NHS hearing aid services

Commissioning guidelines

Introduction

Hearing aids are one of the smallest per-capita cost healthcare services, yet they can significantly improve quality of life. One in seven of the population has a hearing loss and 55% of people over 60 are deaf or hard of hearing. RNID estimates that in addition to the 1.5 million people in England who have hearing aids, a further 3.3 million people could benefit from them.

NHS audiology services need to be commissioned more effectively in order to provide an efficient and timely service to those who could benefit from a hearing aid.

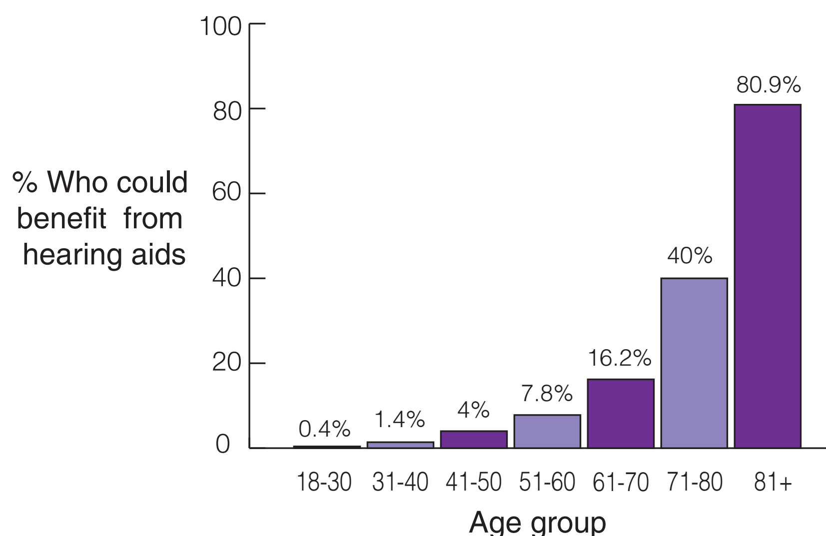
Who are these guidelines for?

You will find these guidelines useful if you are a PCT commissioner. They provide you with up-to-date information about hearing aid services in order to support effective commissioning.

Assessing needs

The estimated percentage of adults who need hearing aids, broken down by age group, is as follows:

Using these statistics, you can estimate the likely number of people in your local population who need hearing aids. However, past experience has shown that on average, only a third of people who could benefit from a hearing aid are likely to actually request one, so do take this into account when calculating actual demand. Bear in mind, too, that demand for hearing aid services may rise in the future, as more people become aware of the many benefits of wearing a hearing aid.



Based on prevalence by age group of an average hearing loss (in the better ear) of 35dB or greater (data from the Medical Research Council)

Commissioners should note that 95% or more of people referred for hearing assessment require hearing aids.

RNID

Changing the world for deaf and hard of hearing people

Why commission hearing aid services separately?

Audiology departments:

- provide diagnostic support to ear, nose and throat (ENT) services
- offer hearing aid services.

They may also provide other more specialised services, such as tinnitus, balance problems and cochlear implant clinics. Hearing aid services form a large proportion of most audiology departments' work, but since they involve continuing care for all hearing aid users, they do not sit easily within the secondary care model. In some areas, they are provided by the PCT.

Commissioning hearing aid services separately from ENT may make it easier to monitor the quality and performance of the service and to judge its value for money, as it will not be hidden within undifferentiated contracts for ENT and associated services. Although direct referrals to audiology are excluded from the 18-week patient pathway target, they are still subject to the diagnostics milestone targets. There is therefore a risk that patients may have their hearing assessed quicker, but may then have to wait longer to have their hearing aid fitted (as this is not subject to the waiting times target). This is not an effective use of resources and would not improve the patient experience. Commissioning hearing aid services separately would mean that PCTs could monitor their performance more accurately to ensure that the patient experience is improved.

Commissioning an effective hearing aid service

Health reform in England: update and commissioning framework: *Annex - the commissioning framework (2006)* states that effective commissioning “makes the best use of allocated resources to achieve the following goals:

- Improve health and well-being and reduce health inequalities and social exclusion.
- Secure access to a comprehensive range of services.
- Improve the quality, effectiveness and efficiency of services.
- Increase choice for patients and ensure a better experience of care through greater responsiveness to people's needs.”

This is achieved through a commissioning cycle that includes the following elements:

- Assessing needs.
- Reviewing service provision.
- Deciding priorities.
- Designing services.
- PCT prospectus.
- Shaping the structure of supply.
- Managing demand and ensuring appropriate access to care.
- Clinical decision-making.
- Managing performance.
- Patient and public feedback.

