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 A - Outcomes Dataset
ANNEX B - Local Prevalence Dataset
ANNEX C - 5 Step Plan for Commissioners
ANNEX D - Checklist and Price Guide
ANNEX E - 10 Myths about Hearing Care

GUIDANCE:

Clinical Commissioning Groups

NHS AUDIOLOGY - ADULT HEARING SERVICES

August 2015

PURPOSE

This guidance updates our first guidance issued in June 2014. It has been designed to provide a bridge for commissioners and providers between that guidance and NHS England's commissioning framework for hearing services which is currently under development.

As such it also supports the delivery of NHS England's *Five Year Forward View, The Forward View into Action – planning for 2015/16* and will also help commissioners and providers meet the goals set in the *Action Plan on Hearing Loss.*

USING THIS GUIDANCE

At a local level this guidance will enable progress to be made on outcomes and better use of resources for patients, populations and the NHS. Specifically it will support commissioners and providers to

- reduce costs and waste
- deliver out-of-hospital care at scale
- continuously improve quality in hearing services
- focus on prevention and maintaining independence in older age
- support people with adult hearing loss – a long-term condition
- meet needs within available resources.

OTHER USEFUL RESOURCES

This guidance can be read in conjunction with Monitor's *NHS adult hearing services in England: exploring how choice is working for patients',* NHS England and the Department of Health's *'Action Plan on Hearing Loss'* and the British Academy of Audiology '*Services: A Guide for Health Commissioners and Health Boards'*.

You can access all the guidance in this series at http://www.the-ncha.com/guidance-2015-18/

CONTENTS

WHY PRIORITISE HEARING?.....2
HEARING NEED 4
ACTION.....6
SUPPORT & TOOLS.....9

WHY PRIORITISE HEARING?

- **NHS England and the Department of Health** published a joint Action Plan on Hearing Loss in March 2015. The Plan highlights the public health risks of hearing loss and the need for action by commissioners on this previously under-prioritised service[1]
- **The World Health Organisation** has identified hearing care for older people as a priority[2]
- **NHS England and Age UK** recently issued joint guidance advising that hearing care can support people age well[3] by reducing the risk of functional decline[4]
- **NICE guidelines** state the importance of hearing tests for people living in care homes [5]
- **Monitor** has confirmed that it is possible for the adult hearing service to *"treat more patients for the same spend"*[6] – e.g. extending choice of provider could help CCGs lower prices by more than 20-25% per patient

EFFECTS OF ADULT HEARING LOSS & BENEFITS OF INTERVENTION

Communication is an essential element of good quality of life at all ages, and it becomes fundamental to maintaining independence and inclusion as people age[7]. **Unsupported age-related hearing loss** significantly increases the risk of **depression[8], social isolation[9], loneliness[10], cognitive decline[11], early retirement[12] and reduced quality of life[13].** NHS England and the Department of Health have highlighted the association between hearing loss and increased risk of **dementia**[14]

Unsupported Hearing Loss

- depression
- social isolation
- loneliness
- cognitive decline
- reduced quality of life

Hearing intervention and **ongoing support improves quality of life** by reducing the psychological and social effects associated with age-related hearing loss[15]. Early intervention can also reduce pressure on health and social services[16].

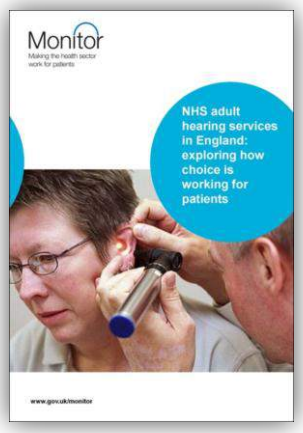
Early Intervention and Ongoing Support

- improves quality of life
- reduces pressure on health and social services

IMPROVING STANDARDS WHILST SAVING MONEY

With the ageing population, improved technologies and greater awareness of the benefits of hearing technology, it is indisputable that the NHS will continue to experience growth in demand for hearing care.

