

NHS Overview and Scrutiny Briefing Note

Audiology

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Background

In 2004, some 213,900 people in England were registered with their local Social Services department as deaf or hard-of-hearing. But it is estimated that 7.5 million (around a fifth of the population) in England actually suffer from deafness or are hard-of-hearing. A substantial majority of people with hearing loss obtain their hearing rehabilitation through the National Health Service. Significant numbers also suffer from tinnitus (“noise” in the ear) and balance disorder; and almost all are treated by the NHS.

Two million people in the UK have been fitted with hearing aids, although it is estimated that only about 1.4 million of these use them regularly. It is believed that a further four million people might benefit from having a hearing aid (some estimates put this figure as high as five to six million). The NHS provides at least 2.6 million adult hearing-aid appointments per year, including 500,000 hearing-aid fittings.

There are 164 NHS Audiology services in England, mostly provided by acute Trusts in a hospital setting; a few are provided by Primary Care Trusts (PCTs). The audiology services undertake:

- hearing screening of new-born children;
- diagnostic testing of new-born children;
- work with hearing-impaired children;
- children’s hearing testing;
- diagnostic work relating to the audio-vestibular (balance) system;
- balance rehabilitation;
- hearing therapy;
- counselling for tinnitus;
- support for Ear, Nose and Throat (ENT) and Audiological Medicine services;
- work with adults with age-related hearing loss.

The work of NHS audiology services is commissioned by PCTs through block contracts, audiology not currently being subject to the Payment by Results system.

Modernising NHS Audiology services

During 2000–5, the provision of all adult hearing-rehabilitation services within the NHS was transformed by the Modernising Hearing Aid Services (MHAS) project, which was a UK-wide government initiative, managed in partnership with the Royal National Institute for the Deaf (RNID).

The two key components of MHAS were: the implementation of an improved rehabilitative process; and the provision of digital hearing aids (as recommended by the National Institute for Health and Clinical Excellence), which had previously only been available privately, often at high cost. Digital devices have programmable “intelligent” amplification

that is considerably better than analogue technology.

The NHS Purchasing and Supply Agency (PSA) was able to get significant discounts on digital hearing aids by large-scale bulk purchasing – apparently securing the lowest unit cost achieved by any purchaser of hearing aids in the world. (So long as hearing aids are bulk-purchased in this way their provision counts as a capital transaction and is, therefore, excluded from Payment by Results.) Roll-out of digital hearing-aids in the NHS Audiology service was completed in 2005.

Between 2003 and 2006, NHS Audiology services for children were also successfully modernised.

The modernised audiology service was complemented by “Hearing Direct”, a telephone follow-up and triage service provided by NHS Direct.

Waiting times

Following modernisation, the NHS Audiology service has, unfortunately, been a victim of its own success. There has been a great increase in the demand for the service and in referrals of both new patients and existing patients seeking to access the modernised service – particularly by exchanging analogue hearing aids for digital ones. This has led to greatly increased waiting times, a development compounded by: the adoption of an improved rehabilitative process – requiring increased appointment times for patients; the fact that prior to MHAS there were already waiting lists for many audiology clinics, exacerbated by shortages of audiologists; and the lengthier assessment and fitting process needed for digital hearing aids.

The most recent returns from the Department of Health (DoH) on waits for diagnostic tests, for December 2006, show 170,033 people in England waiting for an audiology test – 113,474 had waited more than 13 weeks; and 84,374 had waited more than 26 weeks. The average expected wait for an audiology assessment was 17.6 weeks. The average expected wait in the South East Coast Strategic Health Authority (SHA) area was the worst in the country – 45 weeks.

The DoH does not collect data on waiting times for hearing-aid fittings. However, the British Society of Hearing Aid Audiologists conducts an annual survey on this topic. In 2006, the survey found that the average wait in England for an NHS hearing aid, for someone seeking their first device, had risen for the third year in a row to 45–48 weeks.

There were huge variations across the country, with patients waiting on average 73–74 weeks in the South East, which had the worst waiting times. Four hospitals in England (one of which was the Kent and Canterbury Hospital) had waiting times of 117 weeks (i.e. two years and three months), the longest waits in the UK. Users wanting to upgrade their hearing aids from analogue to digital had to wait on average 68 to 72 weeks. At one hospital in England, the wait was 260 weeks (i.e. five years), and at another five hospitals there were waits of over 200 weeks (i.e. nearly four years).

