Commissioning to Meet Hearing Need and for Better Access, Outcomes, Quality and Choice

Community Based Adult Hearing Services

Guidance for Commissioners and Providers

This guidance is produced by: the National Community Hearing Association (NCHA) and the British Society of Hearing Aid Audiologists (BSHAA)

The NCHA is the representative association for community hearing providers in the UK. Membership is open to all providers delivering hearing services in the community including hospitals which provide community outreach.

The BSHAA is the professional body for hearing aid audiologists and dispensers who are registered with the Health and Care Professions Council.

Executive Summary

Today 88% of the 8.4 million people in England with mild, moderate or severe hearing loss are aged 50 and over (AoHL*a*). People with moderate hearing loss can find it difficult to follow speech without support and it is estimated that 5.1 million people aged over 44 in England have a moderate or severe hearing loss (POPPI 2014).

Research has shown that early detection and support for hearing loss can help reduce the risk of depression, anxiety and sadness (National Council on Aging 2000). This is further supported by the Chief Medical Officer's latest Annual Report which acknowledges that appropriate support for hearing loss can have *"a substantial impact on quality of life"* (Chief Medical Officer2014).

Unfortunately despite the clear benefits of early detection and support, many people delay seeking help for up 10 years and this is a significant and growing public health concern

(AoHL *b*; Shield 2006). As in other areas of healthcare early identification and intervention lead to more effective and cost-effective outcomes. Health and Wellbeing Boards (HWBs) and Clinical Commissioning Groups (CCGs) should therefore embrace initiatives that help people with hearing impairment access support as early as possible.

Whilst those aged 45 and over with moderate or severe hearing loss will increase by 775,510 between 2012 and 2020 (Table 2) the greatest growth in demand for hearing services will come from a new generation of older people. This generation will not see disability as inevitable and will expect technological correction and support as a normal part of life. **This change in social attitudes, if supported by HWBs and CCGs, has the potential significantly to improve both public and population health.**

At the same time, without a long-term strategy to improve efficiency, it is likely CCGs will see cost escalation at a rate that makes it difficult to meet this growing need. In turn this is likely to result in inevitable restrictions in access.

In 2011 the Department of Health (DH) identified adult hearing services in the community as one of eight initial priority areas to improve the responsiveness of the NHS and to offer patients greater control and choice (DH 2011). Today, close to 50% of CCGs give their population a choice to access adult hearing services out of hospital and close to home.

CCGs are now in a key position to develop improved thresholds and metrics for quality – e.g. regular follow-up and aftercare, evidence of ongoing technology use and hearing improvement. CCGs can use transparency, commissioning and competition to empower service users and drive change and efficiency at all points in the care pathway. Deploying such tools as fixed-price reimbursement CCGs can get more for their resources and achieve the quality of life gains required to ensure adult hearing services remain cost-effective.

Transparency, competition and a patient centred adult hearing service can help ensure future generations of people with age-related hearing loss continue to be able to access NHS care in a timely manner. However to ensure fair access to quality hearing services, commissioners and providers need to develop long-term relationships – as both NHS England and Monitor recommend – and plan for the future increase in demand and cost-control without restricting access. This is essential if the NHS is to meet its £30 billion funding gap without increasing health inequalities.

If successful we will be able to improve the health and wellbeing of local populations and allow older people to stay independent for longer. Without action it is likely population health will continue to decline with older age. CCGs need to take a long-term view and work with providers to control cost, improve quality and access and improve outcomes. This will require innovation and collaboration. This guidance is a first step in setting out how these challenges can be met.

CONTENTS OF THIS GUIDANCE

1.Background

In July 2011 supported by national patient groups, voluntary organisations and NHS commissioners, the Department of Health decided to extend patient choice for adult hearing services (DH 2011). This is one of eight initial priority areas designed to improve the responsiveness of the NHS and to offer patients greater control and choice. Since then thousands of patients, when given a choice by their GP, have chosen to have their hearing care needs met in a community setting.

