

The Health Select Committee
Inquiry into expenditure issues in the health and care system



1. The National Community Hearing Association (NCHA) represents community hearing providers in the UK. NCHA members are committed to good hearing for all, are responsible for the majority of adult community hearing care services in the UK and have an excellent record of outcomes, safety and patient satisfaction.
2. The British Society of Hearing Aid Audiologists (BSHAA) is the professional body for hearing aid audiologists providing hearing care to NHS and self-funding clients. They practise in large, medium and small companies and as sole practitioners; and they provide a professional, convenient and local service to people with hearing concerns in every community in the UK.
3. As representative professional bodies of community hearing care providers, we welcome the opportunity to comment on the Health Select Committee's inquiry into expenditure in the health and social care system.
4. We are responding to the Health Select Committee's requests for information about
 - NHS services provided by the independent sector and quality, costs and outcomes of these services
 - Merging of NHS and social care budgets
 - How longer contracting periods can deliver better value for taxpayers and improved outcomes for patients

NHS Adult Hearing Services

In the last two years 50% of CCGs have opened up access to community-based hearing services, putting patients first in line with NHS England's ["Everyone Counts: Planning for Patients 2014/15 - 2018/19"](#). As a result many more people have access to a more responsive and equitable service for age-related hearing loss.

Why is this not happening nationally? There is a lack of transparency, accountability and leadership. This has to change.

5. 88% (7.4 million) of people with a hearing loss are aged 50 and over. The majority could have their hearing care needs met out of hospital, in a setting of their choice and benefit from better aftercare and support (Reeves et al. 2000; NHS Improvement 2010; Action on Hearing Loss 2011; RNID 2011; NCHA Data 2014).
6. This is why community-based audiology at scale has been an aspiration for patients, patient groups and Governments for several decades (RNID 1988; Reeves et al. 2000; Department of Health 2007; NHS Improvement 2010; Action on Hearing Loss 2011; Department of Health 2012).

Evidence of Success

7. Success over the past two years shows how the NHS can deliver more hearing care for less whilst improving outcomes, quality and access for people with age-related hearing loss.
8. If there is one barrier to this, it is not finance, it is leadership.
9. 23 years after the Royal National Institute for Deaf People (RNID 1988 - now known as Action on Hearing Loss) called for a community-based hearing service the service remained predominately hospital-based in 2011. In 2011 the charity again called for change, stating

"[t]he 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" (Action on Hearing Loss, 2011) (our italics)

10. The NHS has made more progress in delivering community-based hearing care in the past two years than the previous 24 years combined. This change of pace resulted from adult hearing services being supported by patient groups to become one of eight initial priority areas for the 2012 Any Qualified Provider (AQP) initiative (Department of Health 2011).
11. Unfortunately, despite AQP adult hearing services being a demonstrable success for patients and taxpayers, there are signs that, as these (initially) three-year contracts come to an end, some CCGs will revert to ignoring evidence and what works for patients. There is a risk that history will be repeated and hearing services will be bundled into block contracts where commissioning responsibilities (e.g. outcomes, quality, access and information analysis) are shifted to NHS acute trusts and services for older people can be downgraded without public scandal.
12. With an ageing population it is no longer feasible to follow this historical approach. To meet growing needs and improve outcomes within available NHS commissioners must not be permitted to duck evidence, shift their responsibilities or fail the people they are in post to serve.

Advice to Health Select Committee

13. **Our message to the Health Select Committee and Government could not be simpler. We ask that commissioners**
 - **do what is right for patients and taxpayers**
 - **commission the most efficient and highest quality providers to deliver the best outcomes and access for patients which meet locally assessed needs**
 - **use outcomes and other available service data to pursue these ends**
 - **work on long-term objectives with all providers on a transparent basis to control costs and improve quality and outcomes, and**
 - **do not cut corners today to postpone tough decisions for tomorrow.**
14. If commissioners cannot deliver these objectives with a relatively circumscribed service such as adult and age-related hearing loss, what hope can there be for the larger NHS challenges?

