NCHA
NATIONAL COMMUNITY HEARING ASSOCIATION

BSHAA
British Society of Hearing Aid Audiologists

ANNEX E:

10 Myths about Hearing Care

NHS AUDIOLOGY - ADULT HEARING SERVICES

August 2015

ANNEX E: TEN MYTHS ABOUT NHS HEARING CARE

MYTH 1: ADULT HEARING SERVICES AND ENT ARE THE SAME

Age-related hearing loss is a long-term condition and in almost all cases there is no medical or surgical treatment[1]. People that meet nationally agreed referral criteria – the vast majority of people with adult hearing loss – can access NHS hearing care from a non-medically qualified audiologist and do not have to see an Ear, Nose and Throat (ENT) doctor[2].

Most NHS hearing aid users are aged 70 and over[3]. In people aged 65 and over, conservative estimates suggest at least 89% of adults with a hearing loss will not need ENT review[4]. Moreover, referable conditions are readily detected with screening tools and referred on if required[5].

MYTH 2: AGE-RELATED HEARING LOSS IS NOT AN IMPORTANT LONG-TERM CONDITION AND MOST PEOPLE CAN COPE WITHOUT HEARING AIDS

According to the World Health Organisation adult-onset hearing loss is the fifth leading cause of disability adjusted life years in Europe[6]. In January 2015 NHS England recognised unsupported hearing loss as 1 of 11 risk factors associated with functional decline in older people[7] and recommended older people to have their hearing tested without delay[8]. Far too many commissioners and GPs underestimate the impact unsupported hearing loss has on quality of life – including its impact on physical and mental health. The *Five Year Forward View* explains why the NHS must take a different approach to this and other public health issues if it is to remain sustainable[9].

On 23 March 2015 NHS England and the Department of Health published their Action Plan on Hearing Loss in which they recognised hearing loss as a long-term condition and major public health issue, putting this myth firmly to rest[10].

MYTH 3: ALL PEOPLE WITH HEARING LOSS HAVE COMPLEX ON-GOING HEARING NEEDS

The chronic nature of age-related hearing loss means patients have to make many visits to hospitals for repairs and batteries over their lifetime**.** The vast majority of people with hearing loss therefore require responsive and accessible aftercare, not a medical review (see myth 9).

Early intervention can also reduce the need for rehabilitation and/or improve outcomes throughout life[11]. This means that by redesigning hearing services around patients' needs the NHS has the potential to reduce long-term costs by reducing the total number of complex cases in the population.

MYTH 4: COMMUNITY-BASED HEARING CARE, A KNEE-JERK REACTION IN 2012 DRIVEN BY IDEOLOGY

The goal to deliver adult hearing care out-of-hospital is longstanding[i] (at least 27 years) and spans governments of all major parties and patient groups.

Between 2007 and 2012, the Department of Health stated on many occasions its goal for people with hearing loss was for them to receive care closer to home[12]. For example in 2007 stating that the goal for NHS hearing care was to deliver

- "…high quality, efficient services delivered, closer to home, with low waits and high responsiveness to the needs of local communities, free at the point of access"[13]

This policy was still in place in 2010 when the NHS urged leaders in audiology to

- "… focus on how to deliver effective care outside an acute setting and in, or near to, patient's homes"[14]

In 2015 NHS England and the Department of Health again acknowledged this service *"can be provided in a primary care setting"*[15]

The Royal National Institute for the Deaf (RNID)[ii], the largest charity for people with hearing loss also called for care closer to home in 1988, 1999 and 2011 (Figure 1).

