ACTION ON HEARING LOSS

A national charity since 1911

Valuing Audiology:

NHS Hearing Aid Services in England

Peter Kunzmann

Full Report

Contents

Executive summary

Hearing loss affects 11 million people in the UK, including 9 million in England. With an ageing population, UK-wide numbers are expected to rise to 15.6 million by 2035[i].

Hearing loss can reduce people's quality of life, their ability to communicate with others[ii], and is associated with increased risk of depression[iii] and dementia[iv]. Mild hearing loss is associated with roughly double the risk of dementia, moderate hearing loss with three times the risk and severe hearing loss with five times the risk[iv]. It is, therefore, a large and important public health issue.

Fortunately, for most people with hearing loss, help is at hand. Hearing aids provide a lifeline to millions of people with hearing loss in England. There is gold-standard evidence that hearing aids improve people's quality of life and ability to communicate[v]. Furthermore, there is growing evidence they may reduce the risk of depression and significantly slow the rate of cognitive decline[vi].

Given the transformative impact hearing aids can have on people's lives, we set out to scrutinise NHS hearing aid services. We wanted to identify where they are performing well, where they need to improve, and whether the commissioning arrangements are fit for purpose.

Our findings paint a worrying picture.

Key findings

Lack of accountability

The most dramatic finding of the report is that Clinical Commissioning Groups (CCGs), the bodies responsible for paying for NHS services, are currently ill-equipped to do their job.

As of the start of 2019, there were 195 CCGs in England. Shockingly, over nine out of ten (95%) of CCGs lacked at least one of the bare minimum pieces of information needed to commission effective audiology services, i.e. how much they are spending; how many hearing aids they are fitting; and whether patients are satisfied with the service they are receiving.

Without this basic minimum information, CCGs are displaying grave failure in budgetary and service management. With little evidence about how many people are being helped, or the quality of the services being offered, hearing aid services will remain exposed to the risk of cuts and rationing, may miss out on crucial additional funding, and face changes that are detrimental to patients' long and short-term wellbeing.

Additionally, this systemic lack of oversight on hearing aid services demonstrates that CCGs are still not taking hearing loss and its wider implications for health seriously.

Low rates of access

While data on the number of hearing aids fitted remains incomplete, data is published on the number of people who access audiology services (even if it does not state whether those people obtained hearing aids or not).

Based on this data, rates of access to NHS audiology services are low. Fewer than one in five (19%) of adults with hearing loss accessed an NHS audiology service within the last three years. However, some areas perform better than others. In the best area, Heywood, Middleton and Rochdale CCG, over half (55%) of people with hearing loss accessed audiology, compared to just 1.3% in the worst, Thurrock CCG.

In some areas like North Staffordshire, restrictive policies are in place that deny hearing aids to some patients, even though they could clinically benefit from them.

Most people with hearing loss are, therefore, missing out on vital help – and in some areas the situation is particularly bad.

Failures to adhere to national guidance

Considerable national guidance exists setting out best practice for delivering audiology services, including NICE guidance[vii]. Unfortunately, three out of five (59%) of CCGs lack any kind of policy for implementing the guidance.

National guidance is based on the best available evidence, and failure to implement and adhere to this guidance puts patients' quality of life and ability to communicate at risk.

The future of hearing aid technology

This report also highlights the emergence of new technology (such as remote fitting or even self-fitting of hearing aids) that could improve service efficiency, boost access rates, and improve patient experience.

Key recommendations

Building accountability

CCGs should collect key data on the audiology services they commission, at

minimum: audiology spend, access rates, number of hearing aid fittings, waiting times, and outcome measures. NHS England should require this data be collected in a consistent way and publish the information centrally.

Boosting access

CCGs should strive to improve their audiology access rate. Any policies that deny the provision of hearing aids to those who could benefit from them should be abolished. This should be an immediate first step for CCGs with restrictive policies, such as North Staffordshire. Requiring providers to meet certain numbers may be another step, which could include advertising the availability of services.

Embedding national guidance

CCGs should ensure they are commissioning NHS services in line with NICE guidance and NHS England's Commissioning Framework, and prepare for future guidance such as the forthcoming Joint Strategic Needs Assessment (JSNA) guidance.

Realising the benefits of technology

NHS England should fund a trial of how new audiology technology can be integrated into NHS services.

Chapter 1: Introduction

The impact of hearing loss

11 million people in the UK are affected by hearing loss, including 9 million in England alone[i].

It is well established that hearing loss can reduce people's quality of life, their ability to communicate with others[ii], and is associated with increased risk of depression[iii] and dementia[iv]. Research shows that mild hearing loss is associated with roughly double the risk of dementia, moderate hearing loss with three times the risk and severe hearing loss with five times the risk[iv]. It is, therefore, a large and important public health issue.

My NHS hearing aids...

"They gave me the ability to hear. To socialise and learn language, to go to school and get an education. They've had a massive, positive effect on my life."
- Kaitlin, West Leicestershire

Fortunately, hearing aids can help. There is gold-standard evidence that hearing aids improve people's quality of life and ability to communicate[v]. Furthermore, there is evidence they may reduce the risk of depression and significantly slow the rate of cognitive decline[vi].

It is vital, therefore, that NHS hearing aid services are set up effectively and efficiently, accessible to all who need them, and of sufficient quality to ensure people genuinely benefit.

Commissioning NHS hearing aid services

Hearing aids have been available free on the NHS since its foundation in 1948[i]. In England, hearing aid services, also known as audiology services, are commissioned and paid for by Clinical Commissioning Groups (CCGs). At the start of 2019 there were 195 CCGs in England[viii].

My NHS hearing aids...

"My hearing aids have a huge positive influence on my life. Without them I would be lost."
– Alistair, Richmond

CCGs do not provide NHS services themselves. They commission other organisations, such as NHS

hospitals, or private/third-sector providers to deliver services through the Any Qualified Provider (AQP) system[ix].

In order for CCGs to be sure they are commissioning high quality, cost-effective audiology services that genuinely transform people's lives, they need information. At minimum, they need to know whether services have the capacity to help the number of local people who need them; whether services are of sufficient quality to improve the lives of people seeking help; and whether CCGs are getting value for money.

Without this information, CCGs simply cannot know whether they are commissioning well or badly.

How NHS hearing aid services work

In order for someone to access a full hearing assessment, a referral from a GP to an audiology service is usually required. As recommended in NICE guidance for adult hearing loss, the GP will need to check for any underlying causes such as wax and treat accordingly. If wax is a problem, it should then be removed[vii].

If wax is eliminated as a cause, or if hearing problems persist once wax is removed, the GP should usually make a referral to the audiology service. Within audiology, a detailed hearing assessment is conducted. This includes a battery of tests, along with an assessment of symptoms and the impact the person's hearing loss may be having on their day-to-day life. Once the assessment has been completed, the results are discussed with the patient. If the hearing assessment confirms a hearing loss and hearing aids would benefit, these can be fitted and programmed either on the same day or at a later appointment.

My NHS hearing aids...