The central goals of this policy – to "provide a vehicle to improve access, address gaps and inequalities and improve quality of services" (DH 2012 p.49) –remain. Recent planning guidance from NHS England notes that, for the NHS to improve quality whilst meeting funding challenges

"… will require a significant shift in activity and resource from the hospital sector to the community" (NHS England 2013 *a* p.9)and

"…outcome is what matters rather than the process or organisational form. NHS England wants local partners to determine the delivery vehicle which best suits local geographies and capabilities" (NHS England 2013 *a* p.18).

This document provides guidance on commissioning adult hearing services in line with these recent policies by Monitor, NHS England and the Department of Health and the principles of the Health and Social Care Act 2012. It aims to assist commissioners and providers in developing a responsive and cost-effective community based hearing service for adults as part of an integrated care pathway covering prevention, case-finding, early intervention, hospital intervention, ongoing support and better hearing outcomes.

2. Introduction

2.1 Understanding Hearing Loss in England

With an ageing population the Department of Health (DH) expects demand for adult hearing services to rise significantly over time (DH 2012 p.10). Today in England[1] it is estimated that

- 88% of the 8.4 million people with mild, moderate or severe hearing loss are aged 50 and over (AoHL *a*)
- 5.1 million people (aged 44 and over) in England have a moderate or severe hearing loss (POPPI 2014)

Research has shown that

- people with moderate hearing loss can find it difficult to follow speech without hearing aids (AoHL *b*)
- people with hearing loss are at greater risk of social isolation and reduced mental wellbeing (AoHL *b*; Shield 2006).
- early detection and support for hearing loss can help reduce the risk of depression, anxiety and sadness (National Council on Aging 2000)
- appropriate support for hearing loss can have *"a substantial impact on quality of life"* (Chief Medical Officer 2014 p.59).

2.2. Evidence Base and Rationale for Commissioning Adult Hearing Services

In December 2012 NHS Tees in collaboration with hospital and community providers, the third sector, the Department of Health, the Royal College of Nursing and several NHS commissioners produced high-level guidance on commissioning adult hearing services. Informed by expert opinion, the Department issued Best Practice Guidance which made clear that a significant proportion of people affected by age-related hearing loss did not require referral to ENT prior to an assessment by an audiologist and that direct access to adult hearing services could improve responsiveness (DH 2012 p.10).

The Best Practice Guidance recognised that the care pathway for adult hearing services could be redesigned to better reflect clinical need. This evidence-based approach has the potential to bring significant efficiency savings and allow available resources to be redeployed in order to meet growing demand. For example, when a GP decides to refer a patient through a direct access pathway (based on clinical need) the patient does not need to see a consultant and therefore CCGs will not fund an additional outpatient appointment

[1] In the UK an estimated 10 million have hearing loss and this is projected to rise to 14.5 million by 2031 (AoHL b).

prior to seeing an audiologist, potentially saving £103.00 (range: 103.00-133.65)[2] per patient whilst at the same time improving access to care. We will issue further supporting guidance this Autumn on the potential benefits of re-commissioning adult hearing services including extending choice, reducing potential cost per episode and delivering against auditable quality standards.

The next section explains the evidence base for commissioning adult hearing services and common misunderstandings.

3. Assessing Need for Hearing Services

3.1 Common Misunderstandings about Hearing Needs

Hearing needs are not well understood and often people will delay seeking help for up to 10 years after onset of symptoms (AoHL*b*). Historically health professionals and commissioners have assumed this delay is because patients are not experiencing significant symptoms; however this might not be the case. With the predicted increase in the prevalence of hearing loss, the consequences of delayed intervention and the impact of hearing loss on quality of life and mental wellbeing make unsupported hearing loss a significant public health concern.