1996	"[The RNID m]akes the case for a service which: is geared to the consumer, not the specialist or the salesman; is **planned as part of primary health care**; is flexible enough to allow closer cooperation with the private sector; better protects those consumers who choose to buy their own aid privately; and is capable of serving our increasingly elderly population effectively well into the next century" (emphasis added)
1999	The current structure, where audiology services are **hospital-based [is inappropriate for a technical procedure]. It is also inappropriate for a service that requires continuing patient support** [...]. A locally-based service **would be more convenient [for the elderly to access follow-up** advice]. It is **estimated that a lack of back-up support under the current system is responsible for as many as 20 per cent of patients not using their hearing aid** after the first fitting" (emphasis added
2011	"**The hospital care model is not appropriate for an ageing population** – we are calling for a radical approach to redesign and de-medicalise hearing services to widen access and choice"(emphasis added)

Figure 1: Patient group calling for hearing services to be delivered closer to home and out of hospital (RNID 1988, 1999 and 2011[16])

i It should also be noted that people with the ability to pay can access hearing services in primary care without GP referral, and have been able to do this for decades. This presents an inequality in access that is currently unaddressed by policymakers/stakeholders. The hearing service in primary care settings is delivered by professionals that are regulated by the Health and Care Professions Council and therefore the barrier to accessing NHS hearing care in a primary care setting is purely based on cost control, even though a primary care service would have lower marginal costs for the NHS and thus allow it to see more patients for any given budget – this failure to design services around the needs of patients and base service design on the same principles of cost-effectiveness used to introduce technology into the NHS has, in part, contributed to significant unmet need being left unaddressed by the NHS, with clear knock on effects on the avoidable consequences of unsupported hearing loss.

ii The RNID was renamed Action on Hearing Loss in 2011

Also a 2011 national engagement exercise noted

- **"Patients and advocates** also **felt that the provision of so called 'Cinderella' services, such as hearing services**, wheelchairs and continence services **could be improved through extending choice of provider to these services"** (emphasis added)[17]

Amongst those supporting the extension of community-based hearing care was Age UK[18].

Finally, in 2014 the Department of Health announced

- "…our plan is to change the models of care to be more suited for an ageing population, where growing numbers of vulnerable older people need support to live better […] with long term conditions […]. To do this we need to focus on prevention as much as cure; helping people stay healthy…"[19]

This means the need to transform hearing services and do more out-of-hospital for age-related hearing loss will continue to have cross-party support as long as active ageing remains a priority for government.

MYTH 5: HEARING AIDS DON'T HELP

Unsupported age-related hearing loss (ARHL) has an impact on communication and consequently has been associated with an increased risk of depression[20], social isolation[21], cognitive decline[22], early retirement[23] and reduced quality of life[24]. Hearing aids remain the primary intervention for ARHL[25] and can offset the negative consequences of hearing loss and have been shown to improve quality of life[26]. However, due to the historically low uptake of hearing services in England, ARHL remains a public health challenge[27].

Another challenge is that many GPs and commissioners are unaware of the rate of innovation that has taken place in recent years and still remember challenges associated with obsolete technology – e.g. whistling. Today digital hearing aids offer greater benefits – including noise reduction and a choice of programmes for different listening conditions. In March 2015 Monitor, the sector regulator, confirmed that the vast majority of patients benefit from their hearing aids[28].

Early intervention and ongoing support are also key factors for good outcomes – i.e. if the NHS waits until somebody has a severe hearing loss before offering support, outcomes will be worse due to system design; not hearing aids.

MYTH 6: THE CURRENT SYSTEM CAN COPE WITH HEARING NEEDS

In the last 10 years activity reported by audiology services has increased by 142%[29]. This despite experts noting in 2013 there were an estimated 3.8 million people with unmet hearing needs in England[30]. This equates to some 18,000 excluded patients per CCG whose needs must be planned for above historical trend. Therefore CCGs should plan capacity based on hearing needs, not historical activity.

Moreover after waiting lists reached two years in 2007 pathways were redesigned to increase capacity. Workarounds contributed to restrictions in follow-up care and therefore it is very likely in some regions providers are at capacity and struggling to cope[31]. Based on the available evidence a purely hospital-based model of care is not sustainable.