"Wearing NHS hearing aids has made my life so much happier - I can finally hear my two cats meow! You have no idea how emotional that made me feel!"
– Cheryl, Norwich

Best practice suggests people then receive a follow-up appointment within 6-12 weeks with the option of attending in person, over the phone or via electronic communication[vii]. This is to assess how well the individual is benefiting from their hearing aids and to make any changes, such as fine-tuning of hearing aids. In addition, hearing aids need to be regularly maintained as issues such as wax or moisture for example can lead them to be ineffective[x] if not fixed.

Ensuring all these steps are functioning well is vital if people are to reap genuine benefit.

National guidance

In 2015 a national Action Plan on Hearing Loss was published[x]. This was designed to encourage action and promote change to best meet the hearing needs of children, young people, working age adults and older people, across all public service sectors and at all levels.

> My NHS hearing aids...
>
> *"I have had hearing aids since the age of seven and they have had a great influence on my life. I do not think that I would be able to cope without them. They have really made my life better."*
> – Brian, North Yorkshire

Following that, in 2016 NHS England published a Commissioning Framework [xi], which sets out best practice on how local NHS areas should design their audiology services. And in 2018 the National Institute for Health and Care Excellence (NICE) published guidance[vii] for the NHS on hearing loss which clearly states that hearing aids should be offered to those whose hearing loss affects their ability to communicate and hear.

This will soon be augmented with guidance for NHS commissioners and local authorities to conduct comprehensive Joint Strategic Needs Assessments (JSNAs) for people with hearing loss. JSNAs are the process by which current and future local health and care needs are met.

Adherence to national guidance ensures people receive audiology services designed in line with best-practice and in accordance with the best available evidence.

Our investigation and aims

Given the transformative impact hearing aids can have on the lives of people with hearing loss, we set out to scrutinise NHS audiology services. We wanted to identify where they are performing well, where they need to improve, and whether the commissioning arrangements are fit for purpose.

We chose to look at the level of Clinical Commissioning Groups (CCGs), the NHS bodies responsible for commissioning NHS services.

In order to get our results, we used existing data published by NHS England and the results of our own Freedom of Information (FOI) requests that we sent to every CCG in the country.

We present our results, conclusions and recommendations across the next five chapters:

Chapter 2: Accountability of NHS hearing aid services – scrutinising whether CCGs have a basic minimum level of knowledge and information about the services they commission to make genuinely informed planning decisions.

Chapter 3: Access to NHS hearing aid services – examining how the number of people accessing audiology services in each area compares to the estimated number of people with hearing loss in that area.

Chapter 4: Adherence to national guidance – looking at whether CCGs are commissioning services in line with existing national guidance and requirements, including NHS England's Commissioning Framework and NICE guidance.

Chapter 5: The future of hearing aid technology – discussing emerging technology that may improve patient experience, boost the efficiency of audiology services, and increase capacity to allow for greater access.

Chapter 6: Conclusions and full list of recommendations – setting out the overall picture of hearing aid services and presenting all recommendations for CCGs, NHS England, Public Health England and ourselves.

My NHS hearing aids...

"They are amazing, I had never heard birdsong before and it was a surprise to hear how loud they actually are! My work life is so much better, although sometimes I wish it was a little quieter. They took a bit of getting used to but with perseverance they work great."
– Kathryn, Cornwall

Chapter 2: Accountability of NHS hearing aid services

Overview

The most dramatic finding of this report is that Clinical Commissioning Groups (CCGs), the bodies responsible for commissioning and paying for NHS services, are currently ill-equipped to do their job.

At the start of 2019, there were 195 CCGs in England and the overwhelming majority replied to our Freedom of Information (FOI) requests.

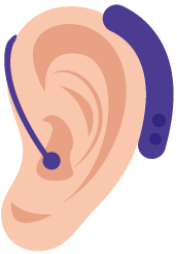
Over nine out of ten CCGs (95%) lacked at least one of the bare minimum pieces of information needed to commission effective audiology services, i.e. how much they are spending; how many hearing aids they are fitting; and whether patients are actually benefiting from the service they receive.

In this chapter, we provide a detailed discussion of how CCGs perform in terms of each of these pieces of information individually, before providing an overall picture.

Without this information, we cannot see how CCGs can effectively commission audiology services. There is huge danger people that with hearing loss are unable to access NHS hearing aids, or obtain high quality services. People's

Nine out of ten CCGs in England don't hold basic information to provide a good audiology service:

How much they are spending



How many hearing aids they are fitting

Whether patients are benefiting

quality of life, their ability to communicate, and possibly even their mental health and cognitive function, are all being put at risk.

2.1 Budgets and spending

Summary

Fewer than 3 in 10 (28%) of CCGs have full budgetary data on their adult audiology spend.

Background

CCGs are the bodies responsible for commissioning, and paying for, NHS services. We wanted to know how much CCGs were spending – and if they were even aware of what they were spending to begin with.

Methodology

As part of our Freedom of Information requests, we asked CCGs to provide data on their audiology spend, including their adult spend and their total (adult and child) audiology spend. We requested the latter as we judged that some CCGs may not be able to provide a breakdown by adult and child spend. To ensure comparability we requested figures in nominal terms. We also asked CCGs whether the data they supplied was complete i.e. represented the spending on all providers they commission or just a sub-set of those providers.

If a CCG either explicitly stated their data was complete, or provided their financial data without any qualifications, we classed them as possessing 'complete adult spending data'. If they were able to supply complete data on their overall audiology (adult and child), but unable to break it down by adult and child spend, we classed it as 'unable to supply an adult breakdown'. If they were only able to provide data from a sub-set of their providers, we classed it as 'partial information', and if they provided no figures, or stated they were unable to, we classed it as 'no information at all'.

Results

Overall, 180 CCGs supplied data in an interpretable form. Fewer than 3 in 10, (28%) were able to provide complete data on their adult spend. Fewer than 3 in 10 (29%) were able to provide overall audiology spend, but were unable to supply an adult breakdown Just over a third (34%) were only able to supply partial information, and just under one in six (9%), were able to supply no information at all.

Spending data held	Number of CCGs	Percentage of CCGs
Complete adult spending data	51	28%
Unable to supply adult breakdown	52	29%
Partial information	61	34%
No information at all	16	9%

Implications

Given CCGs are responsible for commissioning and paying for NHS services, it is shocking that fewer than 3 out of 10 (28%) are able to provide complete adult spending data. In the absence of this data, it is difficult to see how a CCG could ensure that it is getting value for money or whether changes to service design are improving or diminishing efficiency.

NHS mental health service may provide a model for audiology services to follow. NHS England published a mental health dashboard including spending information allowing service users, policy makers and researchers to view budgets at a glance.

Recommendations

CCGs should ensure they have complete data on their audiology spend, covering all providers they commission, which they are able to break down by adult and child spend.

NHS England should require CCGs to collect this data in a uniform way, and publish it centrally.

2.2 Hearing aid fittings

Summary

Just over 1 in 7 (15%) of CCGs in England possess complete data on how many hearing aids they are fitting to adults.

