



Refreshing NHS England Mandate – BSHAA and NCHA Response

As the representatives of community hearing providers in England, we welcome this opportunity to comment on this first revision of the Mandate for NHS England.

The National Community Hearing Association (NCHA) represents community-hearing providers in the UK. NCHA members are committed to good hearing for all and are responsible for the majority of adult community hearing care services in the UK with an excellent record of outcome, safety, and patient satisfaction.

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.

We have seen and support the response and views of the Hearing Loss and Deafness Alliance.

Hearing Priority

1. Preventing hearing impairment and hearing loss is part of each of the five priority areas set for the NHS by government (paragraph 2). It is a key factor in enabling individuals to take charge of their own lives, maintain their independence and functioning in society and is therefore be central to a patient-focused NHS.
2. Having the most effective solution for hearing loss is particularly important for older people, people with dementia and people with multiple long-term condition in terms of maintaining independence, physical and psychological well-being and social functioning^{1,2,3,4,5}. (Priority Areas i-iii). It should

¹ Hearing Loss and Incident Dementia. Lin et al. Arch Neurol. 2011;68(2).

² Popelka et al. The Epidemiology of Hearing Loss Study. J Am Geriatr Soc. 1998;46

³ Tun et al. Aging, hearing acuity, and the attentional costs of effortful listening. Psychol Aging. 2009;24

⁴ What do we really know about hearing loss and cognitive function? Chung K. Hear Jour. 2012;65(01)

therefore be a key element in the Vulnerable Older People's Plan the government and NHS England are developing (paragraph 31).

Progress to date

3. In its first year NHS England (and CCGs) have made a good start in opening up NHS adult hearing services to community providers. In a clinically- led NHS this is enabling community providers to provide high quality accessible and convenient hearing services to NHS patients which, in the past, they have only been able to offer to paying patients. This is a major advance in terms of equality and closing the inequalities gap (paragraph 6).

Despite this, figures show that approximately four million people currently living with an acquired hearing loss would benefit from hearing aids and yet many will delay seeking help by up to ten years⁶

4. Moreover progress has been far from smooth. Still only [44%] of CCGs are commissioning NHS hearing services in the community and far fewer are actively engaging community providers and clinicians in planning shaping and developing services with hospital colleagues. In hearing care this is holding back the government's aim of empowering "clinicians [...] and front-line professionals to improve and innovate [...] to achieve the best health and care outcomes in the world" (paragraph 4). There is so much more we could do, including taking pressure off GPs and developing more integrated services (paragraph 8) through local networks with hospital colleagues and a standard accredited national adult hearing services pathway for CCGs to use to meet local hearing-related needs for an ageing population.
5. Major inhibitors to progress to date have been the cumbersome nature of
 - the Any Qualified Provider (AQP) commissioning processes and contract
 - the IQIPS quality standards.

Neither of these is fit for purpose in our view. These are complex systems designed for use in higher clinical risk services (e.g. hospitals) and are maladapted and inappropriate to the community setting.

6. We would very much welcome the opportunity to work with NHS England and the Department of Health to resolve these issues and ensure hearing can play a full role in the government's vision for a clinically led patient-focussed

⁵ Association of Hearing Loss With Hospitalization and Burden of Disease in Older Adults. JAMA, 2013;309 (2)

⁶ Hearing Matters (2011), Action on Hearing Loss

NHS where no-one's well-being is impaired for lack of access to high quality, efficient local hearing services.

7. Against this background, our detailed responses to the consultation questions follow.
8. We are happy for our response to be made public.

Question 1: What views do you have on the proposed approach to refreshing the mandate?

We would like to see more emphasis on NHS England and CCGs making full use of the totality of health care resources available to meet patients' needs - including in our sector, community hearing care providers - provided of course that it is cost-effective to do so.

Specifically we would like to see a better AQP and quality assurance framework developed – building on what has gone before – but which is more appropriate and proportionate to community hearing services and which allows greater and more widespread responsiveness to patient needs.

Question 2: What views do you have on assessing NHS England's progress to date against the objectives?

