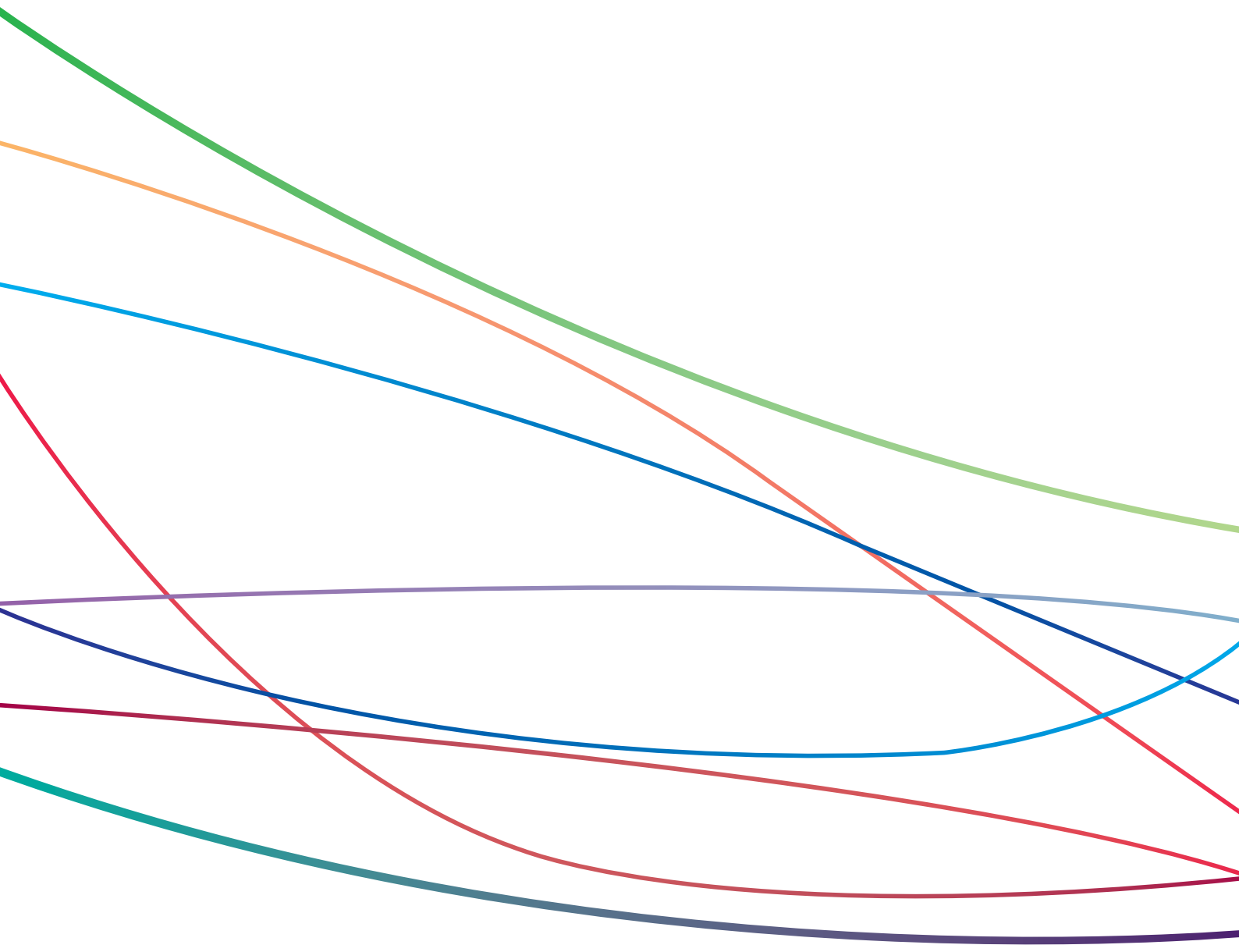
Department of Health

Improving Access to Audiology Services in England



NHS

Improving Access to Audiology Services in England

March 2007

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Foreword

Hardness of hearing and deafness affect the lives of large numbers of people, and can limit active participation in family life and society if not assessed and treated appropriately.