> *"The prevalence of hearing loss among adults above 65 years is thought to be up to five times higher than that for people below 65 years old. Age-related hearing loss is termed 'presbycusis'. Exclusion from communication can have a significant impact on everyday life, causing a feeling of loneliness, isolation and frustration, particularly among older people who have hearing loss. The percentage growth in the number of people aged 65 years and above will be between 18–50%* from 2010–2020 in all regions. The number of people with hearing loss will consequently grow by similar proportions, paralleling these demographic changes."* ***(World Health Organisation 2013 p.9)***

Box 1. WHO on Hearing Loss

The Department of Health (DH) has made clear that *"… providing appropriate interventions can reduce isolation, facilitate continued integration with society and promote independent living"* (DH 2012 p.10). This is further supported by the Chief Medical Officer's most recent Annual Report which acknowledges that appropriate support for hearing loss can have *"a substantial impact on quality of life"* (Chief Medical Officer 2014).

Today, the main cause of hearing loss in UK is the ageing process. It has been estimated that 40% of those over 50 and 70% of those over 70 have a degree of hearing loss (DH

[2]Calculated from Monitor's 2014/15 outpatient tariff for ENT. The range is for the MFF1.0000 (Cornwall) to 1.2976 (UCL, London)

2012 p.10). DH figures suggest 2 million people currently use hearing technology but another 4 million people could benefit from such an intervention (DH 2012p.10). Along with bodies such as WHO (Box 1), experts in the field of audiology have raised the issue of the unmet need and its consequences on quality of life.

There are many barriers to accessing hearing services – including stigma linked to use of hearing technology – but without a change in the way health professionals and commissioners view, commission and provide hearing services, patients will continue to experience barriers to care. Not all patients require hearing aids and other early interventions – such as counselling and advice – might help people adapt to mild hearing loss.

It has become a social norm to accept use of spectacles for presbyopia in one's 40s and yet there is still a lack of information and understanding about presbycusis (age-related hearing loss). Whereas patients will notice that they can no longer read unassisted, they do not always notice the decline in hearing or the impact their hearing loss is having on their daily functioning and others around them. The World Health Organisation has recognised that age-related hearing loss in high-income countries is a major contributor to years lost due to disability (WHO 2004 p.35-36, 42-45 and 51). NCHA and BSHAA members are committed to working with stakeholders to tackle these public health issues, reduce health inequalities and improve hearing outcomes.

3.2 Joint Strategic Needs Assessment (JSNA)

With an ageing population it is essential that Health and Wellbeing Boards (HWBs) consider the hearing needs of their local populations. A local hearing needs assessment (HNA) can be free-standing or part of a wider sensory impairment strategy. In either case the HNA should be part of the JSNA.

Through the HNA, including local engagement and researching the literature, HWBs will find that

- people with moderate hearing loss can find it difficult to follow speech without hearing aids (AoHL *b*)
- people with hearing loss are at greater risk of social isolation and reduced mental wellbeing (AoHL *b*; Shield 2006).
- early detection and support for hearing loss can help reduce the risk of depression, anxiety and sadness (National Council on Aging 2000)
- appropriate support for hearing loss can have *"a substantial impact on quality of life"* (Chief Medical Officer 2014).

In assessing the scale of local hearing loss, HWBs and CCGs will find the hearing impairment statistics provided by Projecting Older People Population Information (POPPI) useful. These can be accessed as follows:

1- register for an account at http://www.poppi.org.uk/

2- once registered login to the site

3- on the left click the “Health” tab and this will display more options

4- select “hearing impairment” and this will display moderate to severe hearing impairment in England

5- above “hearing impairment” you will see the region displayed is “England”

6- on the right there is a menu bar. Choose a local region for example “East Sussex”

7- the figures now show population needs in “East Sussex” and these can be downloaded into an excel sheet by pressing the “download” tab and saving it to a local drive

8- click the tab “show ages 18 to 85 and over” which is located at the top of the table and this will display a more comprehensive statistical set

9- for data for on those <65 scroll to the bottom of the table and select “Visit PANSI to see Hearing impairment for people aged 18-64” and this will take you to a different website.