Need for Leadership

15. Without leadership it is certain that adult hearing services will fail patients and taxpayers once again (see Audit Commission 2000; Health Select Committee 2007; RNID 2011). There is now an urgent need for a grown-up conversation about how the NHS will meet the growing demand for NHS audiology services for an ageing population. Several million people are already not receiving the hearing care support they need and without action this will rise.
16. With a NHS funding gap of £30 billion and a history of hearing aids being left in drawers for want of support, the system must change. Our hope is that the Health Select Committee will give impetus to that change. We have responded to NHS England's Five Year Forward View and to Monitor's review of NHS adult hearing services. In each of our responses we have argued that patients should be put first and services no longer be designed around institutions.
17. NHS England, Monitor, Government and health care experts agree that delivering more care in the community and out of hospital is essential for a sustainable NHS. Policymakers and commissioners must now follow through on the transformation of care which has started in adult hearing services. It is our hope that the Health Select Committee will support us in ensuring NHS resources are not wasted in this way in 2014 and beyond.

Results - NHS services provided by the independent sector and quality, costs and outcomes of these services

18. We welcome the opportunity to share our outcomes. It is regrettable that the Health Select Committee has not called on traditional NHS providers to provide evidence about quality, costs and outcomes for comparison. Unfortunately, there is no evidence that traditional adult hearing services do deliver cost-effective, high quality or equitable care (see Audit Commission 2000; Audit Commission 2002; Health Select Committee 2007; RNID 2011; Atlas of Variation – Diagnostics 2013).
19. In the meantime we are pleased to share the success of NHS community-based adult hearing services.
20. Approximately 50% of CCGs have commissioned NHS adult hearing services using the AQP initiative.

21. At *no* increased marginal cost per patient this has allowed the NHS access to 482 community-based locations, 75% of which offer evening and weekend appointments. That means the NHS has been able to access high quality community estate without PFI, debt or risk.
22. In the areas where CCGs have used AQP, there is 100% coverage for home visits should patients need it – at no extra cost. This means vulnerable people do not have to be transferred by ambulance to hospitals for non-medical care. This saves the NHS vital resources, but more importantly means the service does the right thing for patients.
23. In the first year of the AQP initiative over 85,000 patients chose, via their GP, a new community-based provider for their NHS hearing care. Representing a strong preference for community-based care and showing that, when offered a choice, patients want to have care closer to home. This is understandable given that the average age of NHS adult hearing patients is 76.
24. In 2011 the RNID carried out a review of NHS audiology services and found major gaps in follow-up care for patients fitted with a NHS hearing aid (RNID 2011). In the first year of AQP all patients visiting a community provider were offered a follow-up appointment and 99% received this within 70 days in a community-based location. These results demonstrate a clear improvement in quality of service and have allayed the concerns some patient groups had about NHS hearing services prior to AQP.
25. 97% of patients reported being satisfied with the service received from community-based providers (NCHA data 2014). These NHS data add to the evidence that already supports community provision of adult hearing services being a major benefit for patients (Reeves et al. 2000; NHS Improvement 2010).
26. 90% of patients are still wearing their hearing aids. This is a remarkable improvement and all possible because it is easier to access follow-up support.
27. The AQP initiative for adult hearing services has improved quality of care

“ AQP [...] improved access to adult hearing services by reducing inequalities in access, and has improved the quality of hearing services offered to all adult patients” (Public Health England, 2013 p.21) (our emphasis)

28. Community providers are rightly proud of these results. They have achieved them at less cost to the taxpayer – reducing the traditional tariff by 10% at the same time as introducing quality indicators, sanctions for poor performance and a responsibility not to fit and forget patients (Department of Health 2012).
29. To be clear, there is no cherry picking. The new pathway was designed by experts specifically to mitigate this risk. In fact the AQP specification is the only specification co-designed by all key stakeholders (Department of Health 2012). NHS costing manuals, tariff design and referral criteria show that there is no reason for well-informed policymakers and commissioners to be concerned about transferring this service out of hospital.
30. Whilst these outcomes have been fantastic for patients, this success was not unexpected.