That is why the Department of Health introduced digital hearing aids in 2001 for NHS patients, backed by a drive to reduce the cost of the equipment, and £125m of extra investment. The independent sector began to provide NHS audiology services through the Public Private Partnership (PPP) scheme, and the third sector also became involved. More recently the Department has worked with the NHS to collect better information, which is showing that many people face unacceptably long waits.

This document sets out a simple aspiration: for local health systems to transform the experience of the audiology service for all their patients. This requires a radical reduction in waiting. The most complex audiology cases (those properly referred to ENT) will be covered by the target of treatment within 18 weeks of referral by December 2008. And the remaining routine adult hearing loss cases should be assessed within 6 weeks by March 2008, in line with the diagnostic waiting time milestone on which local commissioning plans are based. It is also good practice for the subsequent hearing aid fitting to be carried out soon after or at the same time as assessment. In short, no local health system will be credible in claiming success on 18 weeks if it does not make excellent progress in tackling long waiting times affecting large numbers of its local population, including those waits that are technically outside the target.

This framework document sets out how health reform levers can be brought to bear to improve quality, efficiency and access to audiology services. It also describes national work intended to support this.

The framework has been developed with the invaluable input of members of a national audiology working group. An expert working group will continue to meet to take forward aspects of this framework and advise on implementation. It will also be a forum for considering other new ideas for service improvement as they emerge.

Local health systems are responsible for commissioning services to meet the needs of local people. This national framework sets out the tools that they can use to transform audiology services.

Ivan Lewis MP
Parliamentary Under Secretary of State
for Care Services
1st March 2007

Improving Access to Audiology Services in England

Introduction

1. The Department of Health's overall aim is to improve a number of key outcomes for patients, namely:
   - Health and wellbeing
   - Safety and effectiveness
   - Responsiveness
   - Efficiency and affordability
   - Equality

2. The vision for people with hearing and balance problems is for them to receive, high quality, efficient services delivered closer to home, with low waits and high responsiveness to the needs of local communities, free at the point of access.

3. The goal is for local health systems to transform the experience of the audiology service for all their patients with a radical reduction in waiting times, with the most complex cases (properly referred to ENT) treated within 18 weeks by December 2008 and with routine referrals sent direct to audiology departments assessed within 6 weeks by March 2008[1]. It is also good practice for the subsequent hearing aid fitting to be carried out soon after or at the same time as the initial assessment.

4. The main way in which transformation will be achieved and sustained is through local health systems applying to the design and delivery of their audiology services the health reform mechanisms of better commissioning and pathway redesign, choice and competition, information and incentives.

5. Each local audiology service should become self-improving, making use of the incentives and levers that exist to meet demand and to drive improved quality and performance to deliver a better experience for patients. Audiology services should be actively encouraged to introduce new service delivery ideas as they emerge without waiting for central intervention. Good commissioning, choice, information, tariffs, the spread of good practice and workforce tools can be used locally to transform the experience for patients.

6. Focusing on the responsiveness of services in particular, the purpose of the 18-week maximum wait target is to cut all avoidable waits and unnecessary steps and to significantly improve the patient experience. The 18-week target does cover those audiology referrals that involve hospital consultant[2]-led services, e.g. ENT. These account for an estimated

1 In line with the diagnostic stage-of-treatment milestone which covers all diagnostics.
2 Medical or surgical

50%[3] of all audiology referrals and include the more complex cases likely to require surgery or more complex assessment and intervention such as paediatric referrals, as well as 20% of adult hearing loss referrals (usually those at the more severe end of the hearing loss spectrum). The target does not cover the other 50% of all audiology referrals for routine adult hearing loss that are sent or come directly to audiology departments.