MYTH 7: THERE IS NO PROFESSIONAL CONSENSUS ON CARE CLOSER TO HOME

In 1997, in a Department of Health sponsored study, heads of NHS audiology departments were surveyed. The response rate in England was 87%[32]. The table below shows that, according to experts, care closer to home had considerable advantages for patients (Table 1); including improved access and the potential to improve hearing aid compliance. It also shows there was strong agreement on the benefits of care closer to home. Data in Annex A supports this; care closer to home improves access to follow-up care and therefore people are more likely to use their hearing aids.

Benefit	Major benefit	Minor benefit	Not a benefit	Reverse applies
Improved convenience/access for patients	95%	4%	1%	–
Encourages hearing aid use and maintenance	57%	24%	19%	1%
Provides better continuity of care	57%	23%	14%	7%
Reduces number of domiciliary visits	39%	33%	25%	3%
Fewer non-attendees at outreach sites	37%	33%	24%	7%
Secures work for department	36%	28%	36%	1%
Reduced waiting times for patients at outreach sites	35%	35%	22%	9%
Improves willingness of GPs to refer[a]	37%	41%	21%	–
Increased job satisfaction for audiologists	27%	40%	24%	9%
Improved communication with GPs[a]	37%	40%	23%	–
Educational for GPs[a]	21%	39%	40%	–
Educational for audiologist	8%	34%	50%	7%

[a] *Percentages based on sample restricted to centres holding clinics at GP sites, n = 75*

Table 1: Head of audiologists' view on the advantage of outreach work in 1997 (i.e. care closer to home (source: Reeves et al., 2000)[33]

MYTH 8: THE GROWTH IN DEMAND FOR HEARING SERVICES IS NEW AND THIS IS DUE TO SUPPLIER INDUCED DEMAND

In this section we discuss

- evidence of a longstanding trend in adult hearing services, one where the demand for the service has risen consistently for over 10 years
- current evidence on supplier induced demand (and how to mitigate against the risk of supplier induced demand).

BACKGROUND

Prior to 2012 adult hearing services were typically

- commissioned using block contracts, which made it difficult for commissioners to know exactly what they were purchasing
- provided in a hospital setting, which made them difficult to access.

In recent years the introduction of choice has improved transparency and allowed commissioners to access better information about contract performance (activity, quality and costs). Choice reforms have also made it easier for people to access services, helping reduce inequalities in access and outcomes – key objectives for the NHS.

The introduction of choice has therefore simultaneously made adult hearing services more transparent and more accessible.

This has made comparing activity and costs before and after the introduction of choice difficult for some commissioners[iii]. For example

- has demand risen or is it just that things are now more transparent and easier to measure?
- is demand rising quicker than it has in the past – i.e. before CCGs existed – or is it growing in line with predicted trends?

Evidence:

Monitor 2015

"The introduction of choice has also made services more transparent. 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" (link).

"Our findings show that choice can make services more accessible for patients, leading to more people getting help" (link).

"…where choice has been introduced [n]ew options for people who may have found it difficult to access care have also emerged, such as providers that specialise in home visits or organisations setting up in areas where patients had previously had to travel long distances to reach the service. These aspects make services easier to access" (link).

[iii] E.G not all CCGs have been able to compare current marginal costs to previous marginal costs on a like-for-like basis. This might have resulted in analytical errors/omissions. CCGs are advised to model cost per patient over three years so that prices can be benchmarked to Department of Health's Best Practice Guidance prices[iii], which is less costly than the non-mandated tariff when compared on a like-for-like basis. CCGs that want confirmation of this – including workshops – should contact enquiries@the-ncha.com for more details.