3.2.1 Prevalence of Hearing Loss in England

Table1. Estimated number of people with hearing impairment in England ages 18 to 85 and older [Source: http://www.poppi.org.uk accessed 15 April 2014][3]

Year	2012	2016	2020
Moderate or severe hearing impairment	5,083,002	5,462,178	5,932,446
Profound hearing impairment	112,147	123,467	134,944

Table 2. Estimated number of people with hearing impairment in England aged 45 and over [Source: http://www.poppi.org.uk accessed 15 April 2014]

Year	2012	2016	2020
People aged 45 and over with moderate or severe hearing impairment	4,935,867	5,316,305	5,711,386

[3]When mild hearing loss is taken into account c. 10.1 million people in the UK (8.45 million in England) have hearing loss (AoHL *a*).

Table 3. Estimated number of people **over the age of 75 living in care homes** with a hearing impairment [Source: http://www.poppi.org.uk accessed 15 April 2014]

Year	2014	2020	Source
How many people live in English care homes	348,087	411,238	POPPI[4]
How many are over the age of 75	344,355	407,241	POPPI
Percentage of people over the age of 70 with hearing loss	**70%**		DH 2012 p.10[5]
Estimates of how many people living in care homes (aged 75 and over) have hearing loss	**241,048**	**285,068**	

Important notes: POPI and PANSI sources **do not**

- provide data for hearing impairment for people under age 18
- provide data for people with mild hearing loss

HWBs and commissioners may also find the following resource useful

- Action on Hearing Loss, a leading charity has published a reliable source of "Facts and figures on hearing loss and tinnitus" which you can access by clicking here

When mild hearing loss is taken into account c. 10.1 million people in the UK (8.45 million in England) suffer hearing loss (AoHL *a*).

Planning to meet need

Current service planning and projections are based on historical demand and often overlook unmet need. This is because many people delay seeking help for up 10 years.

In the future, thanks to work done by charities to promote awareness of hearing loss, people are less likely to delay seeking help and therefore demand for these services will grow owing to

- older people being more aware of and keen to address their hearing loss earlier and
- a growing older population with a higher prevalence of hearing loss.

Given the impact hearing loss has on isolation and its correlation with mental ill health, HWBs and CCGs should embrace initiatives that help people access support as early as possible and be planning in order to meet the future needs.

[4] http://www.poppi.org.uk accessed 15 April 2014

[5] The Department of Health source states 70% of people over the age of 70 have hearing loss and the POPPI tool only provides data in ranges that overlap. To avoid biasing estimates for those below 75, those under 75 have been excluded. Therefore this is a conservative estimate.

Whilst the number of those aged 45 and over with moderate or severe hearing loss is estimated to increase by 776,000 during 2012-2020 (Table 2) the greatest growth in demand for hearing services will come from a new generation of older people who will see hearing correction and support as a normal part of life. **This change in social attitudes, if supported by HWBs and CCGs, has the potential to improve both public and population health significantly.**

Without a long-term strategy to improve efficiency, it is likely CCGs will see cost escalation at a rate that makes it difficult to meet this growing need. In turn this is likely to result in restrictions in access. Taking a long-term view, commissioners are now in a key position to develop improved thresholds and metrics for quality – e.g. regular follow-up and aftercare, evidence of ongoing technology use and hearing improvement. CCGs can use transparency, commissioning and competition to empower service users and drive change and efficiency at all points in the care pathway, for example by measuring how many hearing aid users continue to use their technology, incentivise providers to deliver aftercare and follow up. Deploying such tools as fixed-price reimbursement CCGs can drive more value from their commissioning, achieve quality of life gains by successful adaptation to technology, incentivise better services and support and make adult hearing services more cost-effective.

HWBs and CCGs can access more information on the impact of hearing loss in adults from Action on Hearing Loss and other leading charities. The NCHA also plans to build a future "commissioners" resource into its new website format (to launch in August 2014). Commissioners will be able access links to peer reviewed literature, statistics and other useful information.