Background

In order to know whether local audiology services are meeting local need, it is vital to know how many people are being fitted with hearing aids. NHS England publishes information on completed audiology pathways [xii], however this provides only a partial picture. People may attend an audiology service, receive an assessment, but not receive hearing aids. This would be classed as a 'completed pathway' but would not accurately reflect whether the audiology service was actually meeting local need[xii].

In order to truly know whether a service is meeting local need, accurate information on the number of hearing aids being fitted is vital.

Methodology

As part of our Freedom of Information requests, we asked about the number of fittings taking place in each CCG area for adults and overall (adults and children) and how many of those were just for one hearing aid (a unilateral fitting) or for two hearing aids – one for each ear (a bilateral fitting).

If a CCG provided figures for the number of hearing aid fittings, broken down by bilateral and unilateral fittings as requested – and either explicitly stated their data was complete, or provided their fitting data without any qualifications, we classed them as possessing 'complete adult fitting data'. If they could provide only the overall number of bilateral and unilateral fittings (adults and children), but unable to divide this by adult and child, we classed that data as 'unable to supply adult breakdown'. If they were only able to provide data from a sub-set of their providers, or could not say how many fittings were unilateral or bilateral, we classed it as 'partial information', and if they provided no figures, or stated they were unable to, we classed it as 'no information at all'.

Results

Overall, 179 CCGs supplied data in an interpretable form. Of these, just over 1 in 7 (15%) provided what appeared to be complete data. 1 in 20 (5%) were unable

to supply an adult breakdown, just under half (45%) provided partial information and just over a third (35%) were unable to supply any information at all.

Hearing aid fitting data held	Number of CCGs	Percentage of CCGs
Complete adult spending data	27	15%
Unable to supply adult breakdown	9	5%
Partial information	80	45%
No information at all	63	35%

Implications

It seems absurd that so many CCGs do not know how many hearing aids are being fitted in their area. They are the bodies responsible for commissioning and paying for NHS services. If they don't know what they are getting for their payments, it is difficult to see how they know they are getting value for money, or to what extent the services they are commissioning are actually meeting local need.

Recommendations

CCGs should require providers collect and send them full information on the number of hearing aid fittings that are taking place – broken down by adult and child, and unilateral and bilateral fittings. This information should be used to help ensure services are meeting local need.

NHS England should require CCGs and/or providers to send information on hearing aid fittings – broken down by adult and child, and unilateral and bilateral fittings – and publish this information centrally.

2.3 Outcome measures

Summary

Fewer than 1 in 4 CCGs (24%) report that their providers collect the full range of outcome data suggested in the Commissioning Framework. Almost half of CCGs (45%) were not aware of any outcome data collection at all. This information is vital for performance monitoring and commissioning quality services.

Background

If a CCG wants to know whether the services it is commissioning are meeting local need, it needs data on patient outcomes. The Commissioning Framework recommends that a range of data is collected, notably:

- Continuation with choice of hearing intervention.
- Reported benefits from hearing intervention.
- Service user satisfaction with their choice of intervention.
- Reduced communication difficulties.
- Improved quality of life.

Collecting this data is vital if a CCG is to know whether people are genuinely benefitting from local audiology services, to identify poor performance, and track the impact of changes to services over time.

Methodology

In our FOI requests, we asked CCGs whether they were aware of the aforementioned outcomes data being collected by the services they commission. If all of the outcomes were being collected, we classified this as 'full data'; if only some was being collected, we classified this as 'partial data', if no data was being collected, or if the CCG was unaware whether any data was being collected or not (and therefore presumably not using it), we classed this as 'no data'.

We also asked if the data was published.

Results

At time of writing this report, 190 CCGs had provided data in an interpretable form on this question. Of these, just under 1 in 4 (24%) reported full data collection, just under 1 in 3 (31%) reported partial data collection, and just under

half (45%) either reported no data was collected, or that they were unaware of any data collection.

Level of outcome data collection	Number of CCGs	Percentage of CCGs
Full data	46	24%
Partial data	58	31%
No data	86	45%

Implications

Under 1 in 4 (24%) reported that their providers were collecting the full range of outcome data suggested in the Commissioning Framework. Furthermore, almost half (45%) of CCGs were not aware of any outcome data collection at all.

This is a huge problem in terms of CCG's ability to commission quality services. If CCGs are not aware of whether patients are genuinely benefiting from the help they have received from an audiology department, they cannot know whether the services they are commissioning, and the money they are spending, is actually helping the target population.

While we know nationally that the overwhelming majority of people who receive hearing aids continue to use them and find them beneficial[xiii], it is unclear whether these overall trends are true in every single area. If hearing aids are not fitted or tuned properly, they may fall into disuse. If aftercare and maintenance services are not adequate, then hearing aids may become ineffective. Without collection of outcomes data, it is impossible for a CCG to know if this is the case in their area.

Full data collection enables CCGs to know:

- If the services they are commissioning are helping people with hearing loss, and whether the hearing aids they pay for are continuing to be used.
- Whether certain providers are delivering a lower quality service than others.
- Whether any changes they make to a service, such as changes to tariff levels, budgets or providers, is improving or diminishing service quality.

The Commissioning Framework refers to three validated outcome tools that could be used for these purposes[xi]. These are the Client Oriented Scale of Improvement (COSI), the Glasgow Hearing Aid Benefit Profile (GHABP), and the International Outcome Inventory for Hearing Aids (IOI-HA). Unfortunately, none of these tools alone measures everything, so the framework suggests at least two are used in combination. It recommends these should be the IOI-HA and one other tool either GHABP or COSI – however, it does not stipulate further. It is likely, therefore, that

even areas that do collect the full range of outcomes may collect data in different ways that are not directly comparable.

The collection of data in a uniform and comparable way across England (or, indeed, the whole of the UK) could confer many advantages over and above those listed earlier. Comparable data would allow:

- CCGs that are failing to commission quality audiology services to be identified.
- The factors that drive quality to be studied at a national level. This would allow, for example, research into how factors like budgets, tariffs or service design contribute to service performance.
- Whether, overall, services across the country are improving or diminishing over time.

Fortunately, other NHS services do collect data in comprehensive and consistent ways and may provide a model for audiology services to follow. For example, the NHS's Improving Access to Psychological Therapies (IAPT) programme for common mental health issues requires (and obtains) almost full data collection from every patient using the exactly the same outcome measures and thresholds across England (the PHQ-9 for depression and the GAD-7 for anxiety)[xiv]. This makes it possible not only to measure access to IAPT, but whether it is actually benefiting the people who use the service.

The data generated by IAPT allows for detailed studies into the drivers of performance[xv], which can be used to make evidence-based recommendations to drive up standards. The headline figures produced by the NHS on IAPT performance are not universally accepted[xvi], however, given the standardised way the data is collected, and the transparency of the data, researchers are able to produce alternative, yet still meaningful analyses.

Recommendations

We recommend that CCGs should require their providers collect all the outcomes data recommended in the Commissioning Framework as part of their contractual requirements.