7. As the NHS Operating Framework for 2007/8[4] said, there are risks to the delivery of the 18-week objective because of the potential for referrals that do not need to be made to hospital consultants[5] – such as referrals direct to audiology departments for routine hearing loss – to be redirected via hospital consultants in order to bring them into the scope of 18 weeks. Commissioners should therefore assess the audiological needs of their local populations and any capacity gaps, and develop and commission the right amount of appropriate pathways, from NHS, independent, and third sector providers as appropriate, to substantially reduce waits across the whole patient pathway.

8. Every single audiology assessment, irrespective of referral route, is already subject to the diagnostic test milestones of 13 weeks by March 2007 and 6 weeks by March 2008. These are intended to ensure that all diagnostic tests are carried out sufficiently speedily by March 2008 to make 18 weeks achievable by December 2008. If the GP refers for an audiology assessment, the 6-week period begins at the point of GP referral. Whilst these milestones are not formally part of the 18-week target, no local health system will be credible in claiming success on 18 weeks if it does not make excellent progress in tackling long waits for all hearing loss cases, which affect large numbers of every local population, across the whole pathway. PCTs will need to ensure local providers deliver the milestones by performance management and through their local contracts. PCTs will be performance managed against the milestones by SHAs.

The service today

9. Hardness of hearing and deafness affects millions of people, with hearing aids used by an estimated two million. Treatments for more complex cases include the provision of bone-anchored hearing aids and cochlear implants.

3 DH and Manchester Research Council modelling
4 Para 2.10 http://www.dh.gov.uk/assetRoot/04/14/11/95/04141195.pdf
5 Medical or surgical, e.g. ENT surgeons

10. Data on adult hearing aid services (AHS) is strongest. The NHS provides at least 2,600,000 AHS appointments a year, broken down roughly as follows:

- 600,000 assessments, including new patients and reassessments
- 500,000 hearing aid fittings in one or both ears
- 500,000 follow up appointments to check that aids are working
- over 1,000,000 'repair' appointments, e.g. to re-tube aids
- AHS services also provide support and counselling

11. This equates to an estimated 500,000 complete AHS pathways per annum for assessment, fitting of a digital aid and follow up and 100,000 pathways where no aid is fitted but the patient may have wax management, middle ear management or participate in watchful waiting.

12. The biggest concern is access, particularly to AHS. The National data collection introduced last year shows that, of the 170,000 people awaiting all audiology assessments at the end of December 2006, 113,000 (two thirds) had been waiting more than 13 weeks. The average expected wait for an audiology assessment is 17-18 weeks, which is longer than the expected wait for any other of the 14 groups of diagnostic tests on which monthly data is collected. About 85% of those waiting more than 13 weeks for an audiology assessment

Table: Variation in waits for audiology assessments at end December 2006

	Expected Average Wait (weeks)	Patients waiting over 13 weeks	Total Waiting	% over 13 weeks
North East	32	9,256	13,201	70%
North West	13	13,157	21,277	62%
Yorkshire and the Humber	15	11,892	15,461	77%
East Midlands	22	9,361	13,889	67%
West Midlands	20	18,234	28,026	65%
East of England	10	4,846	8,620	56%
London	20	9,465	13,829	68%
South East Coast	45	12,742	16,101	79%
South Central	12	5,594	11,110	50%
South West	16	18,927	28,518	66%

are on adult hearing loss pathways, and therefore face a further wait (on which the NHS does not yet systematically collect data) for hearing aid fitting.

13. Performance varies across the country. As the table shows, the number of people waiting more than 13 weeks for an assessment varies, with expected average waits from 10 weeks in the East of England compared with 45 weeks in South East Coast.

14. There are also significant variations in models of service, activity levels, workforce skill mix, productivity and costs. These issues have been highlighted by the Department's 18-weeks physiological measurement diagnostics[6] programme which has focussed on identifying waits and solutions for a number of clinical specialties including audiology.

