



National Community Hearing Association
199 Gloucester Terrace
London
W2 6LD
020 7298 5110

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NHS Legislation Engagement

Proposals to change NHS Legislation in England: protecting the rights of and impacts on people with protected characteristics

Dear Colleagues

We welcome and support goals set out in the NHS Long Term Plan, and also agree that legislative change proposals might help deliver certain policy objectives in the Long Term Plan.

The proposed legislative changes however are not without risks and we are therefore writing to ask that particular emphasis and attention be given – both during the legislative process and during the implementation phase of the NHS Long Term Plan – to safeguard the rights individuals who have protected characteristics under the Equality Act 2010, and particularly those with a hearing disability, as part of the NHS Public Sector Equality Duty (PSED)¹.

Although protected characteristics legislation is not new, it has never been fully implemented in the NHS adult hearing service where patients are very likely to have two protected characteristics – age and hearing disability – and yet often lose out on access to timely hearing care and support despite the NHS's own and independent evidence that sets out why this should not happen.

In this letter, and the appended supporting background information and evidence, we set out why the NHS arm's length bodies and the Department of Health and Social Care (DHSC) should now give special consideration to people with adult onset hearing loss – over 90% of which is due to age-related hearing loss – to ensure this group is not further disadvantaged by biases within the commissioning and provider system which have historically, repeatedly and wrongly deprioritised hearing care based on unfounded assumptions about both age and disability.

People with an age-related hearing disability also warrant special consideration because of the adverse impact unaddressed hearing loss can have on mental health and loneliness, and how despite it being the third most common long-term condition in older people and the sixth leading cause of years lived with disability in England, it remains invisible and is still wrongly ascribed a low status within local NHS and care systems.

This failure is made worse by the fact that this is not due to local resource constraints. For example the NHS's own evidence shows that resources are not currently being used effectively and that the NHS can deliver more hearing care within the same hearing problems programme budget provided

¹ as defined in section 149 of the Equality Act 2010

patients and taxpayer interests are put ahead of provider interests – e.g. NHS Improvement evidence shows that it is possible to reduce the cost per adult hearing care pathway by over 20% whilst improving standards, transparency and accountability, and thereby seeing more patients within the same budget or releasing funds to invest in other services. Put simply, current inequalities in access and the equality concerns we set out in this letter are not explained by NHS financial constraints.

At the heart of the matter is the longstanding low priority of the adult hearing service and the fact that adult hearing disabilities are not generally appreciated by clinicians at all levels (including GPs) nor prioritised by public health or given management or organisational attention. It is our great fear then that these endemic problems will, without particular attention and support, continue unchecked and unchallenged into the new world of the NHS Long Term Plan. If allowed to happen, this would fail yet another generation of adults with hearing disabilities, despite the growing evidence that supports early intervention in order to reduce risks and improve quality of life.

We are therefore requesting that the DHSC and the NHS (England and Improvement) give particular attention to ensuring that the net effects of reform within the complex health and care system do not compromise access or care for people with protected characteristics. Key messages from our sector are that:

- age-related hearing loss is a major and growing public health challenge, a leading long-term condition and the sixth leading cause of years lived with disability in England
- people with adult hearing loss need early access to care and lifelong support to limit the adverse impacts their hearing disability has on their quality of life and to reduce other risks associated with unsupported hearing loss
- NHS evidence and guidance shows that offering patients a choice of adult hearing care provider results in improved standards, transparency and value for money which means the NHS can tackle unmet hearing need within its hearing programme budget provided commissioners and providers put patient and taxpayer interests first
- transforming adult hearing services will also help reduce pressure on the outpatient model of care where today hearing aid repairs alone still account for over 1 million hospital outpatient attendances. In total close to 2 million audiology and 300,000 ENT visits could be provided closer to home at less costs, more convenience and equivalent or better outcomes

The challenge then is how such messages get through and are acted upon. One important safeguard would be to build into the new architecture some means for organisations, patient groups and interested parties to challenge complacent statements which indicate views that are inconsistent with the Equality Act. It might however be more helpful to avoid the costs associated with legal challenges and instead issue specific (binding) guidance about NHS duties in respect of individuals with protected characteristic or, in the case of hearing care, to update or supplement the current NHS England, *Commissioning Services for People with Hearing Loss: A framework for clinical commissioning groups*, to ensure the needs of people with protected characteristics are not compromised in the broad sweep of reform.