Unfortunately, poor information and lack of commissioning support underpin most of the challenges with hearing services in local health economies. This hampers commissioners and providers from delivering the *Five Year Forward View* and helping populations to age well. For example, many CCGs are not specific about standards and outcomes in block contracts and still fail to commission follow-up support because they are unaware that this is essential to enabling people to benefit from hearing technology[17].



The good news is that CCGs have an opportunity to reform local services and improve resource management. Commissioners and providers that have implemented the Department of Health's Best Practice Guidance (BPG)[18] have shown that it is possible to reduce marginal costs by 20-25%[i] whilst improving standards and access– proving that the NHS can do more for less[19].

Using this guidance, the Department of Health's BPG and Monitor's report on choice in hearing care, CCGs can now work with their providers in both hospitals and the community to commission comprehensive packages of care that are at least as cost-effective as current BPG[ii].

This proactive approach will help CCGs

- meet the hearing needs of their ageing populations in a sustainable way[20] and
- achieve the goal set by NHS England to *"'bend the curve' on predictive trends"*[21] by mitigating the risks associated with unsupported hearing loss.

***Note**: Commissioners can contact the NCHA at any time for support (including access to primary sources of information) – enquiries@the-nhca.com.*

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[i] Commissioners that have implemented the Department of Health's BPG have been able to procure higher standards in a more transparent and accountable way at prices 20 to 25% lower than the non-mandated tariff. This has resulted in significant savings over three years of care per patient. These savings are even greater in areas where CCGs are not paying MFF. See page 34 of Monitor's 'NHS adult hearing services in England: exploring how choice is working for patients". Commissioners can also contact enquiries@the-ncha.com for support with how to analyse potential savings.

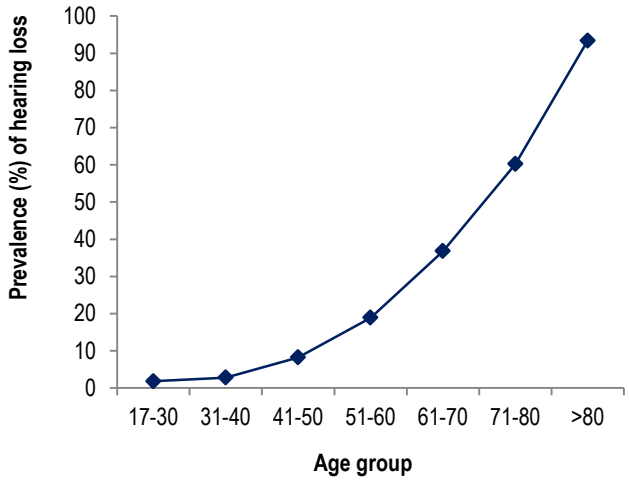
ii Not wanting to introduce choice does not have to be a barrier to getting a better deal for patients and taxpayers. CCGs can for example demand the Department of Health's specification and prices without extending choice. As of 14 August 2015 this is still the most up to date BPG in England. However, if providers refuse and CCGs know they can do more for less by introducing choice, they should do so in line with their duties.

HEARING NEED

In 2010 there were just over 10 million people aged 65 and over, by 2018 there will be approximately 13 million and by 2035 this figure could reach 17 million[22]. The fact that people are living longer is good news but brings new challenges in adding life to years, maintaining independence, and slowing functional and cognitive decline.

AGE-RELATED HEARING LOSS IS THE SINGLE BIGGEST CAUSE OF HEARING LOSS

- Hearing loss is already a major public health challenge and the 6th leading cause of years lived with disability in England[23]
- Age-related hearing loss is the main cause of hearing loss
- As the population lives longer and becomes older the number of people with hearing loss will increase exponentially[24] (Graph 1) as will the need for interventions and ongoing support.



