The Future of NHS Adult Hearing Loss Management

Contents

1. Position Summary

- The British Academy of Audiology (BAA) believes Adult hearing care, including the provision of hearing aids and rehabilitation, should be available to all those who would benefit, provided free at the point of delivery.
- NHS Adult Audiology services should provide safe and effective hearing care for adults with hearing concerns which represents value for money for the NHS/taxpayer and is not for profit.
- Services should offer evidence-based assessment and management of hearing, following national guidelines.
- BAA believes the NHS is best placed to offer evidence-based assessment and management, scientific leadership, integrated pathways and provide hearing healthcare across the lifespan.
- BAA recognises the important role the Private Sector plays in hearing care provision in the UK through offering a broader choice of hearing aid styles and features than typically available via the NHS, as well as offering alternative services such as custom hearing protection that are not ordinarily NHS funded.

2. Background

On behalf of its membership, BAA's vision is to provide a clear and strong voice for professionals in Audiology and to promote excellence in clinical knowledge and practice. The BAA aims to help its members to develop their professional skills, provide a benchmark for quality and professional standards and promote Audiology as an autonomous profession.

BAA recognises the importance to advocate on the provision of Adult Hearing Aid care as this is a fundamental part of Audiology services in the UK.

Since the introduction of the 'Any Qualified Provider' (AQP) policy in 2011, a proportion of NHS Adult Hearing Services in England have been provided by the private sector. In some areas, the private sector has continued to advocate for further NHS Adult Hearing Services being delivered on the high street across all four countries of the UK. The pressure for this has intensified since the national reviews and the ongoing problem of long waiting lists.

In recent years large reviews of Audiology have been established in both Scotland and England with the potential to radically alter the future of NHS Hearing Services. BAA believes that, if executed effectively, these programmes of work have the potential to ensure NHS Hearing Services are safe and effective in the future. With sufficient investment, NHS services are well-placed to deliver public funded hearing services in the UK because:

- Audiology services require infrastructure to deliver safe and high-quality care, including sound-proof/treated rooms and extensive diagnostic medical equipment to cover all routine and complex testing. The NHS has already invested significantly in this, and the infrastructure required to deliver public funded Hearing Services that is currently provided by the NHS is not available elsewhere.
- Audiology services benefit from the presence of all grades of staffing from Healthcare Scientist Assistant to Consultant Clinical Scientist with the flexibility of covering the local population's needs with both operational and scientific leadership. The NHS workforce provides this.
- Services need clinical training for assistant, associate, undergraduate and post graduate levels, and exposure to non- routine Audiology workload. NHS Audiology services are uniquely positioned to provide this, something which is not replicated elsewhere.
- Joined up working is essential for a seamless service for patients. Patients referred to Audiology can require input from ENT, Radiology, Physiotherapy, Psychology etc. The effectiveness of referral, communication and multidisciplinary working between multiple services would be detrimentally affected by Audiology being delivered elsewhere and this is only viable within NHS delivered Audiology services.
- Audiology services measure themselves against quality standards, the NHS structure is set up to support this with governance departments, patient safety and experience teams, audit teams, research and development teams and safeguarding support.
- Audiology patients need consistency of care with life-long support for hearing problems. Contracts covering 3–5-year periods can be disruptive to ongoing care, as when contracts end or are terminated mid contract, there is no ongoing commitment to patients. The NHS can provide this life-long consistent care for patients.
- There are risks to patients being actively signposted to private provision of technology unless the patient raises this themselves. Private hearing instrument sales made up just 28% of devices purchased in the UK in 2022 (BIHIMA, 2023), suggesting most of the population either do not seek alternative styles/features or cannot afford them.

Examples of Private Sector involvement in delivering NHS services exist, for example, Dentistry has been delivered outside of the NHS since the 1950s. Nearly half of dentists have been reported to move away from Dental care due to the system being described as 'unfit for purpose', with 9/10 dentists not taking on new patients (British Dental Association, 2022). Given the already high prevalence of hearing loss in the UK and the ageing population, a reduction in access to Hearing Services cannot happen.

