

Making health and social care information accessible: Consultation response from the National Community Hearing Association and the British Society of Hearing Aid Audiologists



Introduction

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.

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.

The Government, NHS England and Monitor have called for health care professionals to work together in the best interests of patients. We have therefore also taken this opportunity to provide NHS England with a joint response on the overarching principles of this proposal from the following organisations:

- British Dental Association
- British Medical Association
- British Society of Hearing Aid Audiologists
- National Community Hearing Association
- Optical Confederation
- Pharmaceutical Services Negotiating Committee and
- Pharmacy Voice.

Each day our members have millions of contacts with patients, service users, carers and parents. We therefore welcome the intention to make health and social care information more accessible. We support a NHS Information Standard (NHS-IS) that is evidence-based, realistic, proportionate and respects every person's right to confidentiality. It is important that the NHS-IS benefits patients without becoming yet another overly bureaucratic system.

If this system is to work for patients, NHS England and CCGs must make resources and infrastructure more readily available. Without such support implementation will be difficult in most primary care settings and impossible in some. We therefore call upon NHS England as lead commissioner to:

1. provide clear information to the public about the care and support that they can access, including

what support commissioners will fund when service users attend appointments

- which British Sign Language (BSL) interpreters commissioners (NHS England and/or CCGs) have approved in terms of qualifications, quality assurance and safeguarding

2. support providers in community-based settings by

- providing funding for interpreters, translation of information into Braille and other services that NHS England mandates
- providing clear guidance on the distinction between needs and preferences
- taking a pragmatic approach and allowing providers to determine how to collect, organise and record information. The current NHS-IS fails to recognise the complex mix of provider organisations in community-based settings, and that for some – particularly for small and medium sized providers – achieving the standards as currently prescribed may not be possible. For example
 - the requirement for *“Information about a patient or service user’s information or communication support needs (or those of their carer or parent) MUST be recorded as part of an individual’s first or next interaction with the service”* may not always be possible when patients are seeking urgent care or in the case of adult hearing seeking a one-off adjustment from a provider who is not their usual provider
 - the NHS in some cases only funds part of the patients journey and has not supported providers with IT infrastructure.
 - NHS IT policy means that many community-based providers will not be able to meet the NHS-IS without Department of Health and NHS England changing their policies and providing more support.

We are keen to work with NHS England on the introduction of these standards in community-based settings. We hope NHS England will take this opportunity to address the challenges we have identified and we would all be happy to work with NHS England on finding solutions to the issues raised.

NCHA and BSHAA Response

In common with our partner primary care representative and professional organisations, the NCHA and the BSHAA support the proposal for a NHS Information Standard (NHS-IS) that is designed to help meet patients’ needs. Indeed communication is our *raison d’être* and ensuring people can access information in a way that is suitable for them is an important part in improving equality in access to healthcare services. As a sector, with AQP contracts with no guarantee of volume, we have already made significant investment in access for NHS patients including to follow-up and out-of-hours care. We do not question the principle or intent of the IS. We do however have concerns about the approach and implementation.

The detailed comments to each of the consultation questions below are provided on behalf of the NCHA and the BSHAA.

Consultation questions

1. **Do you agree with the vision for the standard?** The vision is explained in section 3 of the Consultation Document.

☐ Yes

☐ Not sure

☐ No

☐ Prefer not to say

2. **Do you agree with what the standard will do?** This is explained in section 4 of the Consultation Document and in the Specification.

☐ Yes

☐ Not sure

☐ No

☐ Prefer not to say

3. **Do you agree with what the standard includes?** This is sometimes called the scope. What the standard includes and who will have to follow it is explained in sections 5 and 6 of the Consultation Document and the scope forms section 8 of the Specification.