As noted above, whilst there has been some progress towards more equitable, accessible and cost-effective adult hearing services in the community, this has been inhibited by the cumbersome nature of the AQP process and the unduly burdensome IQIPS quality assurance framework.

We would very much support the development of more streamlined models, specifically adapted for adult hearing services in the community; in particular the development of a national pathway which CCGs could implement locally with common standards, thereby increasing equity and reducing unjustified variation.

We would also like to see a pilot scheme for self-referral which would reduce pressure on GPs and unnecessary steps in the patient journey for the public. This could be evaluated based on: outcomes, overall effectiveness, access, convenience, and of course cost. We would be very willing to work with NHS England to develop and assist in the operation and evaluation of such a pilot in 2014-15.

Question 3: What views do you have on the proposal to help people live well and longer?

In our view the priorities for helping people live well for longer lie in community support and particularly in the areas of best improved hearing, vision care, oral health, medication concordance and review, mobility and foot care.

Hearing is, in our view as important as any other of these services, with impaired hearing being a significant contributing factor to balance problems, falls, loneliness and depression in older age^{7,8,9}.

We would very much welcome the opportunity to engage more closely with NHS England to address the issue of more holistic and joined-up services for older people in the community to meet these needs.

Question 4: What views do you have on using the refreshed Mandate to reflect the plans to strengthen A & E services?

This question is not applicable to our sector.

Question 5: What views do you have on the proposal to reflect NHS England's ambition to diagnose and support two thirds of the estimated number of people with dementia in England?

We would strongly support this and would particularly emphasise the additional problems, complications and behavioural challenges uncorrected hearing impairment can bring to people with dementia. Such basic matters often pass unnoticed by carers (both family and in residential and care homes) who think that the decline in hearing is inevitable in older age. However, poor hearing leading to an inability to enjoy music, conversation, television, radio, or 'talking books' books can be major cause of frustration and additional isolation for people with dementia.

⁷ An economic evaluation of screening 60- to 70-year-old adults for hearing loss J Public Health (2013) 35(1): 139-146

⁸ Shield B. Evaluation of the social and economic costs of hearing impairment. A report for Hear-It AISBL (Association internationale sans but lucrative), Belgium. 2006

⁹ Arlinger S. Negative consequences of uncorrected hearing loss – a review. 2003. Int J Audiol. 42 (Suppl 2).

Considering the profound impact hearing loss can have on people with dementia, we feel hearing assessments should be a routine part of a dementia assessment.

Question 6: What views do you have on updating the Mandate to make it a priority for NHS England to focus on mental health crisis intervention as part of putting mental health on a par with physical health?

We would support putting mental health on a par with physical health and would emphasise that good health – including hearing - should be a “right” for everyone.

Question 7: What views do you have on the proposals to ask NHS England to take forward action around new access and/or waiting time standards for mental health services and IAPT services?

This question is not applicable to our sector.

Question 8: What views do you have on the ambitions and expectations for the vulnerable older people’s plan?

Question 9: What views do you have on how we should achieve our ambitions on the vulnerable older people’s plan, particularly on how to strengthen primary care?

Question 10: how should the ambitions for vulnerable older people be reflected in the refresh Mandate?

We fully support the proposal for a Vulnerable Older People’s Plan for England and in particular the aims of

- better information sharing
- the development of “more integrated out-of-hospital care”
- and “collaborative commissioning” (paragraph 31).

Adult hearing services lend themselves perfectly to these developments and, as a sector, we look forward to playing our full part in the way services are currently commissioned and provided.

We would argue that community hearing care is in fact a fifth primary care service and should be recognised as such, with community hearing care providers being more directly involved in developing (and consulted on) local commissioning plans with CCGs to build holistic and joined-up care in the community for the most vulnerable in society.

We are very willing to work with NHS England at national level to provide tools and support to CCGs and community hearing providers to help meet local needs.

Question 11: What views do you have on updating the Mandate to reflect the Francis enquiry and the review of Winterbourne view hospital?

We would support updating the Mandate to reflect Francis, Winterbourne View and Berwick. Our only proviso would be to point out that these failings (as so often in the past) were primarily failings of the acute sector and care homes; massive organisations with bureaucratic ‘command and control’ structures or locations closed to outside scrutiny. None of these factors apply in community hearing practices which are patient - and customer - focussed, delivered by small clinical teams with appropriate clinical governance and outcome measurements, provided locally in an open and accessible setting.