Commissioning

15. Commissioning is the means by which the NHS secures the best possible outcomes for patients and taxpayers. Stronger PCTs and the acceleration of practice-based commissioning (PBC), together with the incentives introduced by the health reforms, provide the opportunity for more effective commissioning of audiology services. Guidance on commissioning was set out in the Commissioning Framework[7] in July 2006.

16. Every PCT is responsible for commissioning the full range of health services for its population, including audiology, working in partnership with practice-based commissioners. The Commissioning Framework set out the 'commissioning cycle', which applies as much to audiology as to any other service.

17. The needs of the local population should be assessed, involving a rigorous analytical approach of population segmentation and risk stratification and input from public health professionals, local authorities, GPs, patients and the local community. Nationally, the underlying demand for audiology services has been increasing and will continue to increase as the population ages. Routine hearing loss among adults is by far the most common audiological condition.

18. The rate at which demand presents for assessment has been increasing, most notably with the introduction since 2001 of digital hearing aids, which are a distinct technological step forward over

6 http://www.18weeks.nhs.uk/public/default.aspx?main=true&load=ArticleViewer&ArticleId=557
7 http://www.dh.gov.uk/ProcurementAndProposals/Tenders/RecentlyAwardedAndExistingTenders/RecentlyAwardedExistingTendersArticle/fs/en?CONTENT_ID=4137055&chk=i3NEiK

the standard analogue aid they replace. Digital hearing aids can be set to match more precisely the need of the individual but can take extra time to fit and tune. The effect of this and the increase in demand has been to keep waits up.

19. Existing service provision needs to be reviewed. Local health communities will identify gaps and the potential for improvements in existing services. PCTs will use the aggregated intelligence of their practices and their local needs assessment to identify gaps or inadequacies in provision, as well as broader requirements for service development. The Department estimates that nationally around 300,000[8] extra AHS complete pathways (where 85% of audiology long waits lie) 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, thereby eliminating entirely the risk to 18 weeks described above. This implies an increase in AHS annual provision nationally of between a third and a half, depending on how quickly it comes in over the 21-month period to December 2008. Each SHA, based on the work of its PCTs, will have its own estimate of the capacity gap associated with its long waits and the needs of its population.

20. Commissioners will choose to fill their estimated capacity gap with a combination of greater efficiency in existing services where possible, and, where that is insufficient, new capacity. The current NHS planning process for 2007/8 and 2008/9 for completion by the end of March 2007 is addressing this.

21. Each PCT will have its own relative service priorities, to be set out in its 'prospectus' to signal the strategic direction for local services, highlighting commissioning priorities, needs and opportunities to service providers, offering a focus for discussion with patients and local communities and an opportunity to open dialogues with potential providers and with associated supporting services. Audiology should be explicitly addressed through the process of PCTs developing their first prospectuses.

22. PCTs will want to be clear about the services and service specifications they and their practices and patients want to see developed and will give strategic support to proposals where necessary. They will seek to develop improved pathways and will work with NHS trusts

8 This estimate is based on available data and recognition of the uncertainty about future demand

and NHS foundation trusts, GP practices, neighbouring PCTs, IS and third sector providers, social services and local authorities as appropriate (e.g. for more complex cases such as patients with co-morbid conditions already accessing social services) to ensure that they provide the most effective, responsive and efficient services for their local populations.

23. At present, NHS audiology services are mostly located in NHS acute hospitals, although some, for children in particular, are provided on an outreach basis in the community. Older people make up a large proportion of hearing aid users and the National Clinical Director, in his recent 'Recipe for Care' report identified the need to bring care closer to home and to provide early intervention and assessment for older patients with hearing problems[9]. A small number of audiology services are provided by PCTs in primary care settings. Independent sector provision is growing, with some involvement in NHS provision through a Public Private Partnership over the last 5 years. The third sector is also involved in patient support in some audiology services.

Case study – voluntary sector service provision

Hearing Concern[10] uses a network of volunteers to support NHS audiology services across the country. The volunteers provide rehabilitative advice to help patients live with and manage their hearing loss. Whilst currently small scale, this project illustrates the role that the voluntary sector can play.