Graph 1: Prevalence of hearing impairment in England in each age group[25]

Department of Health

NHS England

"Action Plan on Hearing Loss"
Department of Health, NHS England 2015

"Hearing loss prevalence increases exponentially with age. Age-related hearing loss (or presbycusis) is the single biggest cause of hearing loss and older adults with age-related hearing loss are the largest patient population in need of hearing healthcare"

AGE-RELATED HEARING LOSS IS A LONG-TERM CONDITION FOR WHICH THERE IS CURRENTLY NO MEDICAL INTERVENTION[26]

- The vast majority of people with adult hearing loss do not need to visit an Ear, Nose and Throat (ENT) department or to go to hospital[27]
- They should see a non-medically qualified audiologist as the first line intervention[iii].
- Audiologists can then safely refer on the small minority who need secondary care[28] using agreed referral criteria[29].

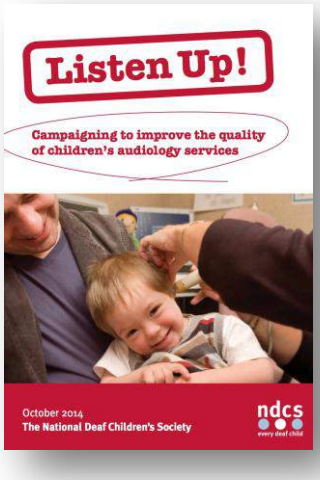
AGE-RELATED HEARING LOSS REQUIRES ONGOING SUPPORT FOR LIFE[iv]

- This places significant pressure on hospital departments – where the vast majority of non-medical hearing care is still provided[30]
- Current growth in demand is unsustainable for a purely hospital-based model of care – e.g. in the last 10 years activity reported by audiology services has increased by 142%[31], this despite there still being an estimated 3.8 million people with unmet hearing needs in England[32].

TAKING A SYSTEMS APPROACH TO MEETING HEARING NEEDS

Some CCGs and providers are struggling to meet current demand let alone historically unmet need. Hospitals in many locations are already under pressure[33] and pushing ever more patients through block contracts is not the answer. If more patients are pushed through such contracts, without greater flexibility in funding or staffing, quality and outcomes will suffer.

For instance the National Deaf Children's Society in 2014 found that one third of NHS audiology services were failing deaf children – an issue which both commissioners and providers must address, together, as a matter of urgency[34].



[iii] *Note: other than for historic reasons, there is no reason a person with hearing loss has to see a GP. They can, as they do with opticians, see their audiologist without GP permission. However at the present time truly direct access to audiology is only available to private patients in England.*

[iv] *This is because age-related hearing loss is a progressive condition and hearing reduces further with time. This means people will need hearing aids adjusted to benefit from them. They will also require hearing aids to be regularly repaired/maintained.*

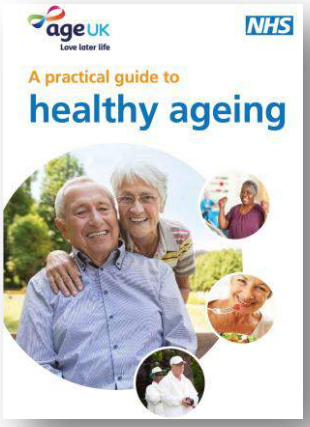
Quality being a function of capacity means that it is essential that each patient sees the right person at the right time and in the right place – i.e. QIPP principles. For example over 1.1 million NHS hearing aids repairs take place each year and delivering these close to home and out-of-hospital would deliver benefits for adults with hearing loss whilst also liberating scarce hospital capacity.

The only way to benefit from these and other opportunities is for commissioners to work with providers in an evidence-based way, focussing on outcomes rather than inputs and putting patients and taxpayers ahead of all other considerations. The shared focus should be on meeting the needs and expectations of service users and using all available capacity to achieve this.

Note: The estimated number of people in each CCG area with a hearing loss is available in Annex B - online. Online tools are being developed to support CCGs in better planning for the future. These tools will be available at www.the-ncha.com later in 2015. (To be alerted to the availability of these tools, please email enquiries@the-ncha.com).