4. Experience of Offering Patients the Choice of Care in the Community

Since being identified as a priority area for greater patient choice, commissioners have been able to open up access to NHS funded adult hearing services for patients close to home and out of hospital – a choice that previously did not exist for NHS patients.

In the first round of commissioning, 44% of Clinical Commissioning Groups (CCGs) opted to expand adult hearing services by allowing a choice of community-based providers in this way. Another advantage has been that CCGs are able to gain more control over pathways within the acute setting – for example removing the need for a funded ENT outpatient appointment when a GP does not feel it is required.

In this guidance we draw on AQP experience to date and NHS England's planning guidelines to support CCGs in procuring adult hearing services in a way that is consistent with the strategic priorities for the NHS (NHS England 2013 *a*).

4.1 Progress since the First Round of Commissioning

Today, 44% of CCGs have used AQP to commission community based adult hearing services and in doing so have already made progress towards meeting NHS England's guidelines on "planning for patients 2014/15 to 2018/19" (NHS England 2013 *a*). For example these CCGs have met the following key objectives with respect to audiology

1. Transformational change that empowers patients and delivers a more comprehensive package of primary care (NHS England 2013 *a.* p5).

   Allowing access to NHS funded care in the community has already resulted in fewer patient visits to hospital for routine hearing care

2. Access to services – "Convenient for Everyone" (NHS England 2013 *a.* p5)

   CCGs have been able to commission adult hearing services in the community and allow patients to access weekend appointments and aftercare closer to home, all at no extra cost per capita to the NHS.

3. "Reducing health inequalities" (NHS England 2013 *a* p.5, 8 and 45).

   CCGs that have commissioned community-based adult hearing services have understood that consequences of hearing loss – social isolation, depression and general reduction in well-being – are avoidable. In taking action they have made NHS adult hearing services more responsive and accessible to patients regardless of socio-economic status[6] and at the same time prevented cost escalation later in life.

Since the introduction of community based adult hearing services, patients accessing care closer to home – via AQP – have reported high levels of satisfaction (forthcoming NCHA publication). Whilst there have been administrative challenges, as expected given the scale and pace of change, providers and commissioners have worked together in the best interests of patients and with the aim of building sustainable service pathways.

4.2 Transitioning into the Next Round of Commissioning

Since the majority of adult hearing services contracts have only been in place for a short while, it would be natural to expect them to be rolled forward particularly in the light of the good results reported so far. 'Stop-start' at this stage in community based adult hearing services would not build the confidence of providers, would interrupt the ongoing care of patients and would also waste the NHS funds invested in approving, administering and managing contracts.

Such an approach would also run counter to the Government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry where it was made clear that "Important as contracting is, good commissioning is much more than the specification of services and

[6]Previously only private patients could benefit from this level of choice and access. This meant that barriers to early intervention were greater for NHS funded patients

outcomes (DH 2013 *a*p.84). It requires a *mature* dialogue with providers and other organisations in the health and care system to ensure that the long-term interests of the public are being safeguarded and advanced" (our italics) (DH 2013 *a* p.84). That aim cannot be delivered by short-term, staccato changes in commissioning and contract terms.

As some initial contracts came to an end in March 2014, CCGs have been responsible for re-commissioning and the NCHA and BSHAA have welcomed the advice from NHS England that *"…where existing qualified independent sector providers are performing satisfactorily against their contracts, CCGs should award a further contract without running requalification procurement processes for these providers"* (NHS England 2013 *b*). This principle seems to have been helpfully followed for 2014-15.

Opening up previously exclusively private community hearing services to NHS patients in their home community has been a major step forward in closing the inequalities gap.

We will continue to support providers and potential providers and work with Monitor, NHS England and CCGs in the best interests of patients so that they continue to have access to cost-effective hearing services based on clinical need and delivered in the way they choose.