We would urge both the government and NHS England, therefore, to ensure that any read-across from the acute sector to primary care is appropriate and proportionate to lower risk services and care delivered in community and primary care settings. Simply “lifting and dropping” requirements designed for acute settings will not in any way improve the safety of patients in the community or support providers in developing services to meet patients’ needs.

Question 12: What views do you have on updating the objective to reflect NHS England’s role in supporting person centred and coordinated care?

We fully support the approach to developing “person centred and co-ordinated care” and would be very keen to play our part in local networks with GP commissioners and community hearing practices to bring this about.

Question 13: What views do you have of updating the existing objective to reflect the pledges in “Better Health Outcomes for Children and Young People”?

We support this proposal.

Question 14: What views do you have on updating the existing objective to reflect the challenge NHS England to introduce the “friends and family test” to general practice and community and mental health services by the end of December 2014 and the rest of the NHS funded services by the end of March 2015?

We would reiterate here what we said in response to Question 11 - i.e. that any read-across from the acute sector to primary care should be appropriate and proportionate to lower risk services care delivered in community and primary care settings. As a sector, we would be very keen to engage with NHS England about how the “friends and family test” might be applied proportionately in primary care.

Question 15: What views do you have on these proposals to improve patient safety?

We support this but again argue strongly that proposals to improve patients’ safety must be appropriate to the sector for which they are developed and to which they are applied. We would be very keen to work with NHS England to ensure that appropriate measures apply in the community adult hearing service.

Question 16: What views do you have on the proposal to update the Mandate for NHS England to work with Monitor towards a fair playing field for providers?

We strongly support the development of a fair playing field for *all* providers. The use of AQP has already significantly driven up standards across hospital care for adult hearing services (eg Cornwall) and, as noted above, this could go much further with better commissioning tools and a more appropriate quality framework.

In particular, we would urge commissioners to engage with all potential providers of adult hearing services (both acute hospitals and *all* community providers) to assess local needs and design pathways to ensure, through the commissioning process, that patients and the NHS benefit from the very best care in accessible, flexible and patient-focused ways.

Question 17: What views do you have on the proposal for Government to provide additional leadership on delivery of agreed pre-existing Government commitments?

We agree but would caution that “additional leadership” should be clearly linked to outcomes and not expand bureaucracy or protectionism both of which have, for years prior to these Reforms, been major barriers to innovation and excellence in the provision of NHS hearing care for adults.

Question 18: What views do you have on the proposal to update the objective to challenge NHS England to support the NHS to go digital by 2018?

Effective communication between health care professionals is a vital part of safe, efficient and high quality patient care.

BSHAA and the NCHA support the principles of a digital NHS and would be keen to work with NHS England so that hearing practices are able to effectively communicate and share data with other health care professionals in a cost-effective way.

Question 19: What views do you have on the proposal to be more explicit on the expectation around reporting?

Once again we would caution against excessive bureaucracy and the burdens on small providers. As providers we have no issue with reporting but, in our view, reporting must be linked to outcomes, meeting needs and add value to the patient journey. The information being reported should be of as much value to patients and

providers as it is to commissioners. Again, we would be very keen to work with NHS England on a proportionate system for community adult hearing services.

Question 20: What views do you have on the proposals to update the objective in asking NHS England to support the recovery of the economy where they can make an important contribution?

We fully support and reiterate our view across that by closer engagement and open partnerships with private sector providers – of all sizes – NHS England will stimulate and create employment and growth in the wider economy.

Question 21: What views do you have on the proposals to make better use of resources?

We support payment (and also co-payment where appropriate) as a matter of principle and would support NHS England in taking steps to ensure recovery of fees from overseas visitors where appropriate. We do not, however, believe this is a problem in the community adult hearing services sector in that patients can only receive NHS funded care if they are registered with a GP in the area and meet the relevant criteria.

Our only caution would be to ensure that whatever systems are put in place are fully funded by the level of resources recovered and that the NHS overall does not incur a net cost as a result.

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