We recommend that NHS England develop a national audiology outcome framework, consistent across all CCGs and providers. Action on Hearing Loss is happy to offer its assistance to help devise this framework.

We also recommend that this data is published by NHS England - this should include a dashboard of headline measures useful to the public and policy makers, along with more detailed information for researchers.

2.4 Overall information available to commissioners

Summary

Over nine out of ten (95%) CCGs lacked at least one of the bare minimum pieces of information needed to commission effective audiology services.

Background

As discussed in the preceding three sections, CCGs need at least three pieces of vital information if they are to know whether the services they are commissioning are providing value for money and meeting local needs. Those are their spending figures, the numbers of hearing aids that are being fitted and patient outcome data. These represent what we believe to be the minimum necessary information for quality audiology service commissioning.

Methodology

Using the same methodology as in each of the previous three sections, we looked at how many CCGs could supply complete adult fitting data, complete adult spending data and reported full data on outcome collection.

Results

Out of the 168 CCGs who were able to provide interpretable data, only 9 (5%) were able to provide complete data on their adult audiology spend and hearing aid fittings, and stated that their providers collect the full range of patient outcome measures highlighted in the Commissioning Framework. To put this another way, over nine out of ten (95%) CCGs lacked at least one of the bare minimum pieces of information needed to commission effective audiology services.

Five CCGs (3%) were unable to supply any information whatsoever on either spend or number of fittings, nor reported any patient outcome data collection.

Implications

It seems impossible to understand how CCGs can do their job without the information set out above. If they do not have complete information on the

numbers of people they are fitting with hearing aids, then it would appear impossible for them to know whether they are actually meeting the needs of the local population. If they do not have complete information on patient outcomes, then it would appear impossible for them to know if they are offering a quality service that is actually benefiting service users. And if they don't have information on how much they are spending, then it would appear impossible for them to know if they are commissioning cost-effective services.

In order to ensure audiology services are up to scratch, it is essential that CCGs hold data on how services are performing in response to local needs. Our findings suggest that CCGs are not commissioning services based on facts or evidence, or the needs of local patients. Commissioners are displaying grave failure in budgetary and service management.

With little evidence about how many people are being helped, or the quality of the services being offered, hearing aid services will remain exposed to the risk of cuts and rationing, may miss out on crucial additional funding and face changes that are detrimental to patients' long and short-term wellbeing.

Additionally, this systemic lack of oversight on hearing aid services demonstrates that CCGs are still not taking hearing loss and its wider implications for health seriously.

Recommendations

In order to rectify this, we recommend that CCGs should collect key data on the audiology services they commission. At minimum this should cover CCGs' audiology spend, access rates, number of hearing aid fittings, waiting times, and outcome measures.

Nationally, NHS England should require this data be collected in a consistent way and publish the information centrally. Action on Hearing Loss is happy to help with the development of this framework.

Chapter 3: Access

Overview

Our results show that across England just under 1 in 5 people (19%) with hearing loss have accessed an NHS audiology service within the past three years. There is also considerable variation between areas. In the best area, Heywood, Middleton and Rochdale CCG, over half (55%) of people with hearing loss accessed audiology, compared to just 1.3% in the worst, Thurrock CCG.

This is putting at risk people's quality of life, their ability to communicate[v], and possibly even their mental health[iii] and cognitive function[iv].

Background

Of people who have hearing aids, almost three-quarters (73%) receive them via the NHS, making the NHS the dominant hearing aid provider[xvii]. The remainder is made up of private sector provision. Prior work suggests that only around two-fifths (40%) of people who could benefit from hearing aids actually have them (either NHS or private)[xi].

We decided to calculate an audiology access rate in each CCG area by comparing the number of people who were seen by audiology services to the estimated number of people with hearing loss in the same area. We also examined CCG policies that may restrict hearing aid access.

Methodology

To calculate an audiology access rate, we obtained data on the number of people being seen by audiology services by looking at the publicly available Direct Access Audiology statistics published by NHS England. Specifically, we looked at the number of people who completed audiology pathways in each CCG area in the past three years. We compared this to estimates of the number of people with hearing loss in an area based on their demographic profile, which were calculated by Action on Hearing Loss, and have been published and endorsed by NHS England.

For this report, we have used the same threshold for hearing loss as suggested in the NHS England's Commissioning Framework. We also included people who had completed pathways in the last three years, as that is the length of time recommended in the Commissioning Framework before reassessment takes place.

Access rates calculated this way are not perfect, as they measure the number of people completing audiology pathways – that is, the number of people who see an audiology service and get an end result. The end result may be they receive hearing aids, or that they are simply assessed then judged either not to need hearing aids, or not to meet the local criteria to obtain them. Nevertheless, given absence of publicly available data on the number of actual hearing aid fittings, and given the incompleteness of the fitting data we tried to obtain through Freedom of Information requests, these statistics are currently the best available way to assess how audiology services are meeting local demand.

To examine policies that restrict hearing aid access, we asked CCGs whether they applied any thresholds for the level of someone's hearing loss before they could obtain hearing aids.

Results

Across England as a whole, the access rate was just under 1 in 5 (19%). That is, 19% of people with hearing loss had completed an NHS audiology pathway in the past three years. However, this hides huge variation that occurs area by area.

In the best area, Heywood, Middleton and Rochdale CCG, over half (55%) of people with hearing loss accessed audiology, compared to just 1.3% in the worst, Thurrock CCG.

Worst areas

CCG	Access Rate
Thurrock CCG	1.3%
Bromley CCG	2%
East and North Hertfordshire CCG	3%
Fylde and Wyre CCG	3%
Blackpool CCG	4%

Best areas

CCG	Access Rate
Heywood, Middleton and Rochdale CCG	55%
Bury CCG	45%
Swindon CCG	39%
Berkshire West CCG	38%
Crawley CCG	37%

We also identified three CCGs that are deliberately choosing to restrict access to hearing aids. North Staffordshire CCG, Dorset CCG and Cambridgeshire & Peterborough CCG all require a high threshold of hearing loss before hearing aids are provided, which means that hearing aids are not provided to all those who would benefit from them.

This is contrary to NICE guidance, which states that provision of hearing aids should be based on need, not threshold alone.

Implications

The results indicate that access to NHS audiology services remains low overall, but with considerable variation area by area.

On a national level, there is evidence to show the main barriers to people accessing audiology services. These include failure for people with hearing loss to seek help – which could be due to failure to identify they have hearing loss, low levels of knowledge that the NHS provides free hearing aids, or embarrassment about wearing them[xvii]. This could be tackled through public awareness campaigns – perhaps through integrating hearing loss into Public Health England's 'One You' campaign[xviii] if it were extended to older people. It

could also be tackled through some form of screening and health advice programme – for example, integration into the NHS Health Check[xix].

There is also evidence that once people do come forward to get help, GPs often fail to make onward referrals to audiology services. A Health Technology Assessment found that, of those who have consulted their GP about hearing, just under two-fifths (38%) also went for audiological assessment[xx]. At Action on Hearing Loss, we are currently working with the Royal College of GPs to provide materials and events to GPs in order to raise GP awareness of hearing loss and encourage appropriate onward referrals.