5. Commissioning Adult Hearing Services for 2014-15 and beyond

The next round of commissioning for 2014-15 is still underway with a revised standard NHS contract (NHS England 2013 *c)*. With the establishment of NHS England and CCGs and a new system of clinically-led, patient-focussed incentives for change, the initial top-down drive for QIPP and improved access and choice in adult hearing services has transferred to local level. This means that CCGs which have not yet improved out of hospital access to adult hearing services should now consider the benefits of doing so with a view to reshaping the spectrum of hearing care to improve access, value and individual and population outcomes in line with the planned future framework of the NHS (see pages 5-7 and 14-15).

5.1 Technical Aspects of Contracting with Independent Sector Providers to Deliver Adult Hearing Services

Contract Variation Notice Periods

To date CCGs have been required to give providers six months notice of any intentions to vary contracts. This is to give providers time to carry out any restructuring required to meet new requirements. Six months remains a fair notice period for major contract change in line with the NHS commissioning cycle - i.e. September for any changes required from the following April. We would expect CCGs to continue to work, plan and liaise with providers to this timescale in future commissioning rounds.

Contract Duration

In order to deliver efficiency gains, both NHS England and Monitor are encouraging commissioners and providers to develop longer-term relationships and have confidence in each other to deliver high quality services. A significant advantage for commissioners is risk sharing with providers. Providers, given reassurance, will invest their own resources to provide primary care at scale in line with NHS England's planning guidance (NHS England a p.10 and 13). However, given the short duration of contracts (12 months) providers have not always been able to support commissioners in reducing long-term cost pressures on the NHS. Recent guidance from NHS England means that CCGs now have the ability to use longer term contracts to deliver cost-effective, high quality and sustainable community services. We would encourage both parties to work towards these longer term goals.

VAT

Despite the fact that commissioning guidance[7] made clear that the prices agreed in AQP contracts should exclude VAT (to ensure a level playing field with NHS Trusts services which do not incur VAT) there has been ongoing confusion amongst commissioners about whether VAT should or should not be included in agreed tariffs – resulting in errors in both 2012-13 and 2013-14.

In its *"Call to Action"* NHS England made it clear that commissioners have to "... find ways to raise the quality of care for all in our communities to the best international standards while closing a potential funding gap of around £30 billion by 2020/21.It will require a significant shift in activity and resource from the hospital sector to the community" (NHS England 2013 *a*p.9).

Without proper and fair treatment of VAT – as recommended by NHS England and Monitor – CCGs risk distorting the playing field in favour of the hospital-based services and in the long-run supporting unsustainable health care models.

For all new contracts therefore, providers are advised to utilise fully the period to pose questions about local tenders for services and AQP contracts to ensure that both sides are clear about how VAT is to be handled and that prices reflect whatever is agreed in each and every case.

5.2 Tariffs and High Level Pricing Principles

There has also been some confusion about mandatory and non-mandatory tariffs. For the avoidance of doubt adult hearing services in the community are **not** subject to mandatory tariffs.

Much as a national contract and nationally negotiated tariff might be desirable for both commissioners and providers, robust data are not yet available to enable this to happen.

[7]This can now be found on page 44 of the Standard Contract Service Conditions

Currently published non-mandatory tariffs are not methodologically sound costings for local services – they are therefore for guidance only.

For the 21014-15 commissioning round, Monitor helpfully highlighted this for commissioners drawing a clear distinction between 'rules' (mandatory tariff) and 'guidance' (non-mandatory tariff) (Monitor 2013).

Both providers and commissioners should note therefore that, despite local misunderstandings

- non-mandatory tariffs are not local prices and should not be read across to commissioning of community based services
- the *National Tariff* does not apply to *community based* adult hearing services whether commissioned under AQP or other local arrangements.

As Department of Health guidance makes clear, when commissioning services locally, prices should be negotiated locally and this remains the position (DH 2013 *b* p.155).

In addition to these principles, commissioners should take care if they choose to use the non-mandatory tariff as a guide or actual price. It is important to ensure that reimbursement remains fair, transparent and that providers are not discriminated against because of the type of ownership. For example, if hospital providers are paid the non-mandatory tariff adjusted for local MFF, this could cause an un-level playing field if the MFF is not equally applied to community providers who will bear similar costs. In such cases commissioners should seek advice from Monitor on the competition and procurement rules aspects of their commissioning plans.