ACTION

Many people do not realise they could benefit from hearing tests. NHS England and the Department of Health are now seeking to change this through their joint Action Plan on Hearing Loss[v]. This builds on work by NHS England and Age UK to promote NHS hearing tests as part of healthy ageing[35].



These initiatives start to deliver on the *Five Year Forward View* aim of taking preventative and public health more seriously[36]. Monitor, the sector regulator, has also recently supported the case to address unmet hearing need in England[37]. This means there is strong national support for improving NHS hearing care.

[v] *The Action Plan details a joined-up approach to tackling the "rising prevalence and personal, social and economic costs of uncorrected hearing loss* ***and the variation in quality of services experiences by people with hearing loss"****. It sets out five key objectives linked to NHS England's business plan, these are: prevention, early diagnosis, integrated patient centered management, ensuring those diagnosed do not need unscheduled care or become isolated and ability to partake in every-day activities including work.*

ADVICE 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**

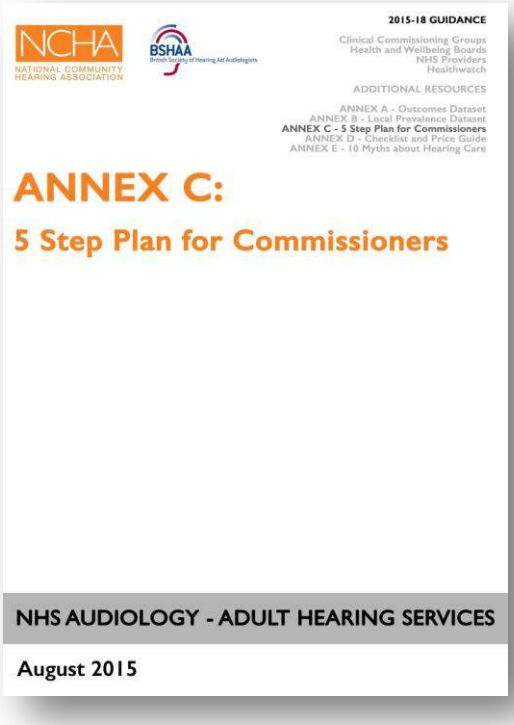
2. **Procure at least three years of accountable care, not activity or block contracts**

3. **Set access and outcomes standards and hold providers to account if they fail to deliver**

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**

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.**

These follow the standard commissioning cycle and are **explained in greater detail in** Annex C.



Note: additional support is available from the NCHA on demand – contact enquiries@the-ncha.com with any questions.