However, is not clear why access rates differ so dramatically area by area – and this is something that should be subject to further study. It is possible that people present at different rates in different areas – perhaps people's willingness to seek help, their knowledge of the free availability of NHS hearing aids, or their experience of stigma may differ area by area. It is also possible rates of GP referral vary area by area due to differing knowledge of understanding of hearing loss.

Another possibility, which we cannot fully rule out, is that some CCGs are simply not sending correct or full data to NHS England – despite their requirements to do so.

There are currently no national targets or recommendations for what CCGs should aim for in terms of access to audiology. However, there are models that can be drawn upon from other NHS services – such as mental health services. The NHS's Improving Access to Psychological Therapies (IAPT) programme, originally had an access rate target of 15%. That is, 15% of people experiencing common mental health issues should be seen by their local IAPT service – this target is now being met and exceeded. A new target that IAPT services should meet 25% of local need by 2020/21 is now in place[xxi]. Potentially, this could be used as a model for audiology services.

Recommendations

In order to improve access rates to audiology, we suggest a number of policies for Public Health England, NHS England and CCGs themselves.

We recommend Public Health England publicise the benefits of hearing aids, their free availability on the NHS and the dangers of leaving hearing loss unaddressed. They should also help ensure people are screened for hearing loss, and receive health information about hearing loss (for example, through the NHS Health Check).

Action on Hearing Loss will also explore national levers and policies to drive up access rates to, and the quality of, audiology services. We call on NHS England to consider and act upon those recommendations.

Also irrespective of any national policies that may or may not be implemented, it is vital that CCGs prioritise improvement of their audiology access rate. Any policies that deny the provision of hearing aids to those who could benefit from them should be abolished. This should be an immediate first step for CCGs with such policies, such as North Staffordshire. Requiring providers to meet certain numbers may be another step, which could include advertising the availability of services.

NHS England should also push CCGs to abolish policies that restrict access to hearing aids.

Chapter 4: Adherence to national guidance

Overview

In order to ensure people with hearing loss are helped as effectively as possible, it is vital that audiology services operate in accordance with the best available evidence. Fortunately, considerable guidance is already available to CCGs on how to do this.

Currently, the key relevant guidance consists of NHS England's Commissioning Framework[xi] which sets out how audiology services should be designed, and NICE guidance[vii], which sets out what treatments and interventions should be offered. This is soon to be augmented by guidance on how local areas can conduct Joint Strategic Needs Assessments (JSNAs) for people with hearing loss. JSNAs help local areas to plan services to meet local levels of need.

In order to assess whether CCGs are actually adhering to this, we examined a few key factors:

- whether ear wax removal services are being commissioned properly;
- whether waiting time targets and recommendations are being met;
- whether people are being offered bilateral fittings (two hearing aids - one for each ear);
- whether audiology tariffs (the amount the CCG pays providers per procedure) are in line with guideline amounts;
- and whether CCGs actually have a policy on implementing NICE guidance.

Both the NICE guidance and the Commissioning Framework state that CCGs should commission a wax removal service, and people should be able to access this in primary care.

In terms of waiting times, the Commissioning Framework recommends that referral to fitting should take place within 36 working days (approximately seven weeks). Furthermore, NHS England publishes data on how many people receive referral to treatment times in 18 weeks, which is the NHS's general waiting time target set out in the NHS Constitution[xxii] for consultant-led care. While most people who are helped by audiology services do not receive care led by a consultant, the 18-week threshold remains a useful benchmark.

In term of bilateral fittings, the Commissioning Framework states that, *"If hearing aids are recommended as the preferred intervention, people generally benefit from being offered 1 for each ear (bilateral) unless there are reasons that this is inappropriate."*

In terms of tariffs, the Commissioning Framework sets out guideline, but non-mandatory, prices for procedures like audiology assessment, the fitting of hearing aids (both unilateral and bilateral), and aftercare and repairs.

4.1 Wax removal services

Summary

Just over half of CCGs (54%) commission a wax removal service provided free of charge on the NHS. However, a large number do not, and one CCG even reported there were charges for wax removal.

Background

Ear wax is a cause of temporary conductive hearing loss. Every year, around 2.3 million people in the UK are affected seriously enough to require some kind of intervention[xi]. It is also a significant cause of inappropriate referrals to audiology services[xi] – which focus on the fitting of hearing aids rather than wax removal.

Both NHS England's Commissioning Framework, and NICE guidance recommend that wax removal takes place in primary care.

Methodology

As part of our freedom of information requests, we asked CCGs if they commissioned wax removal services and whether those services were provided for free or whether people were charged to use them. We used five classifications 'available on NHS for free', 'partly available on NHS for free', 'available on NHS for a charge', 'not commissioned' and 'CCG did not know'. All the classifications are self-explanatory apart, perhaps from, 'partly available on NHS for free'. This is where the CCG responded to say that, for example, some GP surgeries in their area did provide this service, but it was not available at every GP surgery.

Results

Overall, 191 CCGs provided responses that we were able to interpret at the time this report was written. Of these, 103 CCGs stated they commissioned wax removal services, and these were available on the NHS for free. A further four CCGs indicated that wax removal was partly available on the NHS for free in their area. Worse, however, North Hampshire CCG stated that they provide a wax removal but people are charged to use it. This appears to be in violation of the core principle, set out in the NHS constitution, that access to NHS services should be on the basis of clinical need, not an individual's ability to pay.

In 43 other areas, no wax removal service was commissioned at all.

Absurdly, in the remaining 41 cases the CCG – the body responsible for commissioning – did not know, or at least was unable to say, whether or not it commissioned a wax removal service.

Wax removal service	Number of CCGs	Percentage of CCGs
Available on the NHS for free	103	54%
Partly available on NHS for free	4	2%
Available on NHS for a charge	1	0.5%
Not commissioned	43	23%
CCG did not know	41	22%

Percentages do not quite sum to 100% due to rounding

Implications

Wax is a significant cause of temporary hearing loss and a major source of inappropriate referrals to audiology services. Unfortunately, only just over half of CCGs (54%) were able to confirm they commissioned a wax removal service and that it was available to people for free. In almost 1 in 4 CCGs (23%) no wax removal service was commissioned. Similarly, almost 1 in 4 (22%) simply did not know whether they commissioned one. The former goes against NICE recommendations and the Commissioning Framework. The latter reinforces our point that many CCGs lack even basic knowledge about the services they commission and pay for.

The lack of access is likely impacting on many people's lives directly, and also consuming valuable time in audiology services.

Recommendations

All CCGs should implement the recommendations in the NICE guidance and Commissioning Framework and ensure they commission wax removal services, ideally provided in primary care.

4.2 Waiting times

Summary

Across England, well over 9 out of 10 (93%) people are waiting less than 18 weeks from referral to treatment. Furthermore, in almost three-quarters of cases (74%), people are being seen in under seven weeks, the recommended waiting time set out in NHS England's Commissioning Framework.