Reviewing service provision

You should assess services in relation to the standards set out under Performance management (see later) and the current waiting times in order to identify requirements for your service's development. We also recommend that you collect regular feedback from users of hearing aid services to measure their satisfaction with the service, and identify areas for improvement.

Designing services

A modern hearing aid service should use up-to-date equipment to fit high specification, good quality digital hearing aids to agreed protocols, in convenient locations, and make full use of the department's skill mix.

Shaping the structure of supply

There are several ways of increasing the capacity within departments when shaping the structure of supply. These include:

- Using a telephone follow-up service, such as Hearing Direct, to reduce the number of follow-ups in the department by up to a third.
- Considering flexible working patterns for staff, which would enable a more efficient use of fixed resources (such as equipment and rooms).
- Making full use of skill mix – for instance, using audiology assistants to carry out tasks that don't require an audiologist.

As well as this, you may choose to use alternatives to NHS provision, such as the PPP national framework contract for contracting with private sector hearing aid dispensers. However, when contracting with agencies outside of the NHS, ensure that quality standards are maintained, and that you commission ongoing lifelong care, not just discrete episodes of assessment and provision.

Managing demand and ensuring appropriate access to care

It is essential that patients have timely access to a hearing aid service. In particular, for patients over the age of 60, direct referrals to the hearing aid service can save patients' time, and the health service money, by avoiding unnecessary appointments in ENT.

Direct referrals are a more efficient route for patients over 60, and are a significant achievement of a modernised service. The 18-week waiting time target applies to ENT as a whole, but only to the diagnostics element of audiology. Therefore, hearing aid services need to be resourced sufficiently to ensure that waiting times are reduced in audiology, so as to avoid a situation where patients are referred back to ENT again to avoid lengthy waits. This would not be a good service for patients, and would waste resources in ENT. This risk was recently acknowledged in *The NHS in England: operating framework for 2007/08 (p9 2.10)*.
PCTs were advised to 'commission sufficient direct access activity in these areas to substantially reduce waits – for audiology and hearing aid fitting in particular.'

Clinical decision making

GPs should be provided with comprehensive information about local hearing aid services (such as current waiting times) on a regular basis, so that they can provide good and accurate advice to any of their patients who need a referral to the hearing aid service.

Costs

Hearing aid services/audiology are not currently included in the national tariff and are therefore not within the scope of payment by results. The National Schedule of Reference Costs for 2005 gives the following indication of costs for appointments:

Provider	Appointment type	National average unit costs (£)	Interquartile range of unit costs (£)	
			Lower quartile	Upper quartile
NHS Trust	Assessment	55	29	74
	Fitting	68	37	78
	Follow-up	44	20	56
	Repairs	22	13	32
PCT	Assessment	56	51	120
	Fitting	59	47	119
	Follow-up	87	46	154
	Repairs	26	18	37

The cost of the digital hearing aids (capital costs) is determined through national contracting carried out by the NHS Purchasing and Supply Agency. Costs of digital aids range from £55 to over £100 for high power aids (needed for people with severe or profound hearing loss), but they are renegotiated regularly, so do change.

Performance management

This is a key part of the commissioning cycle. Here are suggestions of key indicators that you might use to monitor performance by the service provider:

- Number of patients (by category ENT/DR (direct referral)/reassess) assessed in month.
- Number of patients (by category ENT/DR/reassess) fitted in month (indicate bilateral/unilateral fitting).
- Number of patients (by category DR/reassess) with follow-up completed in month.
- Number of additional ad-hoc appointments in month.
- DNA rate.
- Current waiting time for first appointment.
- Current waiting time between first appointment (DR) and fitting.
- Current waiting time between fitting and follow-up.
- Number of patients waiting (DR and reassessment).
- Repair activity.
- Number of referrals to volunteer support service/hearing therapy/other as applicable.

As well as these performance indicators, it may also be helpful to know what best practice standards service providers should be adhering to. *Best practice standards in adult audiology* and published in 2002 was produced by a taskforce led by RNID. Here are the key points from the document with respect to hearing aid provision.

Hearing aid services should include the following procedures:

- Direct referral to audiology for hearing aid(s).
- Domiciliary or residential care hearing aid provision.
- Full audiometric tests and assessment of everyday hearing and communication needs.
- Provision of hearing aids to meet individual needs, fitted according to agreed protocols, including verification of fit using real ear measurement.
- Information and advice on use of the hearing aids provided.
- Information on further local support available and other relevant products or services.
- Follow-up interview and fine-tuning as required.
- Measurement of patient outcomes.
- Onward referral to specialised services for associated conditions/needs (for example, tinnitus, balance problems, coping with sudden hearing loss).
- Accessible, rapid service for provision of batteries, troubleshooting and hearing aid repairs.
- Hearing aid reassessment/review.