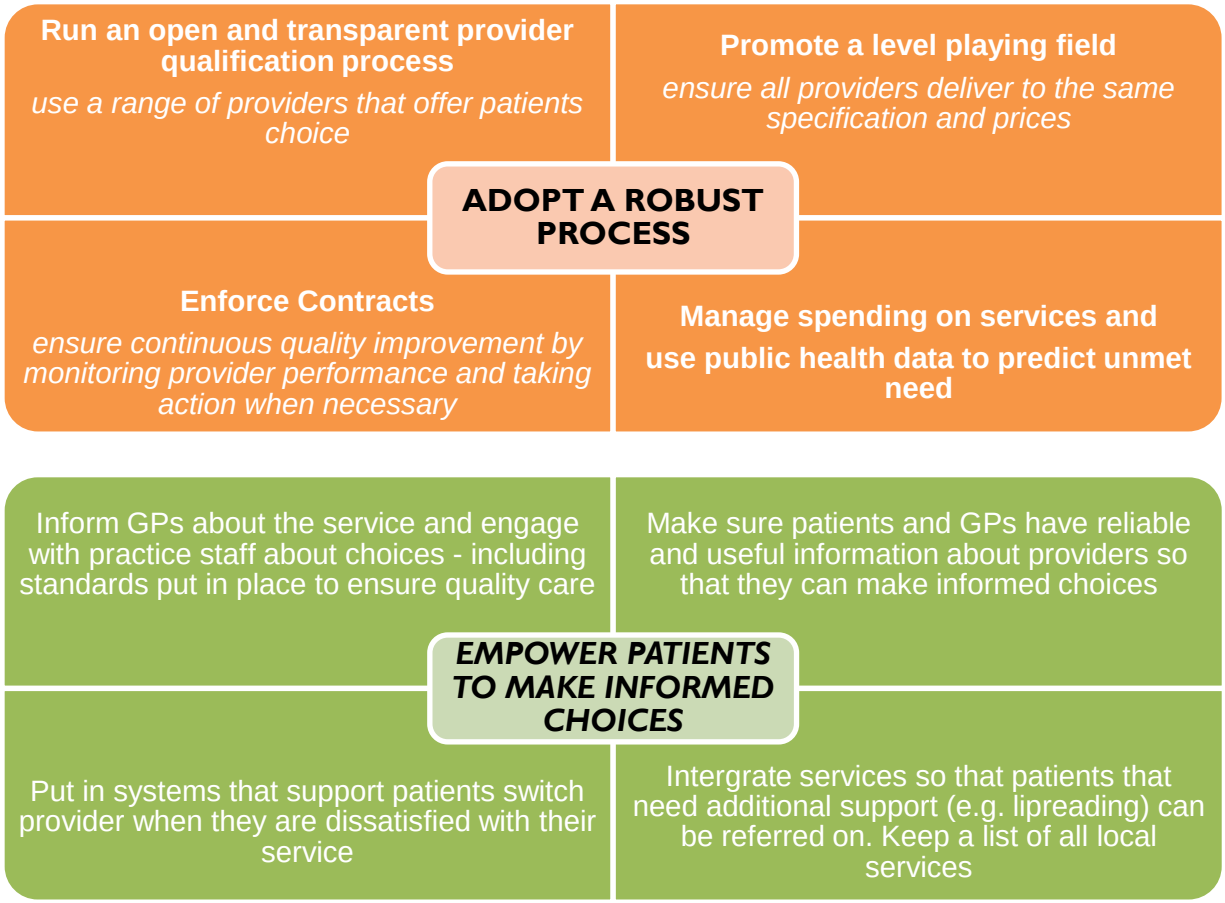
GETTING THE MOST FROM CHOICE

For areas which are considering or have already introduced choice to drive improvements either under AQP or other mechanisms, Monitor has published additional advice on "*ways to improve the effectiveness of choice in adult hearing services*"[38].

Monitor states that *"Choice in adult hearing services can provide a powerful tool for commissioners to meet the needs of their patients while securing value for money. Choice can lead to services becoming easier to access for patients. This may lead to more patients being treated, which in the long term has the potential to reduce pressures on health and social services that could result from unaddressed hearing loss. Choice can also lead to providers offering better value for money: the price of treatment per patient has gone down in many areas while providers have been asked to deliver to more robust or higher service specifications"*[39]. Monitor explains that to ensure CCGs gain the most from choice commissioners should:

1. ***Adopt a robust commissioning process***

2. ***Empower patients to make informed choices***



The recommendations from Monitor can be found in full here and in a checklist format in Annex D

ROLLING OVER

To save unnecessary work and effort Monitor has made clear that if providers are delivering high quality services, with clear standards and outcomes reporting, three year AQP contracts can be rolled over and do not need to be retendered when they reach their original expiry date. Monitor notes that this is an advantage of the AQP system in that, once up and running, successful local services can be continued without the costs and effort of retendering[40].

Monitor has also made clear that community providers are good at working out where capacity is needed and have reminded commissioners that additional providers can be accredited at any time by opening the AQP window. Monitor has also co-produced a webinar with NHS Clinical Commissioners to help CCGs learn about its 2014/15 research into NHS adult hearing services – it can be viewed here.