The Public Private Partnership

Between 2003 and 2005, the DoH, through the NHS PSA, negotiated a national framework contract with two major private-sector suppliers for patients to receive their NHS hearing

aids through the private sector, by way of a three-episode patient journey (assessment, fitting and follow up). This was known as the Public Private Partnership (PPP). It was facilitated by local NHS Audiology services, which also undertook clinical governance monitoring of the scheme. Patients on the NHS waiting list were invited to take part, and at least 68,600 people received hearing aids in this way during 2004–6.

In some areas, the PPP scheme was effective in reducing waiting times without any loss in quality of service. In other areas, up to 50% of PPP patients needed access to the NHS Audiology service for remedial work.

The end of ring-fenced funding

From 2000 to 2005, the £125 million funding for the MHAS programme was ring-fenced by the DoH. In 2005–6, funding for audiology was given to individual PCTs for them to commission local services with. In 2006–7, the DoH started giving revenue allocations for audiology to SHAs, bundled with many other different allocations in “central revenue budgets”, for the SHAs to allocate within their health economies.

These changes, in the context of the financial challenges in many health economies, led to a weakening of the financial position of local NHS Audiology services. In consequence, the PPP scheme effectively collapsed in 2006, as the two private companies involved were unable to support the infrastructure required, in the absence of guaranteed adequate funding. At the same time, NHS Audiology service posts were frozen and services were unable to maintain or increase capacity by means such as the use of locum staff.

National waiting-time target

The DoH has set as a national target for the NHS that, by the end of 2008, no-one should be waiting more than 18 weeks from GP referral to hospital treatment.

Audiology appeared to represent a significant problem for the NHS in meeting the 18-week target – two-thirds of the total number of patients waiting more than 26 weeks for diagnostic tests are waiting for audiological assessment.

However, in May 2006, the DoH announced that referral by GPs direct to NHS Audiology Services fell outside the 18-week pathway. Only those cases involving referral to an ENT consultant were deemed relevant to the 18-week pathway. (The DoH states that 50% of audiology referrals, and 20% of adult hearing-loss referrals, are to ENT consultants; audiologists’ representatives seem to put the latter figure at 10%.) The DoH also indicated that direct-referral audiology patients should not be re-routed to the ENT service in order to get around the bottle-neck in the audiology service and get onto the 18-week pathway.

It has been argued that the exclusion of audiology from the 18-week pathway has meant that financial support for NHS Audiology capacity has been further undermined – as resources in local health economies have been shifted to other services where there are mandatory targets to hit.

Interim diagnostic targets

Alongside the 18-week target, the DoH has two interim targets for diagnostic waits that are intended to act as “milestones” on the way to achieving the 18-week target:

- by March 2007, no-one should wait more than 13 weeks for diagnosis;
- by March 2008, no-one should wait more than six weeks for diagnosis.

Although hearing-aid fitting falls outside the 18-week pathway, referral for hearing tests *is* within these interim targets for diagnostic assessment. It appears that, consequently, the NHS in a number of areas is assessing all patients on the hearing-aid waiting list in order to hit the interim diagnostic targets – regardless of whether there is any realistic prospect of the patient receiving appropriate rehabilitation (including the fitting of a hearing aid). Consequently, by the time the local audiology service is able to provide rehabilitation, the hearing test will be out-of-date and will, therefore, have to be repeated. Thus, the national target may be hit – but resources are actually wasted.

Second-wave Independent Sector Treatment Centres

Episodes of audiology care (three-stage patient pathways) are being included in contracts for the second wave of centrally-procured Independent Sector Treatment Centres (ISTCs), procurement of which by the DoH began in 2006.

Audiologists' representatives have expressed alarm at the lack of involvement of the NHS Audiology service itself in making arrangements for the delivery of audiology by ISTCs. The following issues have been raised:

Type of hearing aid

Concern has been expressed about lack of information concerning the type of hearing aid to be used by the ISTCs. There are issues around quality, repair and maintenance of devices, and whether use of unfamiliar devices will impair seamless follow-up by NHS Audiology service staff.

Cases requiring a specialist opinion

Up to half of patients referred from primary care to NHS Audiology services potentially require onward referral to an ENT specialist. NHS audiologists often manage these cases under local clinical governance arrangements agreed with ENT colleagues. It is unclear what provision will be made in ISTCs to cover this situation and whether patients will complete the three stages of the patient journey (assessment, fitting of the hearing aid and follow-up) whilst waiting for a medical opinion.

Patients with complex needs

Many patients with complex needs are currently identified by NHS audiologists and referred on. Rehabilitation of hearing loss can be a complex and sometimes lengthy process. Patients may need information and advice on assistive listening devices or, for the most severely affected, bone-anchored hearing aids and cochlear implants. Rehabilitation also encompasses communication skills training, and counselling to help patients improve their quality of life. Many patients require more than one follow-up visit after a hearing-aid fitting – sometimes several. It is not apparent that the ISTC contracts will include provision for meeting the needs of such patients by employing the specialist (graduate) audiologists who deal with these cases in NHS Audiology services. And there seems to be no clarity yet regarding pathways and funding mechanisms for ISTCs to refer

these cases on to appropriate services.