In addition to this, the following safeguards would also help mitigate the risk of reversing recent improvements in access to quality hearing care across England and also help ensure that patient and taxpayer interests are put ahead of historical models of care while meeting the PSED:

1. **extend the right to patient choice so that all adults accessing NHS audiology services have a choice of provider – because NHS evidence shows doing so can help improve access to adult hearing services for patients that otherwise might find it more difficult to access care**
2. **ensure new NHS pricing models factor in underlying cost distortions and the impacts these might have equalities** – e.g. that adult hearing services are **not** priced or funded on what NHS England and NHS Improvement have acknowledged are distorted outpatient reference cost data as doing so would, other things being equal, reduce overall access to care
3. **provide independent regulatory oversight to ensure providers and commissioners can be held to account if they do not commission/provide the best value care available** - as doing so will help ensure the maximum number of people with a hearing disability can be supported within any given budget.

Other services for low (NHS) priority, low (NHS) status groups may be in a similar position, but our research suggests that hearing loss stands alone on the scale of adverse impacts and evidence based interventions that are supported by NICE's economic and clinical evidence. Put simply, the burden of disability can be addressed provided the NHS takes hearing disability more seriously and in a way that is consistent with the Equality Act. The NHS therefore has an opportunity here to meet its PSED whilst improving standards and reducing costs in a way that is consistent with goals set out in the NHS Long Term Plan.

In our view this is an important opportunity for the NHS to get hearing care right for millions of older adults that will need to access this support in the years ahead. It would be helpful if officials could bear this in mind during the legislation phase and if NHS leads (NHS England/Improvement) could provide particular support to Integrated Care Systems and Primary Care Networks during the early implementation phases.

The NCHA, which represents community hearing providers, will be very ready to support DHSC and the NHS in this process to ensure the Long Term Plan genuinely does deliver for the most vulnerable in society. The evidence-base and background underpinning this letter is included below for ease of reference. We also attach our formal response to the online survey consultation.

A copy of this letter also goes to Ministers Stephen Hammond and Caroline Dineage, Health Committee Chair Sarah Wollaston MP and Rebecca Hilsenrath, Chief Executive at the Equality and Human Rights Commission.

Yours sincerely



Harjit Sandhu
Managing Director NCHA

Hard copies sent to:

NHS Legislation Engagement Survey, Quarry House, Quarry Hill, Leeds, West Yorkshire, LS2 7UE

Stephen Hammond MP, Minister of State for Health, Department of Health & Social Care, 39 Victoria Street, London, SW1H 0EU

Caroline Dinenage MP, Minister Of State For Care, 39 Victoria Street, London, SW1H 0EU

Dr Sarah Wollaston MP, Chair of the Committee, Health and Social Care Committee, House of Commons, London, SW1A 0AA

Rebecca Hilsenrath, Equality and Human Rights Commission, Arndale House, The Arndale Centre, Manchester, M4 3AQ

ANNEX – BACKGROUND INFORMATION AND EVIDENCE**About us**

The National Community Hearing Association (NCHA) represents community hearing care providers in the UK. The NCHA has worked closely with NHS England, local NHS commissioners, the third sector and provider organisations across England in order to secure quality outcomes for people with hearing loss. As the leading voice for community hearing care we welcome this opportunity to contribute to the NHS Long Term Plan and proposals for legislative change to help implement it.

Background information and evidence

The NCHA welcomes health policy proposals and changes to legislation which genuinely put patients at the heart of the NHS. On this basis we broadly welcomed the NHS Long Term Plan, and certain proposals to change NHS legislation in England to help implement the Long Term Plan.

The proposals to change legislation however are not without significant risks and more importantly also risk missing opportunities to achieve goals set out in the NHS Long Term Plan. This is especially true for people with a hearing disability, as defined by the government's guidance on the Equality Act 2010¹.

In context, more could be done as part of the NHS's Public Sector Equality Duty (PSED) – as set out in section 149 of the Equality Act 2010 – to mitigate against these risks and to advance equality for people with a hearing disability, and in particular those with an age-related hearing disability.

This is important because the NHS's own evidence² shows

- age-related hearing loss is now the third most common long-term condition in older people and a leading cause of years lived with disability in England

- age-related hearing is a major and growing public health challenge because when left unaddressed it increases the risk of mental health problems, social isolation, the rate cognitive decline, inequalities in employment and is associated with an increased risk of dementia, resulting in significant and avoidable costs for individuals, families and society
- the primary intervention for adult hearing loss, hearing aids, is now one of the most cost-effective interventions the NHS provides
- the traditional outpatient model of audiology (adult hearing services), especially where there is no patient choice of provider, is more costly and less transparent than community based models of care. This means the NHS can see more patients and release funds if it extends patient choice to community-based adult hearing services – e.g. NHS Improvement’s research showed that it was possible to save at least 20% per patient pathway and in many cases more than 25% per pathway by introducing a choice of provider in adult hearing care