GROWTH IN DEMAND IS NOTHING NEW

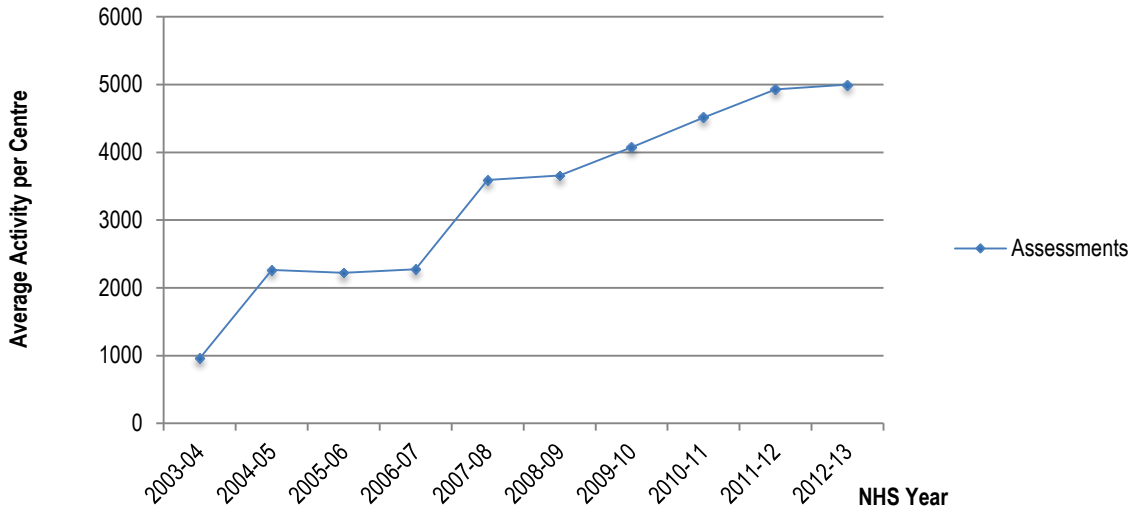
It is important to note that the main drivers of the growth in demand for adult hearing services over the last 15 years have been

- the introduction of new and improved technology (including improved cosmetic experience of hearing aids)
- our ageing population
- (and only recently choice)

This explains the growth in demand for NHS adult hearing services shown in **graph 1.** For example

- growth since 2003 has mainly been driven by the introduction of digital hearing aids. In 2003 experts predicted a capacity shortfall in 2006/7 because of this new demand. Unfortunately that growth in demand, by not being planned for, overwhelmed the existing service that by 2007 people had to wait for two years or more for an audiology appointment. This resulted in a Health Select Committee inquiry and the government taking action – e.g. introducing waiting times targets, redesigning pathways, seeking better value for money and including adult hearing services in its care close to home strategy[34]
- since the 1980s the average NHS hearing aid user has been aged 70 and over[35]. This population has risen the fastest, especially those aged 85 and older[36]. That means the population of older people, hence hearing aid users, also explains the growth in demand for adult hearing services.

Evidence:		
Health Select Committee, 2007 *"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."* (link)	***Department of Health, 2012*** *"The ageing population means that demand for both hearing assessment and treatment services is set to rise substantially over the coming years"* (link)	**NHS England and the Department of Health, 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"* (link)



Graph 1: Average number of patient visits for a hearing assessment per audiology service provider[37].

RECENT RESEARCH FOUND NO EVIDENCE OF SUPPLIER INDUCED DEMAND

It is clear that demand for hearing services has risen year on year since 2003 (**Graph 1**) and therefore growth in demand for hearing services predates the 2012 choice reforms. Nevertheless, since the introduction of choice some commissioners and GPs have been concerned that there might be supplier induced demand.

Monitor, the sector regulator, in its review of adult hearing services (2015) found no evidence of this. Monitor did find that improving access (choice) improves uptake by people that benefit from NHS hearing care and helps commissioners meet their objectives (link).

Evidence

Monitor 2015

- *"….increase in the number of patients is largely driven by the improved accessibility of the service [and] the presence of unmet demand. 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%)"*(link)

- *"…. 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."*[38] (link)

Evidence (continued)

Table: Presents Monitor's recent analysis of Direct Access Audiology which captures AQP referrals. Shows growth in demand pre-dates the introduction of AQP reforms.

Source: Monitor analysis of NHS England dataset (completed pathways) Original table can be *found here*

	2009	2010	2011	2012	2013
Referrals	423,000	443,000	464,000	484,000	496,000
Annual Percentage Increase	4.7%	4.7%	4.3%	2.5%	

WHAT CAN CCGS DO IF THEY ARE WORRIED ABOUT SUPPLIER INDUCED DEMAND?