The Royal College of Ophthalmology reports that 60% of its members feel that Private Sector involvement is having a negative impact on patient care. By removing the 'routine' care from NHS services, funding streams for more complex and more costly care are reduced. The parallel for Audiology Services would be moving 'routine' Adult Hearing Services to the Private Sector, which would consequently have a negative impact on NHS services ability to fund specialist services such as Paediatrics, Vestibular, Tinnitus & Hyperacusis, Auditory Processing Disorder, Implantable Devices and Complex needs, resulting in poorer patient care for those with the most complex needs.

The Health Foundation states, in its report "Waiting for NHS hospital care: the role of the independent sector." That the "*NHS faces a significant challenge to deliver the scale of growth required to bring the waiting list down. The Independent Sector is showing it can contribute to addressing the elective care backlog in some areas of treatment, but it is likely to play a limited role in fully recovering services and will not be a substitute for addressing the major problems facing the NHS."*

BAA believes therefore that a more sustainable approach is required to get services to deliver innovative ways of working to achieve greater access for patients whilst investing in providing safe and quality services. The private sector offer does not resolve the need for more Audiology professionals and does not increase overall capacity.

The RNID's most recent report "In their own words" summarises the position Adult Audiology now finds itself in:
"In recent years, audiology services have faced significant simultaneous challenges due to staff shortages and inadequate funding to meet demand. These challenges have been compounded by COVID-19 service disruptions and competing national health priorities. Worryingly, services have not yet returned to pre-pandemic levels of activity, meaning more and more people are waiting for an audiology appointment. If urgent action is not taken, this number will continue to rise. Given both the growing prevalence of hearing loss, and the high level of unmet need, action is also needed to address future demand for adult hearing services."

BAA recognise that the current status quo cannot continue, and NHS provision needs to consider all points laid out in this document.

3. Purpose of the position statement

The purpose of this statement is to:

- Describe what the BAA considers a safe and effective service for Adults with hearing concerns.
- Outline the minimum expectations for providers to deliver quality services for adults with hearing loss in Audiology services.
- Highlight key areas of the Audiology profession which require systematic investment for Audiology to provide sustainable, quality, Adult hearing care.
- Highlight the competition for resources not only from the Private Sector but also through other forms of competition; competing against other health disciplines; for resources to come to hearing related conditions.

4. What is routine Adult Audiology?

NICE (2018) defines this as the assessment and management of hearing loss in primary, community, and secondary care. It aims to improve the quality of life for adults (over 18 years) with hearing loss by advising healthcare staff on assessing hearing difficulties, managing earwax, and referring people for audiological or specialist assessment and management (NICE, 2018). It is considered the 'bread and butter' of Audiology and makes up the majority of the work Audiology undertakes.

Depending on how a service has chosen to deliver its pathways, in many services routine adult patients access the service through direct access referral pathways, where hearing loss is the primary complaint and no 'red flag' otological issues identified by the referrer.

It is important to note that any patient who has hearing loss and is fitted with hearing aids are never discharged from Audiology, but become lifelong patients being supported with regular hearing aid maintenance, repairs, reassessments and starting new pathways on a 3–5-year cycle. The capacity and demand of services is therefore problematic due to the aging population. Equally, as patients age, they are more likely to have other comorbid and long-term conditions, some of which may mean they need more specialist management, for example dual sensory impairment or dementia, or the shape / severity of their audiogram would suggest they need a broader approach than only having hearing aids. It can be argued that it is hard to predict who is 'routine' and who may need more specialist support. Many 'routine' patients can become complex and therefore an integrated service will have the skills available to accommodate this transition and deliver both aspects of the service.

5. BAA Position

a) Overall principles

- Adult hearing care, including the provision of hearing aids, should be available to all those who would benefit, provided free at the point of delivery and without NHS prescription charges or voucher systems such as those seen in Dentistry or Optics.
- It is currently estimated that 12 million adults in the UK have a hearing loss greater than 25dBHL and this is expected to increase further by 2035 (RNID, 2024).
- Given the well documented links between addressing hearing loss early to improve communication and quality of life, allowing for timely and accurate diagnosis of cognitive decline, and increased healthy ageing (Dawes & Munro, 2024), BAA feels strongly that inability to self-fund hearing aids should not be the cause of increased risk of other comorbidities, which then leads to further pressure on other NHS services.
- BAA recognises the important role the Private Sector plays in hearing care provision in the UK through offering a broader choice of hearing aid styles and features than typically available via the

NHS, as well as offering alternative services such as custom hearing protection that are not ordinarily NHS funded.

