Summary

One in seven people in England suffer from hearing loss of some kind. People with poor hearing are more likely to be socially isolated and to have reduced quality of life. Fortunately, many people can receive an effective treatment. Digital hearing aids are far superior to older models. They give a higher quality of sound and are more comfortable to wear. They can also be used by people who were unable to use analogue aids.

In 2000, the Government introduced the Modernising Hearing Aid Services (MHAS) programme to improve audiology services, mainly through the provision of digital aids. The MHAS programme provided many people with digital hearing aids. However, there was a rise in demand not just from new patients, but also from those wishing to upgrade their analogue aids. Surprisingly the rise in demand was not predicted and led to very long waiting lists and times, exceeding two years in some places. Some PCTs have given audiology services a low priority.

In view of this situation, we decided to hold an inquiry. Following this announcement, the Government published a new framework on audiology, entitled *Improving Access to Audiology Services in England*. Our examination of the framework confirmed our view not only that audiology is not a priority for some PCTs but also that it is still not a sufficiently high priority for the Government. The framework added little that was new; instead it reiterated previous announcements.

A particular concern is that the new framework keeps audiology outside the 18-week referral to treatment target that applies to consultant-led services. This must change soon. Exclusion of audiology from the 18-week target compounds the problem of long waiting times. It has also led GPs to refer patients unnecessarily to consultant-led ear, nose and throat (ENT) departments so that they can be seen more quickly. This increases costs and waiting times for ENT outpatient appointments. While it would be difficult to add audiology immediately to the list of services required to meet the 18-week target by December 2008, we recommend that it be included in this target at an early date.

There is a need to increase capacity, but precisely how much extra capacity will be needed in the future is unclear. Some described future demand as a 'bulge' that could be overcome using short-term measures. Others told us that demand would continue to grow. Effective forecasting is needed. We recommend that the Department undertake a thorough examination of the medium- and long-term demand for digital hearing aids. For this to take place, the Department must collect comprehensive information on all audiology patients, including how long they have to wait between GP referral and receipt of a hearing aid.

Regardless of whether the current high level of demand is a temporary phenomenon or a long-term trend, it is clear that extra capacity is needed now. While there is much good practice in some NHS audiology departments, there is enormous variation between areas. There is much that could be done to make services more efficient. We recommend that audiology departments review the way in which services are provided, examining in particular the skill mix and levels of training needed. These reviews should include the

possibility of operating flexible opening hours, following up patients by telephone, using the Choose and Book system, and pooling capacity to ensure more patients are seen. In addition, it is necessary to consider whether the NHS is making the best use of new audiology graduates.

The Department has decided to involve the private sector through the negotiation of new contracts and as part of phase 2 of the Independent Sector Treatment Sector programme. It is crucial that value for money assessment of these contracts is carried out. This will be difficult without a tariff associated with audiology services and so we recommend that the Department produce a national tariff for audiology.

Many groups, including new entrants to the market such as opticians, are keen to supply and fit hearing aids. We were not presented with any evidence which convinced us that that such new entrants should be excluded from providing audiology services. However, our inquiry into *NHS Charges* found that NHS patients were sometimes encouraged by optical outlets to buy expensive spectacle frames and lenses. Vulnerable people who are hard of hearing must not be encouraged by private providers to 'trade up' to buy more expensive hearing devices than necessary.

Private sector services must be monitored and the quality of care must be assessed on the same basis as the quality of care is assessed in the NHS. The Department should also ensure that NHS capacity and expertise are not depleted due to private sector involvement.

The Department must balance the need to ensure value for money and quality of care with the need to encourage the private sector to invest in facilities and maintain high standards. We therefore recommend that contracts be relatively short-term in the first instance but extendable subject to companies achieving and maintaining high standards of care.

We are reassured that the Department is prepared to be flexible about the extent of private sector involvement, depending on evidence received from local NHS organisations. However, we are concerned that the evidence underlying the original commitments was inadequate. There was little analysis of the areas most in need of private provision. We recommend that the Department specify criteria for private sector involvement in the future, for example, failure to meet the 18-week target once it is in place. The Department must make evidence-based decisions and ensure value for money.