Continuity of care

It is still unclear whether, under the terms of the ISTC contracts, the patient will return to local NHS Audiology services after the three-stage patient journey. It is not known whether the patient will stay with the ISTC for the life of the hearing aid, or whether the local NHS Audiology service will be commissioned to provide maintenance, repair, replacement of lost hearing aids, etc. If NHS Audiology services are to undertake such extra activity, they will need the resources to do so. There is also the question of whether additional referrals from primary care will be required for such continuing care.

Clinical governance

It is unclear whether the ISTC contracts will be covered by the same clinical governance arrangements as applied to the PPP scheme, allowing for monitoring of standards, as well as senior clinical involvement.

Sharing of patient records

If the patient is to have the option of returning to their local NHS Audiology service, there will need to be full and quick access to their patient records, to maintain standards of care. It is unclear whether ISTCs will be required to give such access.

Patient selection

There is some doubt as to the mechanism whereby audiology patients will be sent to an ISTC (whether this will be done through Patient Choice; whether those on waiting lists will be seen first).

Staffing

Questions have been raised about how ISTC-delivered audiology is to be staffed. Given that rules on “additionality” are apparently to be relaxed for second-wave ISTCs, there are concerns about possible poaching of staff from NHS services.

The extent of ISTC procurement

In July 2006, the government announced that 300,000 three-stage audiology patient pathways per year were being centrally procured from the independent sector, to come on-stream from early 2007.

There has been concern that independent-sector procurement on such a massive scale might actually lead to the creation of over-capacity (large waiting lists and unmet need notwithstanding) – and undermine NHS services.

The future of NHS Audiology services

In theory, independent sector-provided audiology is purely additional to that provided by NHS Audiology services. However, commissioners have no choice about whether to use ISTCs, or the volume of work for which they are contracted, since ISTC contracts are

centrally procured by the DoH. (In theory, arrangements are signed off by PCTs; in practice, there seems to be no real local involvement in setting ISTC contracts.) There could thus be a significant incentive for commissioners to treat ISTCs as their core providers and the (non-ring-fenced) NHS Audiology services as additional.

On this basis, a significant shift from NHS providers to ISTCs could occur irrespective of any considerations about the value-for-money or quality of the two types of provider (as has been seen, in other contexts, with first-wave ISTCs).

Audiologists' representatives have expressed fears that the very existence of the core NHS Audiology service could be threatened, jeopardising the range of services that they provide in addition to the routine fitting of hearing aids (and which ISTCs will not provide).

The National Audiology Action Plan / Improving Access to Audiology Services in England

In May 2006, it was announced that there would be a National Audiology Action Plan. The government stated that this would address concerns about the future coherence and comprehensiveness of audiology services in the NHS.

Professional organisations, patient groups and voluntary-sector agencies all expressed disappointment at not being directly involved in the DoH Expert Working Group that compiled the Action Plan. Concern was also expressed that fundamental decisions (not least regarding independent-sector procurement) had apparently already been taken by the DoH.

On 6 March 2007, the DoH published *Improving Access to Audiology Services in England*. This appears to be the promised National Audiology Action Plan.

The document states that delivery of improved audiology services is down to "local health systems" using "the health reform mechanisms of better commissioning and pathway redesign, choice and competition, information and incentives". Each PCT, as the local commissioning body, is expected to set out in its forthcoming first "Prospectus" the strategic direction for local audiology services.

The DoH, according to the document, estimates that, nationally, around 300,000 extra adult hearing-aid complete pathways "would be needed between April 2007 and December 2008, on top of existing levels of NHS provision, to make a maximum wait of 18 weeks from referral to treatment possible for *all* audiology referrals ..." This "capacity gap" will be filled partly through "greater efficiency in existing services where possible" and partly through commissioning new capacity.

The document states that 42,000 additional audiology patient pathways a year have already been centrally procured as part of "the Phase 2 IS [Independent Sector] diagnostics procurement", to come on-stream from April 2007. Further independent-sector provision has been prepared through "a Phase 2 IS elective audiology procurement", apparently to come on-stream by April 2008 – but "the amount to be procured [is] dependent on the outcome of the current planning process". It is unclear how this relates to the government announcement in 2006 that ISTC provision of up to 300,000 audiology pathways a year was being procured (see above).

The DoH plans to produce a number of aids to commissioning, including model care-pathways and model protocols for referral, the document states.