- The aim of NHS Adult Audiology services is to provide safe and effective hearing care for adults with hearing concerns which represents value for money for the NHS/taxpayer and is not for profit. Services should offer evidence-based assessment and management of hearing, following national guidelines and guidance.

b) Technology

- Patients should have access to up-to-date technology available on the NHS contract for the country of residence for hearing aids, implantable devices, and assistive listening devices (where applicable and where funding exists, or they are signposted to accessing this technology through other routes).
- Transparent informed choice and shared decision making should be undertaken with patients when selecting which technology best suits their lifestyle and their preferences. Access to technology such as apps, direct Bluetooth streaming, and remote care should be available to all NHS patients as a base level technology. Equally additional programme options vs having more automated settings and additional assistive technology should all be discussed and documented as part of the patients Individual Management Plan.

c) Person Centred Care

- Patients should receive a holistic approach to assessment and management with person centred care and personalised counselling at every interaction.
- Communication cuts across all areas of life and across all aspects of the lifespan (although often considered age related) and relevant needs should be attained to deliver person centred care including the impact on family and friends.
- Diagnostic assessment should encompass all relevant tests for the patient, these may include pure tone audiometry, tympanometry, acoustic reflexes, Stenger checks and measurements, and otoacoustic emissions.
- Patients should expect to be provided with transparent communication and have a smooth transition when they are referred between services, and to put them, their family, and carers at the centre of decisions that affect them.
- Patients should have access to models of care which leads to greater patient empowerment and self-management.
- Patients should be offered follow-ups and ongoing care (through a range of methods) and should be based on patient's needs.

d) Access

- Patients should expect a timely diagnosis.

- Patients should have access to wax removal services, free at the point of care, which are joined up to Audiology providers.
- Access is an important part of quality services. Patients should not have to wait outside of national targets for the country of residence, but access is only one part of quality, and a broader view needs to be taken than just waiting times.
- Barriers should be removed or minimised in all patient pathways for patients.
- Self-referral models should be considered as standard for hearing loss without any red flag issues, to reduce any unnecessary GP appointments and improve patient experience.
- Providers should understand and demonstrate how to implement positive methods of communication and offer an equal service to deaf and hard of hearing people.

e) Quality Assurance

- Providers should use safe, evidence-based processes and regularly review new policies and procedures to stay up to date with new recommendations.
- Providers should be working to and measuring against evidence-based quality standards e.g. NICE (2018) Adult Hearing guideline / Welsh or Celtic Adult Quality Standards / BAA Quality Standard / IQIPS standard across all locations.
- Providers should assess and identify patterns against the quality standards they are working to and make changes to manage the service based on these patterns going forward.
- All providers should ensure all verbal and written information meets the Accessible Information Standard.
- Providers should be externally and independently reviewed against these standards to ensure their stakeholders of the quality of their service.

f) Workforce

- Audiology professionals must work within their scope of practice and be appropriately trained to deliver care to this level. (See appendix 1, document still subject to consultation and publication).
- All Audiology professionals who can be registered should register themselves on the relevant national register and follow the professional standards laid out by this register, including maintaining CPD to maintain professional competence.
- The workforce needs to consist of skill mixes depending on the needs of the local population.
- The workforce should triage adult care so that appropriate patients are seen by appropriately banded staff and where possible the first point of contact should be through self-referral in a community setting.
- Graduate Healthcare Scientists (roles D-H in appendix 1, subject to consultation) play a key role in the management of problem solving, demonstrating initiative, demonstrating innovative practice, researching, and analysing complex processes and delivering services. Most Audiology professionals should therefore be at graduate Healthcare Scientist level to ensure innovative development of practice.