☐ The scope is about right

☐ The scope includes something it should not

☐ The scope is too small

☐ Prefer not to say

☐ The scope is too big

☐ The scope is missing something

4. **If you believe that the scope is too small or includes something that it should not, please explain here.**

5. **If you believe the scope is too big or does not include something which it should, please explain here.**

Every day our members support people with a hearing loss and we welcome the principles in this NHS Information Standard (NHS-IS). However in terms of scope and implementation it appears to have been drafted without proper input from those who will have to deliver the service, or recognition of the wide variety of providers of NHS services, and the very different ways that different services are provided to patients. For example

- currently NHS IT policy makes it difficult for all community-based providers to access NHS mail and share information and
- many community-based providers – e.g. audiologists, opticians, pharmacists and dentists – have IT systems that are used to manage both NHS and private patients' data and records.

Yet the NHS-IS suggests that all of these providers will be required to follow the standard and fails to address the practical implications of this requirement, including how additional costs (both time and financial) to businesses will be covered. Many community providers operate on very low margins and it would be a retrograde step if the new information standard prevented community providers from continuing to provide NHS services. This would defeat the very aims of improved communication and access the NHS-IS is intended to achieve.

Unlike traditional NHS providers, community hearing providers operate in a competitive, open market where patients genuinely chose between providers and the money genuinely follows the patient. This mean that no community provider can rely on a captive patient-base but must seek to attract and retain each and every patient. As a result they compete to meet patients' and carers' communications needs in ways which best suit those needs which is vital in a communications sector. Over-specification in this area as in the proposed NHS-IS would distort this flexibility and again defeat the NHS-IS's objective.

Whilst commissioners are mentioned in the implementation pack, it is not clear whether commissioner responsibilities for providing the infrastructure and support will be part of the final NHS-IS. We feel it is important that the role of CCGs in ensuring people have access to the support they need when accessing NHS services, on top of what is already provided, should be made explicit in any guidance.

We agree with our colleagues at the BMA, BDA, Optical Confederation and Pharmacy voice that as it stands, the implementation and funding aspects of the NHS-IS need to be worked through before the NHS-IS is implemented. We would be happy to work with NHS England either collectively across primary care or separately as the community hearing sector in finding solutions benefiting patients.

6. What do you think about the steps of the standard / the Requirements set out for health and social care organisations and IT suppliers? The steps of the standard are explained in section 7 of the Consultation Document and the Requirements are detailed in the Specification.

- ☐ The steps / Requirements are about right
- ☐ The steps / Requirements are too small
- ☐ **The steps / Requirements are too big**
- ☐ **The steps / Requirements are missing something**
- ☐ The steps / Requirements include something they should not
- ☐ **The steps / Requirements are wrong in some way**
- ☐ Prefer not to say

7. If you think that the steps / Requirements are too big or include something which they should not, please explain here.

Again, we fully support the principles of the NHS-IS, however we are concerned that without making commissioners' responsibilities explicit, people that need support will not have access to it. There is a risk in our view that the NHS-IS will specify everything that is ideally required in great detail but omit how it can or will be deliverable on the ground.

NHS England needs to engage therefore more closely with community-based providers to ensure the NHS-IS is workable in the community and out-of-hospital. A one-size-fits-all approach will not benefit the people that we serve. For example by requiring record systems to be designed so that they 'flag' when somebody has a vision or hearing impairment to all staff might in some cases breach a person's fundamental right to confidentiality.

In addition to this, it is important to note that the NHS does not provide our members with any IT support – financial or otherwise. Therefore implementing complex IT systems could increase costs and inhibit delivering care out-of-hospital. This contradicts the principle underlying the NHS-IS. For example, the NHS-IS aims to make the NHS more accessible and user friendly to people with communication needs. Yet we have known for many years that people prefer to access their hearing care closer to home which means they are more likely wear their hearing aids because maintenance is easier. Therefore to hear and maintain hearing care closer to home is a positive thing as it means other interactions with the NHS will be easier. Yet the proposed IT system will risk reducing access to hearing care closer to home and leave people needing more support with communication.

We are keen to meet with NHS England’s team to discuss the prevalence of hearing loss and how millions of people with hearing loss can be supported to maintain active and independent lives closer to home, without complex and overly bureaucratic IT systems.

8. If you believe that the steps / Requirements are too small or do not include something which they should, please explain here.