It is important that CCGs exercise their functions

- effectively, efficiently and economically (link)
- with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness (link)

It is therefore important to ensure that NHS resources are used to deliver the greatest health benefit to the population.

Choice was introduced for exactly these reasons, with the Department of Health stating that choice reforms were intended to

- *"Encourage early identification, diagnosis and management of hearing loss through improved patient and professional education"* (link)
- *"drive up quality, empower patients and enable innovation to support the delivery of QIPP"* (link)
- *"[be a] vehicle to improve access, address gaps and inequalities and improve quality of services where patients have identified variable quality in the past"* (link).

Monitor in 2015 noted that

- *"..choice can make services more accessible for patients, leading to more people getting help. Taking steps to make choice work better for patients would benefit some of those millions of people with hearing loss who do not have hearing aids. In the longer term, this has the potential to reduce pressures on health and social services that can be attributed to unaddressed hearing loss. Improving access to hearing services may increase total spend on hearing loss, but we expect this to benefit patients"* (link)

This means that commissioners can be confident that investing in hearing care and meeting unmet need is consistent with their duties (link).

Nevertheless, it is still important that CCGs mitigate against the risk of supplier induced demand.

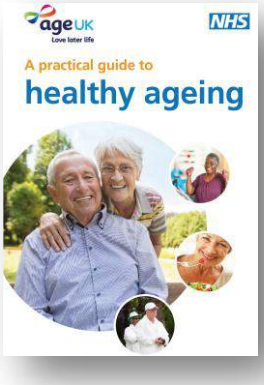
If CCGs are concerned about the risk of supplier induced demand we would recommend, as Monitor has too[39], that they use performance indicators to ensure they achieve the best value for money, minimise wastage and maximise health benefits for the local population – e.g. measuring that people get follow-up care because those that do not are less likely to be satisfied with hearing aids and less likely to use them.

It is also important to clarify how providers should promote hearing services and that hearing care is commissioned based on local needs (via a JSNA) and not past activity. This will allow CCGs to better plan budgets and meet the needs of an ageing population in a sustainable way.

Hearing loss is a public health challenge and the Department of Health and NHS England have supported increasing public awareness about hearing loss. For example in 2012 the Department of Health noted that

- *"The Provider will: Undertake communication activity and marketing campaigns in order to promote the NHS funded service. This will include producing marketing materials, information and literature relating to the service. Both the Commissioner and the Provider have the right to approve content of such materials. Materials may include posters, information sheets or electronic media on accessing the service"* (link)

And in 2015 NHS England (in partnership with Age UK) took steps to promote hearing care in the older population as part of an ageing well initiative – including reducing the pace of functional decline in people aged 70 and over[40].



This means that making people aware of hearing services is supported as a positive public health strategy, but commissioners should work with all providers to ensure local advertising helps meet all commissioning duties.

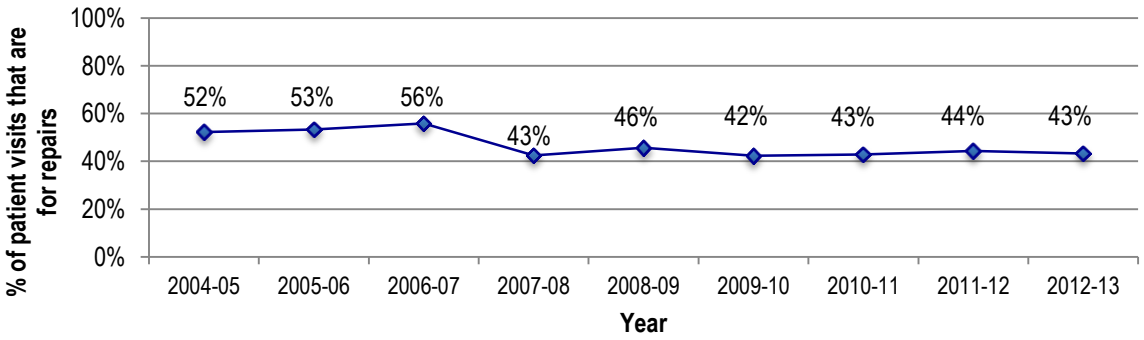
MYTH 9: WELL INFORMED PEOPLE WITH AGE-RELATED HEARING LOSS WANT TO GO TO HOSPITAL