Health Select Committee Previous Views

31. The Health Select Committee will know from its own review of NHS Audiology in 2007 that community providers were asked to assist traditional NHS providers who were unable to meet demand. An independent review of the service delivered by community providers found that they delivered equal, if not better, outcomes than incumbent providers (Davis 2005) and over 95% of patients were extremely satisfied and scored them 9/10 or 10/10 (Ibid).
32. In the Health Select Committee's 2007 report it was noted that the Government intended to purchase 300,000 pathways from the community sector each year to meet growing demand (Health Select Committee, 2007). Unfortunately this plan was not followed through and the service remained predominately hospital based and once again increasingly over-stretched.
33. Despite the Department of Health – in response to the Health Select Committee's report – publishing several documents in 2007 calling for more audiology services to be delivered outside of acute hospitals, progress up to 2012 was, at best, slow.
34. The recent success of community-based audiology can be put down to national leadership in 2012 that required commissioners to engage with their local population and implement change on the ground (Department of Health 2011, 2012). As the data above show, this was a clear success.

35. However, despite Monitor's report to the Secretary of State which aimed to ensure that the best providers can deliver NHS services for patients (Monitor 2013), this is not happening in many areas and, as existing contracts come up for renewal, many commissioners are failing to engage with providers or ensuring they meet their obligations to continuous quality improvement (Health and Social Care Act 2012). The reason for this is simple, poor analysis, a lack of attention to detail and bundling to hide financial pressures within monolithic block contracts. Patients and taxpayers deserve better than this from their commissioners. Older people in particular are being short-changed. That is why we ask for commissioners to stick with the best providers, not the same providers, in the next round of commissioning and beyond.

Merging of NHS and social care budgets

36. The NHS has for too long ignored the impact unsupported hearing loss has on older people. For example, uncorrected hearing loss has negative consequences on individuals and results in increased cost on the health and social care system (Chisolm et al. 2007; Hidalgo et al. 2009; Schneider et al. 2010; Acar et al. 2011; Hjalte et al. 2012; Helvik et al. 2012). If health and social care budgets are combined then the true costs of unsupported hearing loss might nudge commissioners to invest more in preventative services like hearing care.

37. However, before this happens policymakers and commissioners must address the power balance between acute trusts and commissioners. For example, in hearing care, some hospitals continue to operate outdated pathways using block contracts, whilst community-based providers in the same area have to deliver more for less. This is only possible because some acute hospitals have significant leverage over local commissioners. If social care budgets are combined with health budgets before this cultural issue is addressed, it is likely social care will struggle even more than GPs and allied health care professionals to gain access to fair funding.

38. Therefore at this stage, rather than merging budgets we would like to see a change in the culture of commissioning within the NHS and greater partnership working and joint commissioning with social care with a greater emphasis on keeping people independent for longer and helping people avoid becoming patients in the first instance.

How longer contracting periods can deliver better value for taxpayers and improved outcomes for patients

- 39.** Currently hospitals have de facto long term contracts. Knowing you have a contract for life will not deliver value for taxpayers or improve outcomes for patients. As we have seen in hearing care in recent years, this means incumbent providers can continue doing what they have always done and when budget pressures occur commissioners will duck the challenge and commission from hospitals where shortages and shortcomings can be more easily concealed rather than from community providers where information about outcomes, quality and costs is transparent. Therefore all contracts and especially long-term contracts should have clear quality and outcomes assurance systems and reporting mechanisms in place. At renewal, if tough decisions have to be made, it should be the least effective providers which are decommissioned. NHS resources are for patients, not providers and subsidising failure should not be an option.
- 40.** In contrast, community-based providers have clear quality assurance systems but short contracts (1 to 3 years). This means the churn process begins at year 2 which inhibits long-term investment in infrastructure and impedes innovation and quality improvement.
- 41.** In our view commissioners should have clear break clauses for non-compliance and failure to deliver quality and outcomes but otherwise extend the period of contracts for community-based services to at least 5 years. This will allow investment and innovation. The NHS will pay the same marginal rate but the security will allow providers to invest for the long term and still bear a fair level of risk. This would also allow community providers to invest in hearing therapy, wax removal services and other support for people with a hearing loss removing pressures from other parts of the NHS where there are currently 2 million consultations for ear wax per year.

Summary

- 42.** As we noted above, we are keen to have an honest and open conversation at national and local level about what can be achieved within available resources and about how the NHS can to deliver better outcomes, access and choice for patients and better value for taxpayers.
- 43.** We hope NHS England and Monitor will show leadership and work with the whole hearing sector (acute and community) to deliver this much needed

transformational change. We hope that the Health Select Committee will also give impetus to this in its report - both patients and the NHS will benefit and fewer older people will end up in care.

Further information

We would be happy to forward documents referenced in our submission and give evidence in person.