As it stands today, the NHS-IS will soon require providers to invest more in IT to notify practice staff of a hearing loss whilst at the same time commissioners consider cutting funding for hearing aid provision. These two objectives are incompatible.

We believe NHS England is sincere in its goals to make the NHS more accessible. We therefore feel that CCGs and HWBs should have to include sensory loss – hearing and sight – on their local Joint Strategic Needs Assessments (JSNAs). This is particularly important for hearing care because the negative impact of unsupported hearing loss is not widely recognised - for example it can lead to early retirement, social isolation, depression, medical errors etc.

9. If you believe one or more aspects of the steps / Requirements is / are wrong, please explain here.

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10. What do you think about the types of communication support and information formats we have included? These are listed in section 8 of the consultation document and in the technical document which accompanies the Specification.

We agree with our colleagues in eye health – the Optical Confederation – that organisations should record people’s information or communication needs rather than their disability. We also share their concern that the current proposal on obtaining and recording information is overly bureaucratic.

Again we feel there is a need for NHS England and all CCGs to be transparent with service users and clearly explain how information and communication services will be funded.

11. Do you agree with quality considerations we have included? This is outlined in section 10 of the Consultation Document and in the Specification for the standard (section 9.2)

and in the Implementation Guidance. Quality considerations include things like the qualification of interpreters and how to make sure that information in different formats is correct.

☐ Yes

☐ Not sure

☐ **No**

☐ Prefer not to say

12. If you have comments on the quality considerations we have included, please explain here.

Again, like our colleagues in eye health, we support the intention that information and communications provided should be of good quality. However we too have concerns about implementation.

We believe the most cost-effective and sustainable way to ensure high quality support is available for NHS England and CCGs to ensure suitably qualified and vetted professionals are registered locally and readily available to help with the provision of NHS services.

Like all of our colleagues in community-based settings, where we deliver routine care on a daily basis, we disagree with the statement that organisations should not allow patients to have a member of their family or a friend act as their interpreter. We accept that everyone has a right to privacy, but individuals also have the right to choose. People should be given a choice and it should always be made clear that a professional can be made available to assist them if they wish.

13. What do you think about the advice and support which we are planning to give to organisations? This is outlined in the Consultation document section 12 and in the Implementation Guidance, especially section 7.

☐ The advice and support is about right

☐ **The advice and support is missing something**

☐ The advice and support is too small

☐ The advice and support includes something it should not

☐ The advice and support too big

☐ Prefer not to say

14. We are planning to give organisations 12 months to implement the standard. What do you think about this?

☐ 12 months is about right

☐ **12 months is too short**

☐ 12 months is too long

☐ Prefer not to say

15. What do you think about our plans for making sure that organisations follow the standard? This is explained in section 13 of the consultation document and in section 17 of the Implementation Plan.

Like our colleagues across primary care we are concerned that commissioners (NHS England and CCGs) will not be geared up to support and deliver the NHS-IS even in general medical practice let alone in other areas of primary care.

There is a cultural challenge in the NHS and in the way in which age-related hearing loss is currently commissioned by CCGs across England. For example at the time of this NHS-IS consultation, commissioners are considering

- raising the hearing loss threshold before people can access hearing aids
- decommissioning support for people with mild and moderate age-related hearing loss, and
- requesting only one hearing aid be fitted to people with a bilateral hearing loss.

We are therefore very concerned that at a time when there are 8 million people in England with a hearing loss and 90% are aged 50 and over, local CCGs are looking to ration support for the only proven clinical intervention – hearing aids. Yet at the same time, NHS England is considering publishing a NHS-IS that will require NHS providers to support people with hearing aids and hearing loss. Put simply, the NHS is on one hand accepting its commissioners can withdraw hearing support for older people, and on the other hand requiring providers invest in complex IT systems and protocols to flag who has a hearing loss. This does not seem like the NHS mentioned the NHS Five Year Forward View (October 2014). The NHS-IS will require much more joined-up thinking between NHS England and CCGs than has been evident to date.