That despite the burden of disease and the avoidable risks and economic costs associated with unaddressed hearing loss, and the cost-effective and evidence-based interventions that can be provided out of hospital and closer to home:

- the commissioning system has continued to over pay for outpatient based adult hearing services without sufficient checks and balances in place – e.g. the NHS has acknowledged these services often cost more and are less transparent and accountable than in regions where there is a choice of community-based hearing care (audiology)
- the commissioning system has failed to challenge ‘DRG creep’ – e.g. up-coding patient pathways to ‘complex hearing aid fits’ in order for providers to increase revenue, avoid accountable service specifications, patient choice etc.

The net effect of the current status quo has been to create a significant welfare loss – with the NHS under providing access to quality and accountable hearing care for any given NHS hearing problems programme budget. Within this complex systems failure the net effect has been to unnecessarily compromise access to care for people with protected characteristics (an age related disability). In some cases, for which we have examples that we would be happy to share again with NHS leadership, local commissioners have proposed rationing access to care for people with age-related hearing loss based on increasing in demand, driven by an ageing population, whilst ignoring the clinical and economic evidence – e.g. suggesting rationing access to hearing aids for people aged 50 and older without any evidence to support such an age threshold; and in fact in spite of higher quality evidence to support the provision of hearing aids to people aged 50 and older.

This is low priority status and its adverse impacts on people with a hearing disability is not new, and explains why the NHS adult hearing service has suffered from multiple systems failures over decades – e.g. this has also been acknowledged by the Audit Commission, Health Select Committee and others³.

Put simply, patients with a hearing disability have often been left worse off as the result of limited checks and balances, and there is little evidence to suggest this will change under new proposed models of care.

This chronic low priority status has resulted in a significant unmet need and a growth in the avoidable years lived with disability in England, and as a result the Department of Health and Social Care, NICE, NHS England and NHS Improvement now do recognise hearing loss a major and growing public health challenge in England, which if tackled could help reduce the impacts on individuals, families, wider society and the health and care system. This acknowledgement, although welcomed, however has not led to the necessary local action to limit the impact of hearing disability has on older people in particular.

Therefore, it is in this context – a growing older population with a hearing disability that has to date been disadvantaged by existing and historical models of care and biases about the impacts of hearing loss – that we believe that the NHS Long Term Plan and proposed changes to legislation should now help ensure

- people with adult hearing loss, who are not ill, do not have to go to hospital for non-medical hearing care, something patient groups have called for since 1988⁴ and the NHS has tried to achieve since 2007³. This will help reduce the impact of a hearing disability on individuals via earlier intervention and ongoing support closer to home. It will also help advance equalities, reducing for example the discrepancy in access to support for people with hearing and vision related disabilities. The NHS's own evidence has also shown that where more choice is provided providers have innovated to provide more accessible services for groups that previously found it more difficult to access care⁵
- the NHS gets the best value for money and most accountable model of adult hearing care, saving in excess of 20% per pathway on the traditional outpatient model of care whilst simultaneously improving standards and transparency as evidenced by the NHS's own research⁶. This will help the NHS release funds to provide more hearing care within the same budget envelope and in doing so help reduce the years lived with disability and inequalities that currently exist in England as a result of unmet hearing need
- adult hearing care is delivered in primary and community-based settings, designed around the needs of patients and system wide benefits and in doing so liberate over 2 million visits to hospital outpatient departments and an equal number of GP visits per annum – e.g. over 1 million hearing aid repairs still take place in England's hospitals each year and in total close to 2 million audiology and 300,000 ENT visits could be provided by a primary care audiology service. Which in turn will help ensure more equitable and sustainable access to care for all patients with hearing and ear related health needs.

However, unless the root cause of existing system failures are addressed none of the above will be achieved and people with hearing loss, and in particular people with age related hearing disability are likely to continue suffering from restricted access to quality care based on non-evidence based, and sometimes discriminatory, views on what is an age related disability.

This is why, when viewed in its entirety, the evidence to date strongly supports the need to give special consideration to adult onset hearing loss, and in particular age-related hearing loss.

Taking action now can also help reduce the risk of yet another system wide service failure in the adult hearing service³. Importantly, it will also help the NHS ensure it achieves its public sector duty to advance equality and reduce the risk of people with protected characteristics – age and hearing disability – being disadvantaged in a way that contradicts the clinical and economic evidence, NHS Constitution and goals set out in the Long Term Plan.

End

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