



**Commissioning Services for
People with Hearing Loss:**

**A framework for
clinical commissioning groups**

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1 Foreword

By Professor Sue Hill OBE, Chief Scientific Officer for England

Hearing problems are a growing challenge across society with over nine million people in England living with some form of hearing loss which impacts on their ability to fully participate in society. The scale of this issue requires a broad response from the health and care system and beyond.

I was very pleased to lead the development of the Action Plan on Hearing Loss for the health and care system in 2015, which represents a true partnership of all stakeholders and provides an excellent blueprint for bringing together a wide range of organisations from all sectors committed to improving services for children and adults with hearing loss.

This commissioning framework provides a clear guide to what good commissioning looks like for hearing loss services and meets one of the key recommendations of the Action Plan on Hearing Loss. This framework will ensure that clinical commissioning groups (CCGs) are properly supported to make informed decisions about what is good value for the populations they serve and provide more consistent, high quality, integrated care to meet the needs of local people with hearing loss across England. In turn, it will help reduce inequalities between access and outcomes from hearing services.

This is increasingly important given that the [NHS Five Year Forward View](#) is reshaping the commissioning and provider landscape, with more emphasis on prevention, new flexible models of service delivery tailored to local populations and their needs, and integration between services delivered closer to people's homes. A "one size fits all" model of delivery is no longer suitable and the drive is to encourage people to take far greater control of their own care to get the right treatment at the right time, leading to improved outcomes.

Responsibility for these commissioning decisions is placed firmly at a local level in the NHS structure to ensure account is taken of the varying needs of different populations. The framework will help CCGs to address this, as well as deliver on their responsibility to commission hearing services that offer more integrated services, closer to home and deliver better outcomes and value for people with hearing loss.

In developing this framework, we have taken into account the wealth of knowledge, evidence and experience that our partners and stakeholders have within the hearing loss community to ensure it is based on evidence and best practice. We are very grateful to the CCGs, commissioning support units (CSUs), subject matter experts, and charities and professional representative groups who, as members of the Hearing Loss and Deafness Alliance, have given so much of their time to co-produce this framework with us.

2 Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- Given regard to the need to reduce inequalities between service users in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Further guidance to support CCGs and NHS England in meeting their legal duties in respect of equality and health inequalities can be found at <http://www.england.nhs.uk/about/gov/equality-hub/legal-duties/>.

An equality and health inequalities impact analysis has been drafted alongside the development of the Commissioning Framework. The analysis will be published in August 2016. The impact of the guidance on groups protected under the Equality Act 2010 will be reviewed annually.

3 Introduction

Hearing is central to our health and well-being. Approximately, one in six people experience hearing loss, which is a major cause of poor development of language and communication skills and also impacts on employment, mental health, independence and quality of life. It is responsible for an enormous personal, social and economic impact throughout life. It will become an even bigger challenge over the next decade due to the growing ageing population and increased exposure to workplace and social noise such as MP3 players.

Hearing loss affects people who are born deaf and people who experience it later in life. Whilst there has been substantial progress in improving the health services available to children, young people and adults over the last 10 years, significant challenges remain. More needs to be done on prevention, early diagnosis and support for those who have permanent hearing loss as well as improving both the commissioning and integration of services and tackling the large amount of variation in access to and quality of services.

[The Action Plan on Hearing Loss](#) was published in March 2015. It aimed to encourage action and promote change across all public service departments and stakeholder organisations across the voluntary, professional and private sectors, to deliver improved services and hearing outcomes and support for the increasing numbers of people with hearing loss.

This framework has been developed as part of NHS England's commitment to implement the Action Plan on Hearing Loss. It is intended to support local commissioners with their commissioning of non – specialist¹ services for people with hearing loss (the single biggest cause being age-related) across a spectrum of providers, to improve quality, access and consistency to benefit those people who need to use hearing loss services. The framework brings together evidence, standards, guidance and case studies to promote more person - centred, integrated and innovative approaches and encourage best practice across hearing loss service commissioners. Information on other services including specialised services, tinnitus, balance and children's services is provided for context and reference, for example it may be useful in determining referral criteria, but is not covered extensively within this framework.