Most patients prefer to access care closer to home[41]. Most patients with hearing loss meet Direct Access Audiology (DAA) referral criteria. Comparing reported hearing assessments to DAA it is estimated that 71% of all hospital hearing assessments could take place out-of-hospital and in community-based settings[42].

A recent study found that patient choice of hearing care provider was influenced by past experience rather than informed choice. For example if patients had been to a

hospital already then they were most likely to state they prefer going to a hospital, whereas this was reversed for patients that had been to a community-based provider[43]. Preference for the default choice is well documented in the behavioural science literature[44]. It raises challenges for commissioners who are tasked – in the NHS *Five Year Forward View* – with doing more out-of-hospital to make the NHS sustainable. This is why CCGs must plan ahead to help change social norms that are over reliant on the hospital-based model of care even for non-medical care like age-related hearing loss. This over reliance on the hospital-based model of care has also been noted by the World Health Organisation, which recognises that such overreliance is unsustainable – see *WHO, Primary Health Care, Now More Than Ever* (here).

If patients understand that age-related hearing loss is a long-term condition and regular visits are required for life to get hearing aids repaired or to collect batteries it is very unlikely they will choose to visit an acute hospital. **Graph 2** shows that most visits to audiology departments are for repairs (see myth four, the RNID called for care closer to home as far back as 1988. Older people with hearing loss need to access regular technical not medical support).



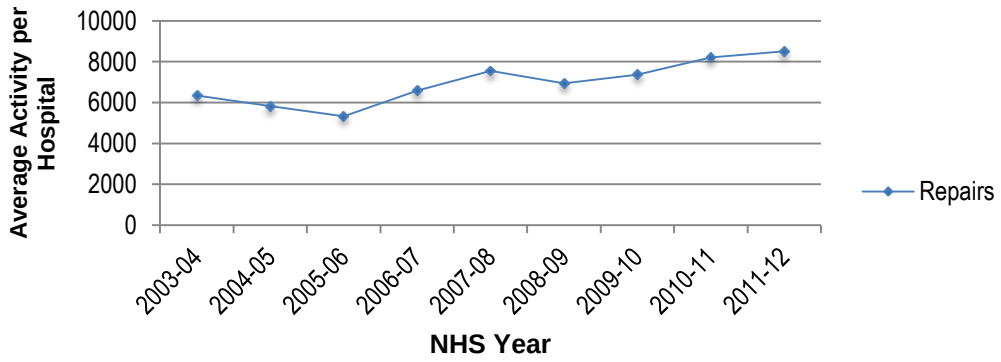
Graph 2: Percentage of adult patient visits that are devoted repairs in each year per audiology service provider[45].

MYTH 10: THERE ARE NO SYSTEM-WIDE BENEFITS TO DELIVERING MORE ADULT HEARING CARE OUT-OF-HOSPITAL

Simon Stevens has noted it was important for the NHS to take a system-wide approach to meet efficiency challenges set in the Five Year Forward View[46]. Currently thousands of visits are made to each hospital-based audiology department to access hearing aid repairs (Graph 3).

Shifting this activity out-of-hospital would

- cost patients less and could therefore reduce inequalities in access and outcomes[iv]
- cost the NHS less per patient[47]
- free up capacity for audiology and ENT departments to improve care for other patient groups – e.g. audiology departments can be busy[48] and liberating capacity can have a positive impact on quality for patients that need ENT and other health care support – e.g. such initiatives might allow some departments to improve quality of care for paediatric services and address concerns raised by the National Deaf Children's Society about variation in quality across the NHS in England[49]
- free up hospital capacity for other services – e.g. delivering adult hearing services in community-based locations could transfer 1.7-2.3 million patient contacts per hospital per year out of hospitals and allow hospitals to better process manage other (ENT or other specialities) pathways and this could help reduce overtime and reliance on agency staff.

