With the average age of a hearing aid user being 70 and over, and hospital capacity limited, it is time for CCGs to review how their local health economy is configured and to consider delivering more adult hearing care closer to home. This will also increase capacity in the acute sector to manage medical causes of hearing loss and other conditions that require consultant led clinics.

5. Ensure that GPs are aware of the full range of services and offer choices to patients and ensure that people have access to care at home if they need it - *this will help meet recommendations in NICE guidance and reduce health inequalities*

- Tackle health inequalities by commissioning home care
- Inform all GPs that this service is available to avoid the risks associated with unnecessary patient transfers

NICE has recognised the importance of hearing care for people living in residential care[25]. Experts have also noted that people with unmanaged hearing loss and dementia are more likely to go straight to expensive care packages compared to those whose hearing loss is supported[26].

NHS England and the Department of Health on 23 March 2015 stated:

*"[t]he **Government's ambition is to support older people to stay independent and in their own homes** for longer avoiding unnecessary admission to hospital or entry into care. **Hearing is a major factor in maintaining independence and achieving healthy ageing**. There is **a significant socioeconomic gradient associated with hearing loss bringing greater inequality and an impact that can go unrecognised**. **Hearing loss is a major reason for poorer and less frequent social interaction, is often a contributor to depression and is independently associated with dementia. People with unmanaged hearing loss** and either dementia or mental health problems **are more likely to go straight to a higher cost intervention, such as a care home, than would be the case if their hearing loss were effectively managed. Research in care homes suggests high levels of undiagnosed hearing loss, and under-optimisation of hearing aid benefits for users** …. **older people living in care homes** in England [with a hearing loss] **will need support to maximise their independence and wellbeing.**" (emphasis added)[27]*

On 5 March 2015 Monitor in its review of NHS adult hearing services noted: *"some new providers are targeting patient groups who have found it difficult to access services in the past for mobility or other reasons (eg housebound patients, residents in care homes). In our view, this can improve access for these groups."*[28]

CCGs now need to ensure that the needs of the growing population living in residential care are met. Domiciliary care for hearing loss is easy to commission and already provided in many, but not all, CCGs in England. Therefore commissioning care at home for these patients should be a priority and be seen as part of statutory obligations to tackle health inequalities.

END

For full reference list and additional notes click here

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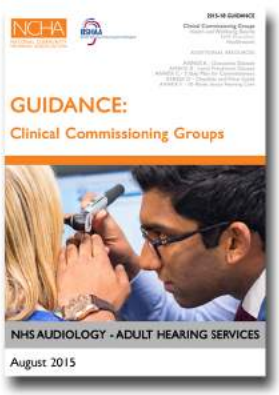

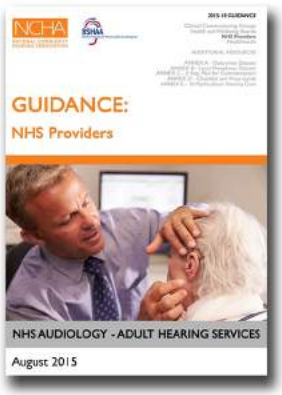

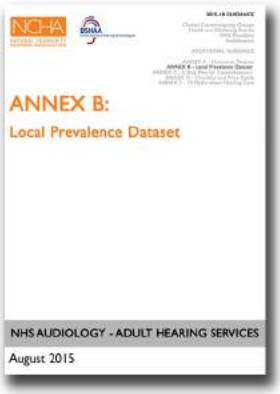

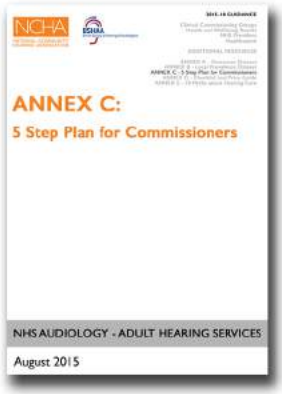

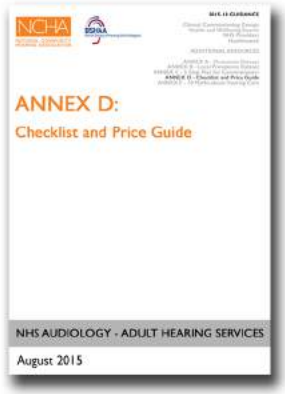

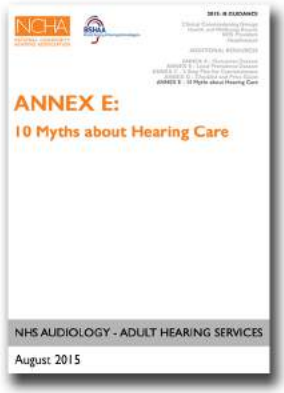

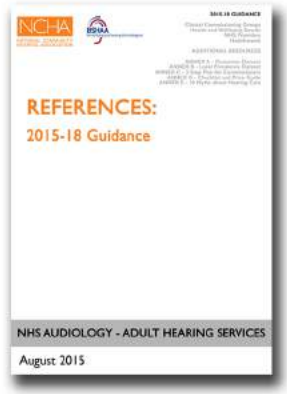

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