SUPPORT & TOOLS

We work with CCGs to support them with commissioning, data, contracts management and living within their resources. This support saves time and resources for CCGs, enabling them to focus on the main task of effective local commissioning.

You can contact the NCHA for support to

- engage with patients and providers
- understand local needs
- analyse local data
- focus on outcomes and patient feedback
- plan how to meet demand within likely available resources
- commission for outcomes and access at lower cost.

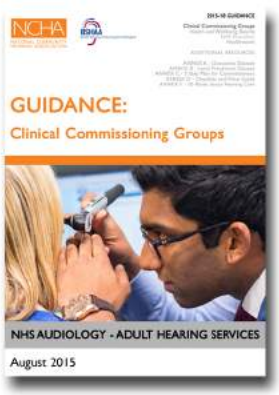
In addition the following tools are now available

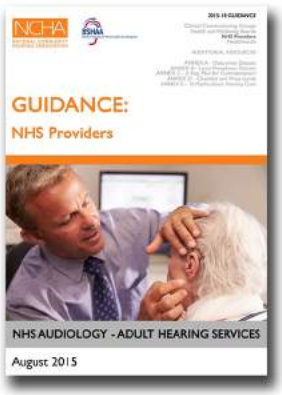
- baseline community outcomes for 2013/2014 – Annex A
- prevalence of hearing loss by CCG area – Annex B
- five step plan for commissioners (unpacked) - Annex C
- guidance on prices and Monitor advice for areas which are thinking about or already operate choice – Annex D
- ten common myths about hearing care which CCGs should not be taken in by - Annex E

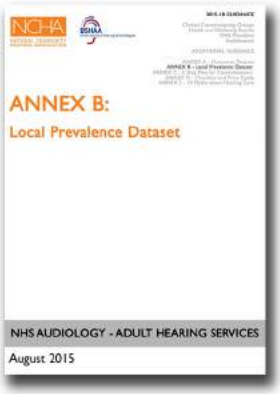
FURTHER SUPPORT AND INFORMATION

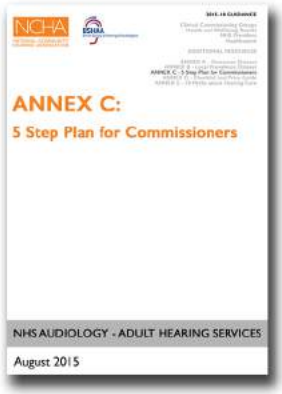
NHS commissioners should also contact enquiries@the-ncha.com directly for access to literature and support with other evidence and data sources. For full reference list and additional notes click here

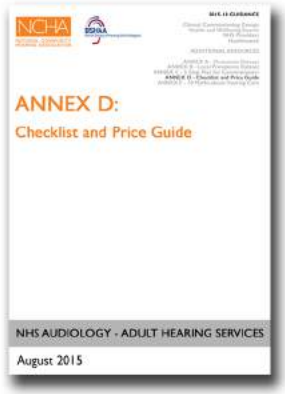
GUIDANCE IN THIS SERIES

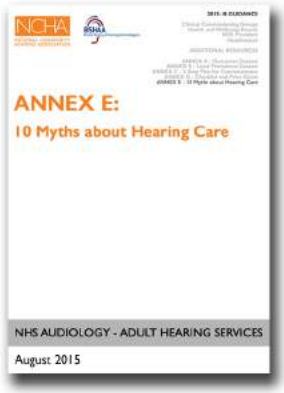


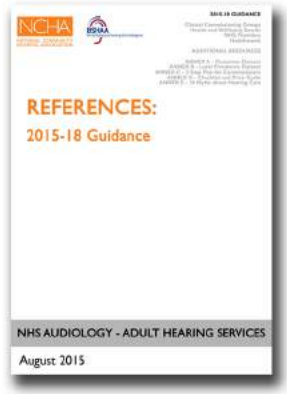












Digital copies of all the reports are available at www.the-ncha.com/guidance2015-18