Finally, commissioners should consider the possibility that some patients might require high-powered hearing aids and yet not need a hospital referral. In such cases commissioners might wish to cost such devices separately and put local arrangements in place for provision (DH 2012).

5.3 Central Commissioning Support

As planned, the Department of Health has withdrawn its interim central support for approving qualifying providers for AQP.

For future rounds, approval of community based providers (just as for any other providers) will be carried out locally by commissioners and Commissioning Support Units (CSUs) using the national AQP qualification questionnaire and documentation ***or*** other locally agreed contracting frameworks.

Supply2Health also closed on 28 March 2014. Future AQP offers will be posted on Contracts Finder: https://online.contractsfinder.businesslink.gov.uk/. Providers can set-up email alerts by registering as a "Supplier" on the website.

Commissioners and providers should also note that South London and Greater East Midlands CSUs will operate a support hub for commissioning adult hearing services. These hubs will provide support for AQP offers and include: advertising on Contracts Finder and running AQP offers online; compliance evaluation and supporting service evaluation.

During 2014 the NCHA and BSHAA will be making contact with all CCGs and CSUs to see what further support commissioners need and how we can best work together to expand community hearing services in all areas for the benefit of patients and the NHS.

6. Looking Ahead

The NCHA is looking to publish standardised community data on services and quality on a national aggregate basis to inform evaluations and future commissioning rounds. (Local commissioners with contracts in place already have these data locally for contract monitoring and service planning purposes.)

This will be increasingly important as community adult hearing services are rolled out across all communities so that improved access, support and follow-up and better outcomes are achieved for individuals and populations.

To ensure we can capture this, the quality and outcomes measures under the standard contract need to be improved and become more patient-focussed without adding to cost. The NCHA and BSHAA will seek to engage with NHS England and hearing charities representing patients on these matters later this year.

Commissioners and providers alike need to develop an overarching commissioning framework for hearing services, within which commissioners, providers and potential providers can work together at local level to achieve the best outcomes and support for patients at all points along the pathway including a flourishing hospital-based audiology and ENT services for those who need specialist referral.

Improvements are also needed in assessing local hearing health needs and planning to meet those needs. The NCHA and BSHAA will continue to work with sector partners through the Hearing Loss and Deafness Alliance to develop further needs assessment data and tools building on the information at Section 3.2 above.

Both commissioners and providers have to make the most of this opportunity to develop a better, more locally responsive and integrated hearing service that is sustainable and able to meet growing demand. NCHA and BSHAA members will continue to engage with all stakeholders to deliver these goals in the coming year.

Annex 1: References

AoHL *a* (Action on Hearing Loss) "Hearing Matters". Action on Hearing Loss. Action on Hearing Loss. London. Calculation based on statistics provided in appendix on page 76

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Shield (2006) "Evaluation of the Social and Economic Cost of Hearing Impairment - a report for hear-it"

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WHO (2013) "Millions of people in the world have hearing loss that can be treated or prevented- awareness is the key to prevention".

Annex 2 – Contact Details and Further Information

For further information or in case of difficulty

- providers (and potential providers) should contact the NCHA (harjit.sandhu@the-ncha.com) or BSHAA (chiefexecutive@bshaa.com)
- commissioners should contact their NHS England Area Team commissioning lead. Commissioners are also welcome to contact the NCHA and BSHAA as above
- For AQP enquires you can contact the AQP Support Hub (SLCSU.AQPsupporthub@nhs.net).

CCGs Contacting the NCHA for Support with Provider Members

The NCHA recognises that CCGs are under considerable pressure and might want to engage with local providers as a collective group or to invite stakeholders to engagement exercises. The NCHA and BSHAA would be willing to assist with this.

If you have any specific questions on this or would like to know where to seek the advice, support or research on any hearing related matters please email harjit.sandhu@the-ncha.com.

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