24. For the years ahead, the Department has already facilitated the procurement on behalf of SHAs of 42,000 new pathways per annum as part of the Phase 2 IS diagnostics procurement, due to come on stream from April 2007. The Department has also prepared a Phase 2 IS elective audiology procurement on behalf of SHAs, with the amount to be procured dependent on the outcome of the current planning process.

9 'A Recipe for Care – Not a single ingredient' (January 2007) http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4142425&chk=8v8oMf

10 Hearing Concern is a national charity working for people who are deaf or hard of hearing

Case study – Independent Sector provision of NHS audiology services under current Public Private Partnership contractual arrangements

An independent sector hearing aid services provider is working in partnership with a major NHS teaching hospital trust in the West Midlands as part of arrangements to manage NHS patients who require a hearing aid. The company provides around 15 clinics per week to the trust, and is currently contracted to deliver NHS hearing aid services to over 1500 of the trust's patients. The clinics are based both in the hospital and high street settings in order to provide flexibility to the trust's patients. The partnership approach within the contract also includes joint-working on patient-related administration between the company and trust in order to increase efficiencies.

25. By April 2007, PCTs will agree contracts with local secondary care providers for activity levels in 2007/8 including audiology activity (in the non-PbR schedule). The new national health contract focuses on the delivery of services within 18 weeks, with financial incentives and good contract management to drive delivery.

26. Commissioners are responsible for commissioning the right pathways for their patients and for ensuring that they represent best value. It is clear that there is enormous scope nationwide to cut unnecessary waiting out of pathways. At present, AHS pathways tend to involve separate visits for assessment, fitting, follow-up, repair and ongoing advice and counselling. To improve patient convenience and speed up access to fitting, and to make more efficient use of audiologists' time, one-stop assessment and fitting has been trialled in a number of 18 week physiological measurement development sites, including Norwich, Birmingham, North Staffordshire and Leeds. While long waits remain in some of these trusts, positive results are being seen with additional capacity being liberated.

Case study – one-stop assess and fit at Norfolk and Norwich University Hospital Trust

Norfolk and Norwich University Hospital Trust has been trialling new 'open-ear' technology, which enables the patient to leave their initial appointment with a hearing aid fitted. The technology is based on an open ear mould hearing aid tip, which fits most ears. Further efficiency is achieved by using an audiology assistant to carry out the final parts of the fitting and secretaries to make follow up calls to patients using a structured questionnaire.

The trust has seen referral to treatment waiting times for new patients fall from 28 weeks to 21 weeks in the last year and for those re-entering the service for re-assessment and fitting of a digital hearing aid from 25 to 11 weeks. The audiologist involved has increased productivity by 15%. Patients are pleased both with the speed and the new technology which is more cosmetically acceptable. The trust now plans to train other staff members and to extend the solution to all suitable patients.

27. To inform local commissioning, the Department will publish model care pathways that draw on innovation and good practice and give local commissioners clear blueprints as a starting point for the design and provision of local services. The adult hearing loss pathway will be published in March 2007, glue ear in April 2007 and cochlear implant, balance, bone-anchored hearing aids and tinnitus by October 2007.

28. The adult hearing loss pathway will explain that:

- appropriate new and returning patients should receive one-stop assessment and fitting based on available technology;
- preparation (e.g. removal of earwax) should be carried out in advance in primary care or as part of the one-stop appointment;
- follow up and reviews, including for reassessments, could be conducted by telephone, postal questionnaire or in person by an audiology assistant;
- patients who have received an aid should get maintenance, battery replacement, and advice from locations convenient to them in line the Care Closer to Home programme, which could involve the third sector or IS provision on the high street;
- patients that still have an analogue aid should be prioritised for a reassessment of their hearing loss and be provided with a digital aid ahead of those who already have a digital aid.