However, there is huge variation between areas. In Corby CCG, for example, everyone is seen within seven weeks; however, in Fareham and Gosport, almost 6 in 10 people (58%) were waiting over 18 weeks.

Background

In England, the NHS Constitution sets out that people have the right start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions.

The Commissioning Framework recommends a slightly more stringent target, suggesting people's wait from referral to fitting should take place within 36 working days, or approximately seven weeks.

We looked at how audiology services in different CCGs are performing against these times.

Methodology

The Direct Access Audiology statistics produced by NHS England provide a breakdown of how long people have been on waiting lists for NHS services. We looked at the data for uncompleted pathways – that is, the people who were still on the waiting list to be seen by an audiology department.

We compared the number of people trying to access audiology services who had been waiting over seven and over 18 weeks to the total number of people on the waiting list in each CCG area. We used the most recently available data at the time of writing (from February 2019).

Results

Fortunately, across England, well over 9 out of 10 (93%) people are waiting less than 18 weeks. This means, while there is still room for improvement, most people trying to access NHS audiology services are able to do so in line with the general NHS benchmark.

Performance looks slightly worse if the more stringent recommendation set out in NHS England's Commissioning Framework is used as a benchmark. The Commissioning Framework suggests a referral to fitting time of 36 working days, or approximately seven weeks. Across England, almost three-quarters (74%) of people are being seen in under seven weeks.

Unfortunately, there are dramatic differences between CCG areas on performance. In Portsmouth, for example, the 18-week threshold was being exceeded in almost 6 in 10 cases (58%), in other areas, such as Corby CCG, nobody was waiting longer than seven weeks.

Worst areas

CCG	% Waiting longer than 18 weeks	% Waiting longer than 7 weeks
Fareham and Gosport CCG	58%	75%
South Tyneside CCG	56%	74%
Portsmouth CCG	53%	72%
Sunderland CCG	53%	72%
South Eastern Hampshire CCG	52%	70%

Best areas

CCG	% Waiting longer than 18 weeks	% Waiting longer than 7 weeks
Corby CCG	0%	0%
Halton CCG	0%	0%
St Helens CCG	0%	0%
West Kent CCG	0%	0.6%
Warrington CCG	0%	0.7%

Implications

The results show that most people accessing NHS audiology services are able to do so within the 18-week NHS standard, and the more stringent seven week recommendation set out in the Commissioning Framework. However, in some areas of the country, waiting times are dramatically longer.

While the reasons for this variation are not completely clear, we have received some insight from directly contacting some of the areas involved. Portsmouth CCG has cited staffing difficulties as the reason behind the long waiting times.

Recommendations

We call on CCGs to work to ensure the services they commission enable all people to access audiology services within 18 weeks. Those that are already meeting this requirement should then aim higher and meet seven week recommendations set out in the Commissioning Framework. Meeting waiting-time targets should not be at the expense of the quality of the audiology services provided.

4.3 One hearing aid or two

Summary

Most people in England area able to obtain two hearing aids – one for each ear. Just over 7 out of 10 (72%) fittings are for two hearing aids. However, in some areas, performance is considerably worse.

Background

Most people with hearing loss experience issues in both ears – and people generally benefit from receiving a hearing aid in each ear rather than just one. This approach is endorsed both by NHS England's Commissioning Framework and NICE guidance. To quote from the Commissioning Framework:

"If hearing aids are recommended as the preferred intervention, people generally benefit from being offered 1 for each ear (bilateral) unless there are reasons that this is inappropriate. Fitting of bilateral hearing aids is beneficial as many modern hearing aids interact with each other to offer greater improvement in speech discrimination in everyday environments. It is estimated that in people aged 50 and over the bilateral fitting rate might range between 85 percent and 90 percent…"

In this section, we examine to what extent audiology services in different CCG areas are providing people with two hearing aids.

Methodology

As part of our Freedom of Information requests, we asked about the number of fittings taking place in each CCG area and how many of those were just for one hearing aid (a unilateral fitting) or for two hearing aids – one for each ear (a bilateral fitting). From this we calculated the percentage of fittings that were bilateral and unilateral.

Results

68 CCGs provided at least some data on their hearing aid fittings that could be broken down by unilateral and bilateral fittings for adults. Across those CCGs, over 7 out of 10 (72%) people received bilateral fittings and almost 3 out of 10 (28%) received unilateral fittings (i.e. only received a hearing aid for one ear).

However, there was large variation between CCGs. Of those CCGs that supplied data, the highest percentage of bilateral fittings was Herefordshire, where such fittings were received by over 19 out of 20 people (96%). However, that was

based on incomplete data. The area with highest percentage with complete data on adult fittings was Blackburn and Darwen, was almost 19 out of 20 (93%) bilateral fittings.
The lowest levels were Coventry and Rugby where only just over 1 in 20 people (7%) received bilateral fittings – despite the fact that the data was complete, and the CCG told us that it had a policy that two hearing aids are always offered when adults have an aid-able hearing loss in both ears.

The lack of data supplied by many CCGs may, however, hide other problem areas. Some CCGs, such as Croydon, Gloucestershire, and Sheffield CCGs stated that they had policies that favoured the fitting of one hearing aid only – but were unable to supply data on the actual number of adults who received unilateral and bilateral fittings. It is likely these areas also performed poorly in terms of the percentage of bilateral fittings.

Worst areas

CCG	Percentage of fittings that are bilateral
Coventry and Rugby CCG	7%
Warwickshire North CCG	8%
Greenwich CCG	11%
Hull CCG	15%
Medway CCG	19%

Best areas

CCG	Percentage of fittings that are bilateral
Herefordshire CCG	96%
North East Hampshire and Farnham CCG	96%
Kernow CCG	95%
East Staffordshire CCG	94%
Blackburn and Darwen CCG	93%

Implications

Most people trying to access hearing aid services in England are able to obtain bilateral hearing aids, in line with the recommendations set out in NICE guidance and the Commissioning Framework. It is worrying, however, that in some areas people are being denied access to bilateral fittings.

Recommendations

We call for all CCGs to commission services that provide bilateral fittings as the norm (two hearing aids – one for each ear) in line with the recommendations in the Commissioning Framework and NICE guidance.

4.4 Tariffs

Background

Many CCGs use a tariff system to pay for audiology services. That is, they pay their providers per procedure performed. This would usually be a certain payment for just giving someone a hearing assessment, other payments for assessing and fitting one or two hearing aids, and an amount for aftercare and maintenance.

Unlike for some services provided by the NHS, there is no nationally mandated tariff for audiology services. However, reference tariffs for audiology were included in the 2016/17 National Tariff Payment System (NTPS) and listed in the Commissioning Framework. These non-mandatory reference tariffs are set out below.

Tariff item	Reference tariff price
Audiology hearing aid assessment only	£53
Pathway for hearing aid assessment, fitting of one hearing aid device, cost of one device and first follow up	£268
Pathway for hearing aid assessment, fitting of two hearing aid devices, cost of two devices and first follow up	£370
Hearing aid aftercare (repairs)	£25

We looked at the tariffs CCGs were actually using, how these compare to the reference tariffs and how they have changed over time.