- Providers should have robust scientific leadership in place to ensure best evidence-based practice is instilled in the service.
- Providers should have collaboration and close working across all specialist teams in Audiology (e.g. tinnitus / vestibular / implantable devices) and ENT, Radiology (for Non-Medical Referral's), Dementia/Memory Services, Geriatricians, Speech and Language Therapists, Paediatricians, Psychology etc. The team should also link into education and research, Local Authority groups, volunteer services, and relevant third sector organisations. There should be direct contact with other departments such as governance departments, audits teams and safeguarding which link to providing a safe, high-quality service.
- There should be integrated pathways between primary, secondary, and tertiary care.
- There should be opportunity for training and career progression at all levels.
- There needs to be investment in the provision of education and training routes for qualifying new Audiology professionals across all four countries of the UK to provide an ongoing and sustained workforce.

g) Innovation

- With waiting lists at a height across all four nations of the UK the BAA acknowledges that NHS providers need to innovate to maintain quality but look to reduce backlogs, especially around delivering diagnostic activity levels that support plans to address the diagnostic waiting times.
- NHS Providers should utilise the adoption of flexible innovations in technology and care models, the use of real estate and the overall workforce, where this brings patient benefit and improves efficiency.
- Greater investment is needed in innovation for Audiology. This includes funding to convene service providers and commissioners, technology innovators, patients, and academics; to trial and pilot new initiatives; and evaluate their impacts.
- BAA will facilitate networks for further innovations through Heads of Services and Clinical Leads, and NHS providers need to be open to new and diverse ways of working to achieve the balance between access and quality.
- Service innovation should be embedded as standard to ensure services are sustainable and can grow to meet current and future needs.

h) Commissioning of NHS Adult Audiology Services

- Services should be commissioned around patient and population needs.
- Commissioners should not assume that all hearing service providers offer equal patient outcomes and equivalent value for money.
- Commissioners should be evaluating and ensuring optimisation of workforce, estate, capacity, and investment across primary and hospital care.
- Commissioners need to remove barriers for the provision of remote care, through IT and Information Governance departments so that innovations can be maximised.

- Further investment is required and if invested in NHS systems and services these are more likely to lead to long-term sustainable opportunities rather than short term contracts and solutions.
- Commissioners should seek evidence of improved patient outcomes following pathway completion via questionnaires such as the COSI, GHAPB etc. from both NHS and if applicable any Private Sector providers for quality monitoring purposes.
- Pathways that offer novel service provision (e.g., remote provision) should show equivalent (or improved) patient outcomes, compared to traditional face to face hearing care pathways.
- To ensure their funding is well-spent, commissioners should be seeking out patient experiences to guide and inform them of the 'value for money' for the services they fund.
- Commissioners should regularly request and audit PROMs & other agreed KPIs with transparent reporting systems from the providers they commission to ensure value for money.
- Commissioners should recognise quality assurance models in the country of residence, mandate, and resource these programmes for all providers with contracts for seeing NHS patients.
- Commissioners should always prioritise patient safety, experience, and outcomes, over cost.
- Transformation of services needs to be accompanied by continuous improvement, the use of updated policies from research and relevant investment is required for this to happen.

6. Resources

A list of key health policy documents and references that have helped shape this document:

NHS Constitution The NHS Constitution for England - GOV.UK (www.gov.uk)

NHS England 2023/24 priorities and operational planning guidance

NHS England Paediatric Hearing Services Improvement Programme: system recommendations for immediate action

NHS England Accessible Information Standard

Welsh government A healthier Wales: long term plan for health and social care

Welsh government Integrated framework of care and support for people who are D/deaf or living with hearing loss

Scottish Government Health & Social Care Plan – Healthier Scotland

NHS Scotland NHS Scotland Recovery Plan

Scottish Government Independent Review of Audiology Services in Scotland

Hearing & Deafness Alliance Meeting local healthcare needs, a simple guide for Integrated Care Systems – Hearing Alliance

British Academy of Audiology Scope of Practice: Audiologist v4 (due for consultation and publication late 2024)

Royal National Institute for the Deaf In their own words: Insights & Ideas from adult hearing service patients

Royal National Institute for the Deaf Our facts and statements - RNID

Royal National Institute for the Deaf The latest developments in research to understand the link between hearing loss and dementia - RNID