The document underlines the requirement to meet the national interim targets on diagnostic waits and says it is “good practice” for the hearing aid to be fitted “soon after or at the same time as the initial assessment”. This is clearly in response to concerns about the tendency of national targets to produce “perverse incentives” to prioritise diagnosis without prioritising treatment (see above).

In respect of Patient Choice, the document says that patients should already be offered a choice of provider for audiology referrals to ENT consultants; and consideration is to be given to allowing a choice of provider for patients referred direct to audiology services. In the meantime, Version 4.0 of the Choose and Book system, due for release in 2007, will enable booking of direct-referral audiology appointments.

The document also states that the DoH will develop benchmark costs for audiology and consider introducing a standard national tariff for audiology services. In the meantime, PCTs can “develop prices [apparently meaning local tariffs] that support choice and efficiency, rather than block contracts”. (However, in the absence of Payment by Results arrangements, block contracts will presumably continue to apply to audiology; and ISTC prices will presumably be agreed by the DoH, not at local level by PCTs, given that ISTCs are centrally procured.)

Health Select Committee Enquiry

The House of Commons Health Select Committee recently conducted a short enquiry into audiology services in England, and its report is expected soon.

Waiting times for audiology services in Kent and Medway, by hospital (2004-6)

Hospital	Weeks to first appointment			Weeks from first appointment to fitting			Total wait in weeks			
	2004	2005	2006	2004	2005	2006	2004	2005	2006	Analogue to digital
Darent Valley Hospital, Dartford	6 to 7		Now Medway Maritime	32		Now Medway Maritime	38 to 39	NA	NA	NA
Kent and Canterbury Hospital, Canterbury	8	NK	13	52	104	104	60	104+	117	104
Kent and Sussex Hospital, Tunbridge Wells	104	52	52	52	NK	13	130	52+	65	52
Maidstone Hospital	8 to 13	13	22	8	21	34	16 to 21	34	56	52
Medway Maritime Hospital, Gillingham	4	4	4 to 6	15	NK	13 to 17	21	NK	17 to 23	104 to 156
Queen Elizabeth the Queen Mother Hospital, Margate	52	52	52		54	3 to 4	NK	106	55 to 56	52 to 78
Royal Victoria Hospital, Folkestone (now at William Harvey Hospital, Ashford)		26	11		78	78	NK	104	89	78

Source: British Society of Hearing Aid Audiologists annual surveys

People registered as deaf or hard-of-hearing in Kent and Medway, by category of disability and age (as at 31 March 2004)

Local authority	All people registered as deaf or hard-of-hearing	People registered as deaf, by age					People registered as hard-of-hearing, by age				
		All Ages ¹	0-17	18-64	65-74	75 or Over	All Ages ¹	0-17	18-64	65-74	75 or Over
Kent CC	7,225	2,920	240	1,155	300	1,225	4,305	75	550	530	3,145
Medway UA	1,070	445	55	240	45	105	625	10	135	120	360

1 "All ages" total includes some cases where the age was not known; therefore, the age groups may not add to the total.

Source: Triennial returns on form SSDA 910, submitted to the Department of Health by councils with Social Services responsibilities

Numbers waiting for audiology assessments, and assessments carried out, in Kent and Medway, by provider and commissioner (December 2006)

Provider	Total Waiting	Number waiting 13+ Weeks	Number waiting 26+ Weeks	Number waiting 52+ weeks
East Kent Hospitals NHS Trust	2,257	1,917	1,525	658
Medway NHS Trust	635	521	457	352
Maidstone and Tunbridge Wells NHS Trust	1,393	748	371	
West Kent PCT	181	41	1	

Tests carried out during the month		
Planned tests ¹	Unscheduled tests ²	Waiting list tests (excluding planned waits)
	699	201
245	414	107
18	748	54
		50

Commissioner	Total Waiting	Number waiting 13+ Weeks	Number waiting 26+ Weeks	Number waiting 52+ weeks
Eastern and Coastal Kent PCT	2,595	2,151	1,710	800
Medway PCT	359	319	287	214
West Kent PCT	1,559	796	381	1

Tests carried out during the month		
Planned tests ¹	Unscheduled tests ²	Waiting list tests (excluding planned waits)
32	760	219
146	153	57
86	954	139

1 Planned tests are those that are carried out as part of a treatment plan and must, for clinical reasons, be carried out at a specific time or repeated at a specific frequency (and hence involve planned waiting).

2 Unscheduled tests are those that are carried out on Accident and Emergency patients or following an emergency admission.

Source: Monthly returns on form DM01, submitted to the Department of Health by commissioners