16. Do you have any comments on the Specification for the standard which are not included as part of other questions? If so, please include them here.

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17. Do you have any comments on the Implementation Plan for the standard? If so, please include them here.

Please see our answer to question 15. We are very concerned that NHS England, in producing this NHS-IS, is not aligned with the actions of some CCGs.

We support NHS policy that puts patients first and respects older people’s right to live active and independent lives.

We support a NHS-IS that means the growing number of older people with a hearing loss will have more responsive care.

This NHS-IS could, in theory, mean that for the first time health care professionals will be thinking about hearing loss on a daily basis – e.g. the average age of a hearing aid user in 2013/14 was 76 and many people in this age group will be using other NHS services. We would welcome this, because good communication can improve the quality and safety of care.

However, none of this is likely to be achieved if the most basic intervention for a hearing loss– a hearing aid - is increasingly been restricted by commissioners because they have not planned for

- an ageing population and predictable increase in demand for hearing care
- unmet need, and
- changing expectations from an ageing population that no longer wants to wait 10 years to act when they have a hearing loss.

Put simply, today NHS commissioners are trying to control expenditure by restricting access to hearing aids that cost the NHS between 14p and 20p a day over a five year period per patient. Therefore we feel the implementation plan should also have training for CCGs on the impact of uncorrected hearing loss on older people and the communication needs of people that struggle to hear when attending for NHS care.

18. Do you have any comments on the Implementation Guidance for the standard or support for organisations? If so, please include them here.

With community-based providers of NHS adult hearing care already delivering communication support with a patient satisfaction of 98% and a hearing aid compliance of 95% in 2013/14 for 10% less than the NHS paid in 2011 it seems counter-intuitive that all this would be put at risk by a NHS-IS that would make costs increase for providers. If commissioners will not fund these changes it will ultimately resulting in more people with unsupported hearing loss.

As outlined above the IT systems our members use are not financed by the NHS. In addition to this the NHS commissions community-based hearing care in most areas on a contract that offers no guaranteed activity and at most a three year contract. These circumstances will make it very difficult for NHS community-based hearing providers to meet the NHS-IS in its current form. Yet it is precisely our members who are qualified to support people with a hearing loss and reduce costs elsewhere in the system.

We remain supportive of the aims of the NHS-IS but are concerned about how the goals it aims to achieve will be delivered without a lot more thought, proper funding and implementation planning and more joined-up working between commissioners and providers. We would very much welcome meeting with NHS England to discuss this.

19. What do you think the impact of the standard will be?

- ☐ Very good
- ☐ Good
- ☐ Neither good or bad (neutral)
- ☐ Bad
- ☐ **Very bad**
- ☐ Prefer not to say

20. Due to the short timescales we have to read everyone's responses and make changes to the final standard, we have limited the space for 'free text'. If you have already given your views as part of the engagement phase, these have been considered in drafting the standard. If you do not feel that you have been able to share your views as part of this survey, please use the space below. We will try to consider any views you record in this section, but will not be able to respond or report on them in detail.

As explained above, we have concerns that this standard will fail to deliver results for the people it was designed to help and that, without proper planning, funding and engagement with primary care providers implementation will be partial, inconsistent and chaotic in the community sector and possibly also in the secondary care sector and at the boundary between the two.

It is disappointing to note that this important standard – especially considering the content of the 5 Year Forward View – appears to be rushed for political rather than reason of genuine access improvement by NHS England.

Along with our colleagues from across primary care we would be keen to see this standard work and keen to discuss further our concerns, and how they can be addressed, with NHS England or Ministers.

Thank you for taking part in the consultation on the draft accessible information standard.

Please email your completed survey to us at england.nhs.participation@nhs.net or post it to Sarah Marsay (Accessible Information), 7E56, NHS England, Quarry House, Quarry Hill, Leeds, LS2 7UE. Please make sure we receive your completed survey **by 9th November 2014** as this is when the consultation closes. For updates about the development of the accessible information standard please visit the NHS England website www.england.nhs.uk/accessibleinfo