GP Online Services open to 'any qualified provider' revealed by DH | GPonline

Health Service Journal Exclusive: CCG interest in 'any qualified provider' scheme dwindles | News | Health Service Journal (hsj.co.uk)

Health Service journal NHS risks losing specialty to private sector, says Royal College

Health Service journal Use of private providers damaging NHS eye care, survey reveals

NICE Hearing loss in adults: assessment and management

NICE Shared decision making

The Health Foundation Waiting for NHS hospital care: the role of the independent sector

British Dental Association Nearly half of dentists severing ties with NHS as government fails to move forward on reform

BBC Full extent of NHS dentistry shortage revealed by far-reaching BBC research

Association of Optometrists Millions make do with poor vision due to cost of living crisis

The British Irish Hearing Instrument Manufacturers Association Market Statistics Q1 2023 & Q3

The British Irish Hearing Instrument Manufacturers Association Market Statistics Q4 2022

Hearing Loss and Dementia: Where to From Here? - PMC (nih.gov)

With thanks to our Lead Authors:

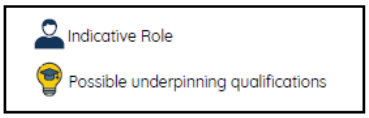
Directors, British Academy of Audiology

http://www.baaudiology.org

Version 1: 12th August 2024

Citation: British Academy of Audiology (2024) BAA Position Statement: The Future of NHS Adult Hearing Loss Management.

Appendix 1 – BAA Scope of Practice Matrix (subject to final consultation)



	Knowledge	Responsibilities	
A	Requires basic factual knowledge of a field of work.	Carry out clinical, technical, scientific or administrative duties according to established protocols, procedures, or systems of work.	Healthcare Science Assistant Level 2 Healthcare Science Associate
B	Requires knowledge of facts, principles, processes and general concepts in a field of work.	Carry out a wider range of duties than the person working at level A, and will have more responsibility, with guidance and supervision available when needed. Contribute to service development, and are responsible for self development.	Senior Healthcare Science Assistant / Healthcare Science Associate Level 4 Healthcare Science Associate
C	Requires factual and theoretical knowledge in broad contexts within a field of work.	Work is guided by standard operating procedures, protocols or systems of work, but the worker makes judgements, plans activities, contributes to service development and demonstrates self development. They may have supervision of some staff.	Hearing Aid Dispenser Level 5 Hearing Aid Dispenser
D	Requires comprehensive, specialised, factual and theoretical knowledge within a field of work and an awareness of the boundaries of that knowledge.	Use knowledge to solve problems creatively, make judgements which require analysis and interpretation, and actively contribute to service and self development. They may have responsibility for supervision of staff or training	Healthcare Science Practitioner / Audiologist/Senior Hearing Aid Dispenser BSc Audiology
E	Requires a critical understanding of detailed theoretical and practical knowledge, are specialist and / or have additional responsibilities (e.g. management and leadership, education and training, or research and innovation).	Demonstrate initiative and are creative in finding solutions to problems. Responsibility for team performance and service development and they consistently undertake self development	Senior Healthcare Science Practitioner / Senior Audiologist M-level modules in specialist area
F	Requires a critical awareness of knowledge issues in the field and at the interface between different fields.	Demonstrates innovative practice and has a responsibility for developing and changing practice and / or services in a complex and unpredictable environment.	Clinical Scientist MSc
G	Requires highly specialised knowledge, some of which is at the forefront of knowledge in a field of work, which they use as the basis for original thinking and / or research.	Leaders with considerable responsibility, and the ability to research and analyse complex processes. Responsibility for service improvement or development. May have considerable clinical and/or management responsibilities, be accountable for service delivery or have a leading education or commissioning role.	Principal Audiologist, Clinical Lead, Educational Lead Management and leadership, PG cert in education
H	Requires knowledge at the most advanced frontier of the field of work and at the interface between fields.	**Leaders with considerable** responsibility for the development and delivery of a service to a population, at the highest level of the organisation **with (ultimate)responsibility for quality assurance**.	Consultant Clinical Scientist Higher Specialist Scientist Training