Service standards

Staffing levels and resources required will depend on the service model adopted, but in all models the following service standards should be met, in order to ensure that a quality service is provided. Services should be resourced to enable the following standards to be met.

- The appointment length should allow for enough time for procedures, listening to patients, assessing needs and giving information and advice, and for obtaining outcome measures. This means allocating:
  - at least 60 minutes for the first assessment visit (this was reduced to 45 minutes as a result of experience in the Modernising Hearing Aid Services (MHAS) Programme)
  - at least 60 minutes for a hearing aid fitting visit (this was reduced to 45 minutes as a result of experience in the MHAS programme)
  - at least 30 minutes for a hearing aid fine tuning appointment, and
  - at least 30 minutes for a follow-up visit.
  - at least 60 minutes for a reassessment/review visit (this was reduced to 45 minutes as a result of experience in the MHAS programme).
- People who are assessed as likely to benefit from hearing aids should be offered the hearing aids that will give them the best hearing benefit in everyday life from the range of models for which the NHS has a contract. If none of these are suitable, they need to be offered a model that is better for their needs.
- The service should offer bilateral (one hearing aid for each ear) fittings unless there are audiological or medical reasons for only providing patients with one aid, or unless the patient has a preference for only one aid at the time of the visit.
- All patients who are attending to have their hearing aid fitted should be offered at least one booked face-to-face or telephone follow-up appointment.
- All patients should be given clear verbal and written information and advice on continuing care and rehabilitative services, community equipment services, and other services, organisations and groups that may be helpful to them, together with up-to-date information on how to access these.
- Hearing aid users should be recalled for reassessment and review of their aids no later than three years after their last assessment.
- Waiting periods for initial and subsequent appointments should be as follows:

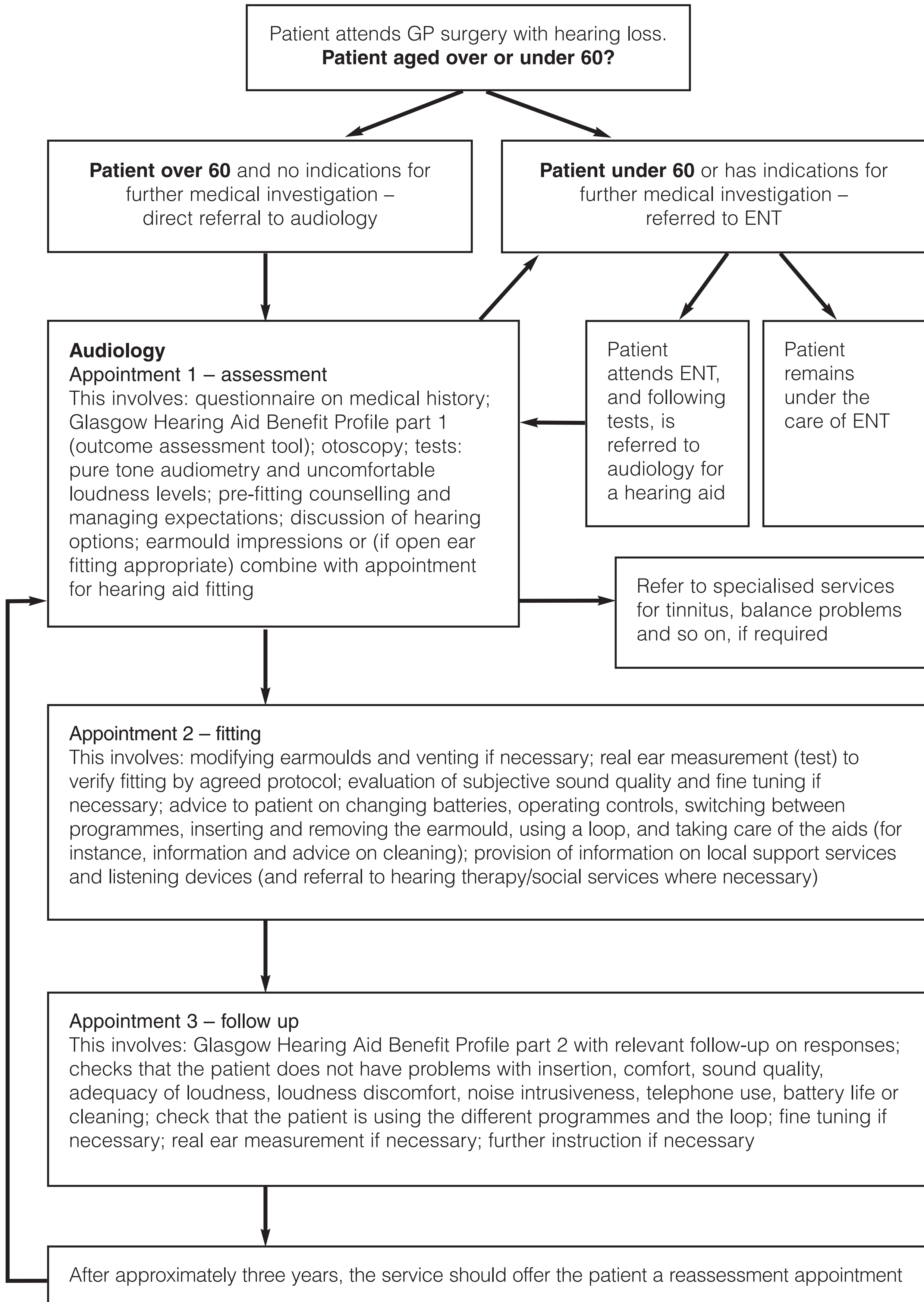
Referral to first assessment	No more than four weeks
Assessment to first hearing aid fitting appointment	No more than four weeks
First to second hearing aid fitting appointment	No more than eight weeks
Reassessment/continuing care	No more than four weeks from patient request
Referral for rehabilitation services	No more than four weeks