A wide range of stakeholders have helped to co-produce the framework including CCGs, CSUs, partner organisations, subject matter experts and the charities and professional representative groups who are members of the Hearing Loss and Deafness Alliance as shown in appendix 1. They have contributed to the content of the framework which:

- Describes hearing loss and audiology services in general;
- Outlines the case for addressing hearing loss through effective commissioning;

¹ CCGs should be familiar with their commissioning responsibilities in relation to hearing and wider audiology services, these are outlined in section 8 and appendix 3.

- Sets out best practice guidance and principles for CCGs when commissioning hearing loss services;
- Provides information on planning, securing and monitoring hearing loss services to deliver better outcomes and value for people; and
- Shares learning from CCGs and others in redesigning and improving hearing loss services to secure quality improvements and efficiencies for service users.

3.1 How to use this framework

Throughout the framework the term “hearing loss” is used to cover all forms of hearing impairment and deafness. Information on the types of hearing loss, how it is measured and how it presents in adults and children is described in appendix 2 to provide more background information and understanding for CCGs.

CCGs should be familiar with their commissioning responsibilities in relation to hearing and wider audiology services. These are outlined for paediatrics and for the armed forces (serving and veterans) in sections 8.5 and 8.6, respectively and appendix 3 to clarify the role of CCGs, NHS England and other parties.

Section 4 sets out why a commissioning framework for hearing services is needed in England. Evidence supporting a compelling case for action to tackle the rising prevalence and personal, social and economic costs of uncorrected hearing loss, as well as the variation in access to and quality of services is presented for CCGs to consider and act upon.

What matters to people with hearing loss and deafness so that they have a good experience of care and achieve the outcomes they choose is detailed in section 5. It covers points raised by people with hearing loss, their families and carers which CCGs can use to help inform local discussions on improving and redesigning services.

Section 6 provides best practice guidance and principles to support commissioners to secure services in the best interest of service users and act in a way that will help them comply with their regulatory responsibilities.

Commissioning plans for hearing services should reflect population needs, evidence and reviews of service provision. Section 7 outlines what CCGs will need to consider in assessing local needs and signposts them to the main sources of data available on hearing loss.

Section 8 provides information to support CCGs with procuring hearing services that deliver the best quality and outcomes and provide value for money. It highlights the need to move towards more outcome based commissioning and the crucial role of service specifications in setting out the key requirements for delivery of the service. Recommended outcomes and a model service specification for adult hearing services are presented for CCGs to consider and modify to meet local needs and circumstances. Links to outcomes for tinnitus, vestibular related dizziness and children’s services can also be accessed. A summary of the special arrangements for armed services (serving and veterans) is included so CCGs are aware of these.

The importance of CCGs having robust reporting arrangements and monitoring systems in place to ensure providers deliver expected outcomes and quality is reiterated in Section 9. Examples of current incentives being used by some CCGs are provided and other sources of data that should be helpful for CCGs in monitoring services are discussed.

Section 10 highlights case studies of different commissioning models for adult hearing services that may help CCGs wishing to review and redesign hearing services for their local populations.

The final section of the framework recommends that it should be continually updated to reflect new regulations and guidance, for example, the forthcoming development of the guideline on adult-onset hearing loss due to be published by the National Institute of Health and Care Excellence in 2018.

3.2 Summary of commissioning tips for CCGs

A number of core elements are identified within the framework which will be helpful to all CCGs in their commissioning of services for adults with hearing loss:

3.2.1 Engage and involve service users, families and carers

Service users provide valuable insight into how services can be improved and can be involved in a variety of different ways in addition to providing feedback through service user surveys. By listening to their views and experience you can truly understand the need for and benefits of hearing services, from hearing aids to wider support and equipment. For example consider involving service users in: informing and shaping the service specification including outcomes, key performance indicators and quality requirements; tender shortlisting and interview panels; and forming part of the performance steering groups with the providers of hearing services.