29. The impact of these measures locally in terms of increased productivity and patient experience will depend partly on the existing service models employed locally. The Department believes that it is possible to increase adult hearing loss pathway productivity significantly using this kind of approach.

30. As well as insisting on best practice pathways, commissioners can derive further extra value by requiring better referral practice and better waiting list management. Model protocols will be published shortly to ensure that patients who need to be referred are referred to the right kinds of services (e.g. direct access, ENT) and that patients who do not have an aid are prioritised. There is anecdotal evidence that the 20% of adult hearing loss cases that are referred to ENT could be reduced with more referred direct to audiology.

31. Experience of waiting list 'validation' for outpatients and inpatients suggests that commissioners can derive up to a 10% reduction in list size. Unvalidated lists include the details of patients who, for example, no longer require the service, or who have moved and are duplicated on more than one list. Validation of lists enables more efficient use to be made of available capacity because the details of patients are accurate. Early triage then helps to better prioritise patients on the basis of need and waiting time. We will review whether new or additional guidance is needed on waiting list management, and disseminate best practice experience with practical examples of how it can be done.

32. Commissioners may also require providers to employ the 'priority treatment list' (PTL) approach to manage their waiting lists. A PTL tool has been designed and disseminated[11]. This requires local services to list the details of patients waiting for a routine assessment in order of the date on which they were referred for the test and then to call patients for their tests in that order, ensuring openness and fairness. An 'assess & fit' PTL will be piloted to enable all adult hearing service pathways to be managed on a referral-to-treatment basis.

33. All of these measures can serve to increase efficiency and free up capacity.

34. Proposals for quality assessment and monitoring, with an agreed minimum specification, will be developed during 2007 to underpin a growing variety of types of provision. Linked to this, a service-monitoring tool similar to the 'global rating scale'[12] used for endoscopy services will be piloted. This will help

11 accessible to SHAs on Steis
12 http://www.grs.nhs.uk/

practices and PCTs to commission on the basis of quality in its broadest sense, assessing each local service on a range of factors such as quality, safety and effectiveness, responsiveness and efficiency. It may be possible for the lowest performing services to benchmark their performance against higher performing services.

Choice

35. Empowering patients to choose a provider is proven to improve services and reduce waits. Choice-at-six-months for orthopaedics was a key factor in driving down inpatient waits in that specialty, and the choice-of-scan initiative, tied to set waiting time maximums, has had a clear impact on waiting times for MRI and CT scans. Policy on choice at referral at present applies to all referrals from GPs to first consultant outpatients, including audiology referrals to ENT.

36. Version 4.0 of Choose and Book, for release in 2007, is being designed to enable direct referrals to audiology services and booked appointments for patients to be made from GP surgeries. This heralds a broadening of choice-at-referral which will enable patients to choose from a range of audiology providers.

37. The Department has already published its clear priorities for 2007/8 in the Operating Framework. However, we will keep under close review the possibility of introducing a choice-of-scan-type approach for audiology (choice of audiology service) later in 2007/8 or from April 2008 when the extra IS capacity procured on behalf of the SHAs and their PCTs is likely to have come on stream.

Local prices

38. The Department will look to develop benchmark costs, and is committed to considering the introduction of national audiology tariffs as soon as practicable bearing in mind the recommendations of the Lawlor review of payment-by-results. In the meantime, local commissioners will want to work with their providers to generate the conditions for choice and contestability to flourish. The absence of national tariffs in this area means that PCTs are empowered to do this and develop prices that support choice and efficiency, rather than block contracts.

Information

39. The publication of information is a powerful driver of patient choice and peer opinion. Until recently there was no available information on audiology services. Since the middle of 2006, NHS data on waits for audiology assessments has been published by the Department[13],

13 http://www.performance.doh.gov.uk/diagnostics/index.htm

and this will continue. In the spring, the Department will begin to publish NHS referral-to-treatment (RTT) data covering those audiology pathways that are within 18 weeks. As local services will need to record RTT times for 18-week patients, it would make sense to record RTT times for all audiology patients. We will consider whether a national data collection of all audiology RTT times is necessary.