- Services should follow published national recommended procedures and protocols.

Rehabilitation

The hearing aid service should provide comprehensive rehabilitation services to support adult patients.

Appendix 1 – Best practice patient pathway



Appendix 2 – Benefits to patients of a good hearing aid service

Having a hearing loss is very distressing, as it makes everyday communication very difficult, and simple tasks become problematic. Hard of hearing people are often unable to follow and join in conversations, and can become excluded from and by their families, friends and work colleagues. They may be unable to hear the doorbell, watch TV or use the telephone. This can lead to their loss of independence and well-being, and can result in some cases in them losing their job and becoming isolated from society.

Hearing aids can make a huge difference to the quality of life of deaf and hard of hearing people, by making conversations easier, enabling them to use the telephone and hear important environmental sounds such as a doorbell or the telephone ringing, or a pan boiling over. Timely access to good hearing aid services ensures that people who need a hearing aid can maintain their independence, employment, confidence and still be included in daily activities.

The quality of the service that you commission is important, because the effectiveness of the hearing aids provided to a person depends on so much more than just the quality of the hearing aid. An effective service also depends on:

- the expertise with which the hearing aid is programmed to meet the patient's needs
- the support the patient receives to ensure that they use their hearing aids effectively
- the accessibility and responsiveness of continuing services for maintenance, repair and review as people's hearing changes.

What does a good hearing aid service look like?

RNID believes that a good hearing aid service can be described as follows:

> The patient is assessed for and fitted with appropriate hearing aids in a timely manner, which meet their individual needs and substantially improve their quality of life, enabling independence and reducing the chance of social isolation. The patient receives the information, support and ongoing care that they need in order to benefit fully from their hearing aids and other hearing services. The patient is satisfied with their hearing aids and the service they receive.

This vision can be achieved in a variety of ways.

Appendix 3 – Policy context

Hearing aid services were recently modernised in a project led by RNID. Digital hearing aids are now being routinely provided by the NHS, with bilateral fitting where necessary, and a new patient pathway, with routine follow-up for all patients. This has greatly improved the hearing aids and the service that patients receive. However, it has also increased the time spent with each patient and the demand for the service, which has led to longer waiting times. Waiting times for hearing aids were already averaging nearly six months (with considerable geographical variation) before the modernisation programme began. It was focussed on the introduction of digital technology at vastly reduced prices to the NHS, but it was not given the resources to address the longer-term historical problem of waiting times.

Delays in getting hearing aids have a highly detrimental effect on the quality of life of those who need them, particularly older people (who form the majority of people waiting). This may result in a negative impact on the health and social care system elsewhere, such as in mental health services, or in A&E.

The waiting that patients experience in hearing aid services is vastly out of line with waits now experienced in other parts of the healthcare system (such as outpatient or primary care waits). Patients wait years for digital hearing aids, compared with months, weeks or days for other healthcare interventions. As hearing aid services are not consultant-led, they are not subject to the 18-week referral to treatment target due to be met by 2008, but this does not mean that the services' long waits should be ignored. As waits in other parts of the healthcare system are reduced further, the stark contrast between waits for hearing aids and for other treatment will become even more pronounced. Alternatively, GPs may try to get their patients seen quicker through referring them to ENT (which is subject to the 18 week target), thus increasing demand on ENT services.

We're RNID, the charity working to change the world for the UK's 9 million deaf and hard of hearing people.

There are a number of
ways to find out more

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