Methodology

As part of our Freedom of Information requests, we asked CCGs for their tariffs for each of the last three years under the same headings as those in the reference tariffs. For the purposes of our analysis, we have looked only at CCGs which are using the same tariff structure as the reference tariffs. Other CCGs paid providers in different ways – such as paying different amounts by kind of hearing aids, or grouping hearing aids provision and aftercare together, or using block payments. We have excluded those CCGs from this analysis due to lack of comparability.

Results

73 CCGs supplied information on their tariffs for 2015/16 and 2018/19 and also used a tariff structure that matched with the reference structure across that time period. How the average tariffs across those CCGs compare to the reference tariff is set out in the table below.

Tariff item	Reference tariff price	Average reported tariff 2018/19	Average reported tariff 2015/16
Audiology hearing aid assessment only	£53	£51.10	£50.65
Pathway for hearing aid assessment, fitting of one hearing aid device, cost of one device and first follow up	£268	£257.82	£267.38
Pathway for hearing aid assessment, fitting of two hearing aid devices, cost of two devices and first follow up	£370	£356.78	£366.89
Hearing aid aftercare (repairs)	£25	£26.14	£26.68

As can be seen, in all areas except aftercare, the average tariffs CCGs used in 2018/19 are below the reference tariffs. Also, again in all areas but hearing aid assessment, average tariffs have reduced between 2015/16 and 2018/19.

As in most aspects of our research, there was considerable variation between different areas. The CCG with the lowest tariffs for assessments and fittings was Shropshire CCG. The CCG with the lowest tariff for aftercare was Bassetlaw CCG. Conversely, the CCG with the highest tariff for fitting two hearing aids was Wiltshire CCG, the highest for one hearing aid was Islington (joint 1st with Haringey CCG). The highest for aftercare was Blackburn and Darwen CCG and the highest for assessment was Great Yarmouth and Waveney CGG.

The variation is shown in the table below. Where a CCG has the lowest recorded price for a tariff item, it is highlighted in red and where a CCG has the highest recorded price for a tariff item, it is highlighted in green.

Shropshire CCG	Bassetlaw CCG	Wiltshire CCG	Islington CCG	Blackburn and Darwen CCG	Great Yarmouth and Waveney CCG
Audiology hearing aid assessment only					
£18	£63.95	£55	£64.31	£53	£72.96
Pathway for hearing aid assessment, fitting of one hearing aid device, cost of one device and first follow up					
£114	£248.03	£294	£338.19	£268	£299.03
Pathway for hearing aid assessment, fitting of two hearing aid devices, cost of two devices and first follow up					
£179	£338.71	£584	£474.82	£370	£412.59
Hearing aid aftercare (repairs)					
£25	£9.94	£49	£31.57	£68	£39.55

Implications

On average, CCGs use lower tariffs than the reference values set out in the 2016/17 National Tariff Payment System (NTPS). Tariffs were lower in 2018/19 than in 2015/16. Also, there is considerable difference in tariff payments between areas.

It is unclear whether the areas with low tariffs are offering a lower quality of service than those with higher tariffs, or whether they are simply more efficient. Without comprehensive and uniform data collection, including on patient outcomes, this is very difficult to assess on a national level. CCGs may, however, be able to track this on a local level if they have locally comparable data before and after the change.

Recommendations

As set out in section 1.3 on Outcome Measures, CCGs should aim to collect the full range of data recommended in the Commissioning Framework. This data can be used to track the impact of tariff changes over time. If, for example, a reduction in a tariff leads a poorer quality service, the tariff level should be reviewed.

Nationally, we believe the lack of ability to judge whether lower tariffs represent poorer service or better efficiency reinforces our call for uniform data collection and publication.

4.5 NICE guidance

Summary

Almost 6 out of 10 (59%) of CCGs indicated they lacked a policy for implementing the NICE guidance on hearing loss published in 2018.

More than half of CCGs lack a policy for implementing NICE guidance on hearing loss

Background

The National Institute for Health and Care Excellence (NICE) produces evidence-based guidance and advice to improve health and social care. In 2018 it published guidance on hearing loss in adults.

The guidance makes a number of recommendations, including that people with hearing loss should be referred to an audiology service; that people with aid-able hearing loss in both ears should receive two hearing aids; and wax removal should take place in primary care. The guidance also recommended that organisations carry out a baseline assessment against the recommendations to find out whether there are gaps in current service provision.

We wanted to know to what extent CCGs were facilitating the implementation of that guidance.

Methodology

We asked CCGs if they had a policy on the implementation of the NICE guidance. We also gave space for comments if they wanted to elaborate on their answer. We classed CCGs as having a 'specific policy' on implementation if they simply answered 'yes' to the question, or if they indicated they required audiology providers to adhere to NICE guidance in their contracts or service specifications. We classed CCGs as having a 'general policy' if they stated they required all their providers (not just audiology services) to apply relevant NICE guidance. CCGs were classed as having no policy if they simply answered 'no', left the question unanswered, or indicated that while they would look at this matter in future, at present they had no policy in place.

Results

At time of writing, 191 CCGs had supplied results to this question in an interpretable form. Of these, just under 3 in 10 (28%) had a specific policy on NICE guideline implementation and a further 1 in 8 (13%) had a general policy. Unfortunately, 113 CCGs (59%) had no policy. Combining the specific and general policies totalled 76 CCGs or 41%.

Policy towards NICE guidance	Number of CCGs	Percentage of CCGs
Specific policy	54	28%
General policy	24	13%
No policy	113	59%

Implications

Most CCGs (59%) do not appear to have a policy on implementing NICE guidance. This is disappointing, while adherence to NICE guidance is not mandatory, the guidance is authoritative and based on a comprehensive assessment of the available evidence. If CCGs are to keep pace with evidence and best practice, is it important that NICE guidance is used.

NHS England could help CCGs implement the NICE guidance and other national guidance by promoting the existing guidance in a way that is easy to use and access.

Recommendations

CCGs should require providers to adhere to NICE guidance - for example, by including specific reference to NICE guidance in service specifications or contracts.

CCGs should also carry out a baseline assessment of how the services they commission are performing against NICE guidance.

NHS England should develop and roll out a quick glance good practice guide for CCGs and other NHS bodies, providing an introduction to the resources that are available around hearing loss such as NICE guidance, the Commissioning Framework, and the forthcoming Joint Strategic Needs Assessment (JSNA) guide.

Chapter 5: The future of hearing aid technology

The current system

In this report we have set out a number of actions that CCGs and NHS England could take to improve audiology services. These proposals could be implemented relatively quickly. In the slightly longer term, we believe there is scope for more radical changes to audiology services.

New hearing technology is emerging which we believe could provide significant benefits to patients, significant efficiencies within the audiology pathway, and allow for improved access rates.

When someone has suspected hearing loss, they attend an audiology service in person, where tests are conducted such as ear examination (otoscopy) and hearing testing (audiometry). If hearing loss is confirmed, the person is then fitted with hearing aids which are then tuned. People often then re-attend in person for a follow-up appointment where re-tuning may be conducted in order to optimise performance[xi].