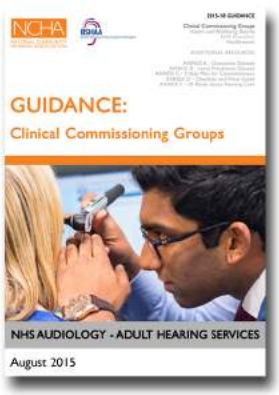


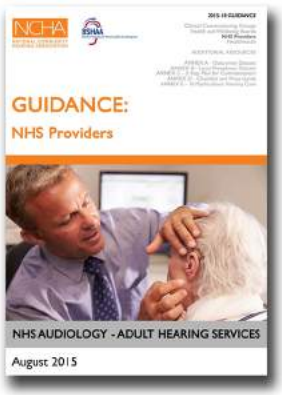
Graph 3. Average number of patient visits for hearing aid repairs per audiology service provider[50].

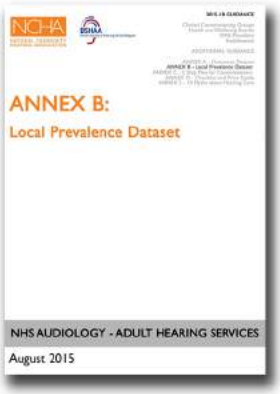
END: For a complete reference list click here

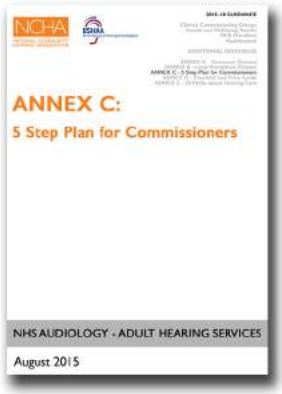
[iv] *CCGs and policymakers should note that travelling further imposes a greater cost on patients – also most patients accessing NHS hearing care are 70 and over and therefore mobility can make travelling more challenging. CCGs should also consider the risk of infection (e.g. when visiting acute hospital for non-medical care). Therefore where and how and at what costs (on patients and the NHS) hearing care is delivered should all be carefully considered when considering commissioning non-medical care for age-related hearing loss. For example given follow-up care and aftercare are key to continued use of hearing aids, making patients travel further than necessary to access repair services between fixed and/or very restricted hours could result in worse outcomes. These inequalities can be readily resolved by commissioning care closer to home, free at the point of service, using Department of Health's 2012 Best Practice Guidance that was designed by experts in NHS commissioning, NHS reimbursement and hearing care.*

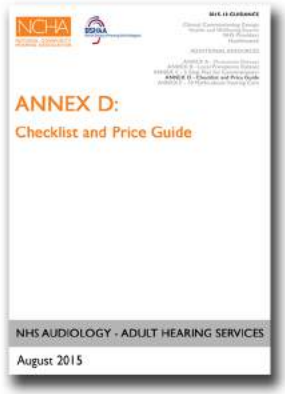
GUIDANCE IN THIS SERIES

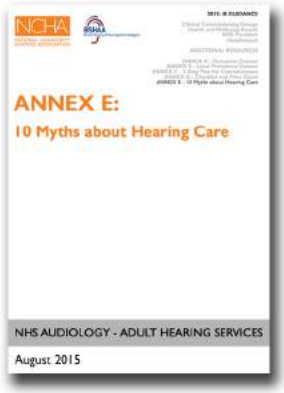


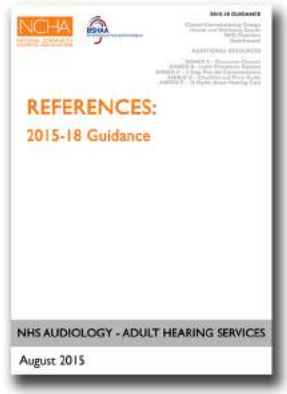












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