40. To support active choice, information on health services needs to be presented to patients in clear and engaging formats. We will ensure that comparative information is made available on the "healthy choices" website, which is expected to go live in the summer.

41. The achievement of 18 weeks will be judged, not just by RTT data but by what patients actually experience of the services they receive. That means their experience not just of access but of quality, safety and other factors. A set of patient experience metrics by which to judge 18 week achievement in each locality is being developed. We intend that this will cover audiology services including direct access services.

Spread of good practice

42. The Department will help by making available audiology good practice information and tools in various areas, including evidence which has been gathered from nine NHS development sites as part of the 18 weeks physiological measurement programme. All evidenced good practice will continue to be made available on www.18weeks.nhs.uk and disseminated widely by other appropriate routes.

43. SHAs are encouraged to operate audiology networks of clinical leaders with IS and third sector representatives, to help with the spread and adoption of good practice.

Case study – West Midlands SHA audiology network

West Midlands SHA has established a network of providers of audiology services to share ways to address long waiting times. The network is sponsored by the SHA Director of Commissioning. Heads of audiology Departments and PCT Commissioning Leads get together quarterly to consider the use of spare capacity – for example moving patients across PCT boundaries – and using alternative providers in the NHS and IS.

44. SHAs and PCTs should pilot and evaluate their own new and innovative ideas which in some cases the Department may be in a position to sponsor.

Workforce tools

45. Workforce is critical to implementing this framework. Plans must be affordable, and should be supported by significant role redesign, skill-mix and productivity gains. Providers will want to consider developing competence based models of the current and the future workforce with emphasis on tackling blockages in the pathway and developing alternative processes where there are shortages. It is also beneficial to ensure that financial planning for training supports the strategy and that new MPET flexibilities are used and that vacancies, for example, are seen as opportunities for skill-mix changes rather than insurmountable blockages.

46. Most importantly, it is crucial that local staff are engaged with service and process redesign and that local leaders and clinical champions are identified. Support is available in the National Workforce Projects directory of resources[14].

47. A toolkit of materials will be developed to support local health systems in adjusting workforce profiles to reflect the new model pathways and volumes of activity required. It will include a survey of the current workforce and roles, modelling based on the new pathways, including of associated new roles and underpinning competencies and identification and development of supporting education and training for use by SHA and PCT workforce planners and commissioners. At present, skill mix and numbers of staff vary between organisations and settings but without obvious correlations in terms of outputs.

48. This year over 300 new hearing aid audiologists will be trained by Higher Education Institutions to respond to demand from High Street hearing care practices. They will complete a Foundation degree operated as an "earn as you learn" partnership with high street employers. Over two years, this degree programme will combine academic and workplace learning and skills development. This work has been informed by and will align with a broader DH programme of work to modernise scientific careers, linked to skills and competence development as part of the skills for health work programme.

14 www.healthcareworkforce.org.uk

Summary of key outputs

49. Key outputs, as they appear in the document, are:

- Expert working group – foreword (ongoing)
- Model care pathways – para 27 (March – October 2007)
- Referral protocols – para 30 (May 2007)
- Waiting list management best practice – para 31 (May 2007)
- Assess and fit PTL pilot – para 32 (by end 2007)
- Quality assessment and monitoring – para 34 (by end 2007)
- Service-monitoring tool – para 34 (by end 2007)
- Choose and book for audiology – para 36 (2007)
- Decision on choice of audiology initiative – para 37 (2007/08)
- Benchmark costs developed – para 38 (2007)
- Decision on tariff for audiology – para 38 (2007)
- Decision on data collection for audiology RTT – para 39 (2007)
- Information for patients on "healthy choices" website – para 40 (2007)
- 18w patient experience metrics including audiology – para 41 (2007)
- Good practice information and tools – para 42 (March 2007)
- Workforce toolkit – para 47 (Summer 2007)

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