For the patient, this can involve making multiple journeys, perhaps at inconvenient times, to an audiology service. For the service itself costs are incurred in equipment, premises and staff time – and disruption may occur if people miss appointments. New technology could help resolve these issues.

Ear examination and hearing testing

Currently expensive equipment is required to perform ear examination and hearing testing. However, regarding the examination, it is now possible to use disposal attachments for smartphones which are relatively cheap and can be used at home, in GP surgeries or pharmacies. The images are then sent to an audiologist who can review them remotely. With respect to hearing testing, it is now possible to perform these tests via the internet or smartphone apps combined with simple headphones.

For the NHS, this presents an opportunity to reduce equipment costs. Also, for some patients at least, this would negate the need to attend an audiology service in person (although the option of attending an audiology service must remain for patients who are less comfortable or less able to use the new technology).

Premises

If fewer people need to attend audiology services in person, and the equipment used for ear examination and hearing testing can be used in more flexible settings, this provides an opportunity to reduce premises costs. Rooms currently dedicated for audiology use could be freed for other purposes or used as flexible spaces by a range of NHS activities.

Better use of audiologist time

It currently takes 90 to 150 minutes of an audiologist's time to assess and fit someone with hearing aids. A trial in Berkshire has suggested that, using certain new technology, audiologist time could be reduced to as little as 30 minutes[xxiii]. Self-fitting hearing aids are also coming on to the market, which could further automate the process.

For patients who are comfortable with new technology and have the capability and dexterity, these could provide significant benefits in terms of convenience and their ability to take charge of their own health. However, the option of attending an audiology service must remain for patients who are less comfortable or less able to use the new technology.

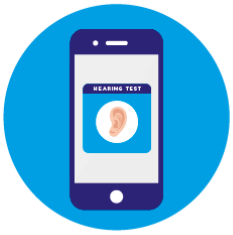
Reduction in missed appointment costs

Currently people usually have to attend audiology services in person at specific times for assessments, fitting and tuning. The venues are not always easy to get to, and people can experience transport delays and other issues. These can all add up to missed appointments, which are a drain on time and resources. Conducting parts of the process (or perhaps the whole process) remotely would make access more convenient for service users, and in some cases, remove the need for specific appointment times. If ear examination can be conducted remotely, for example, the ear images can simply go to an audiologist's inbox and be dealt with flexibly.

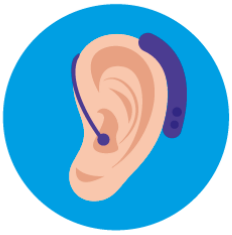
We believe the cumulative impact of these changes would make services more convenient and accessible to patients and lead to cost savings and efficiencies within audiology services.

New technology could revolutionise the hearing aid pathway.

Ear Inspection
Ear inspection can be conducted with disposable attachments for smartphones, and the images sent to audiologists remotely.



Hearing Test
Hearing tests can be conducted via smartphone apps.



Hearing aids
Self-fitting hearing aids are coming on to the market.

Tuning
Audiologists can tune hearing aids remotely, without the need for someone to attend an audiology department.

Recommendations

Given that these new technologies are beginning to enter the market, and their potential to improve the efficiency of NHS services, enhance patient experience, and boost access rates, we believe NHS England should facilitate a trial of new technology within audiology services.

Chapter 6: Conclusions and full recommendations

The overall picture

Overall, our report paints a worrying picture. Hearing aids are a lifeline for huge numbers of people across the UK, however, the bodies that commission and pay for NHS hearing aid services are ill equipped to do their job. With little evidence about how many people are being helped, or the quality of the services being offered, hearing aid services will remain exposed to the risk of cuts and rationing, may miss out on crucial additional funding, and face changes that are detrimental to patients' long and short-term wellbeing.

Additionally, this systemic lack of oversight on hearing aid services demonstrates that CCGs are still not taking hearing loss, and its wider implications for health, seriously.

CCGs must raise their game, and NHS England must ensure they do.

Furthermore, too few people are accessing audiology services, and are missing out on the benefits that hearing aids can bring. CCGs and other bodies must strive to increase access rates. Unless they do so, people's quality of life, their ability to communicate, and possibly even their mental health and cognitive function is being put at unnecessary risk.

Although national guidance exists for commissioning audiology services, there is a concerning picture on adherence. If patients are to receive the best possible help, in accordance with the best available evidence, it is vital that national guidance is adhered to.

Finally, in the longer-term, new technology may provide a way to empower patients, make audiology services more accessible, and lead to important cost savings and efficiencies within services.

Full recommendations

CCGs should:

- Collect key data on the audiology services they commission. At minimum, this should cover CCG's audiology spend, access rates, number of hearing aid fittings, waiting times, and outcome measures.

- Prioritise improvement of their audiology access rate. Any policies that deny the provision of hearing aids to those who could benefit from them should be abolished. This should be an immediate first step for CCGs with such policies, such as North Staffordshire. Requiring providers to meet certain numbers may be another step, which could include advertising the availability of services.

- Ensure they are commissioning NHS services in line with NICE guidance and NHS England's Commissioning Framework, and make use of other national guidance such as the forthcoming Joint Strategic Needs Assessment (JSNA) guidance.

- Carry out a baseline assessment of their audiology provision against NICE and Commissioning Framework recommendations to find out whether there are gaps or omissions in current service provision.

- Abolish any charges associated with audiology services (such as wax removal).

NHS England should:

- Push CCGs to abolish policies that restrict access to hearing aids, and promote the implementation of NICE guidance and the Commissioning Framework.

- Require uniform data collection in audiology services, and ensure this is published in an easy to use dashboard. At minimum, this should cover audiology spending, access rates, hearing aid fittings, waiting times, and outcome measures. Action on Hearing Loss is happy to help develop a framework for this.

- Develop and roll out a 'quick glance' good practice guide for CCGs and other NHS bodies, providing an introduction to the resources that are available around hearing loss such as the Commissioning Framework, NICE guidance, and the forthcoming Joint Strategic Needs Assessment (JSNA) guide.

- Review and implement recommendations to drive up access rates to, and the quality of, audiology services.

- Facilitate a trial of new technology within NHS audiology services to maximise efficiency.

Public Health England should:

- Publicise the benefits of hearing aids, their free availability on the NHS and the dangers of leaving hearing loss unaddressed.

- Help ensure people are screened for hearing loss, and receive health information about hearing loss (for example, through the NHS Health Check).

Action on Hearing Loss will:

- Challenge cuts to audiology and areas with low performance.

- Push to raise awareness in CCGs about the importance of audiology, including publicising how efficiencies can be made.

- Push NHS England and the Department of Health and Social Care to require uniform data collection in audiology.

- Work with the Royal College of GPs to address gaps in GP knowledge and awareness.

- Explore national levers and policies to drive up access rates to, and the quality of, audiology services.

- Explore the role new technology could play in helping the NHS deliver better quality and more efficient hearing aid services.

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