3.2.2 Review and analyse local needs and service provision to plan for the future

Relying solely on past activity to plan future services may result in avoidable budget pressures. Using all available evidence, local information and service data (including outcomes) on hearing loss will help to prioritise areas for change and make improvements in quality, access, outcomes and efficiency and determine where new service models or additional capacity may be required.

3.2.3 Use an outcome based commissioning approach

Moving towards more outcome focused commissioning will have a positive impact in terms of access, choice, quality and other related outcomes that benefit the service user and assure CCGs that services are providing good value for money. The stakeholders involved in the co-production of this framework have agreed some core outcomes that CCGs can use which include:

- Continuation with choice of hearing intervention;
- Reported benefits from hearing intervention;

- Service user satisfaction with their choice of intervention;
- Reduced communication difficulties; and
- Improved quality of life.

These outcomes can be readily measured and collected to improve and compare services, and CCGs could consider publishing outcomes data to help service users decide which services to choose.

3.2.4 Improve access, choice and quality for service users

People wait on average 10 years before they seek help for their hearing loss. CCGs can encourage more people to seek help by ensuring services are easy to access and available in different settings across a range of providers including the NHS, independent, charitable and voluntary sector. They can use outcomes data and patient feedback to innovate and improve quality.

3.2.5 Develop service specifications for all hearing services

Evidence-based service specifications are essential in setting out what services to deliver and the planned outcomes to be reported and monitored by the service. They allow CCGs to hold all providers to account for delivering the service as specified. Service specifications should be consistent when providers are providing the same service and every provider should have one in place. Commissioners should be open to new ideas about how to meet needs and deliver services wherever they come from, including working closely with other parts of the health and social care system. A model service specification supports this framework and should be tailored to meet local requirements accordingly. The model adult service specification can be accessed at <https://www.england.nhs.uk/wp-content/uploads/2015/03/HLCF-Service-Spec-CP-CR.docx>.

3.2.6 Implement robust reporting and monitoring systems

It is essential that CCGs use the formal processes, incentives and sanctions available to them through the NHS Standard Contract to set high standards for providers and to make sure that referral pathways are working and commissioned hearing services deliver the expected outcomes and quality for people with hearing loss. Using a range of data sources as well as outcomes can help gauge the quality and success of the service. Contracts should include detailed requirements for reporting arrangements.

3.2.7 Put in place exit arrangements in local contracts

Commissioners must ensure that they set out very clear exit arrangements in their local contracts. These will ensure that, where contracts expire or are terminated, continuity of service can be maintained, payments made in advance for elements of care not yet delivered can be recouped, and duplicate provision of hearing aids can be avoided. This is recommended for all contracts, but will be particularly important where the payment structure selected involves a significant element of payment in advance, for example, in the three-year pathway payment approach.

3.2.8 Adhere to NHS regulations and hold all providers to account

Always follow NHS regulations and NHS England and NHS Improvement guidance as these have been developed specifically to maximise outcomes and value for service users. They will help make sure that service users' interests are at the heart of decision-making and commissioning and will ensure that all providers are held to account.

3.2.9 Share learning on commissioning hearing services

Talk to other CCGs and consider the different commissioning models for adult hearing services and examples of what CCGs are doing that are highlighted in this framework and use them to help shape the commissioning of hearing services locally.

This framework is intended for commissioners to use alongside other regulations and guidance in place to help ensure they meet the needs of service users and commission hearing services that are efficient, drive up the quality of care provided and promote equality of access and choice, ensuring that people with hearing loss are actively supported and empowered to lead the lives they choose for themselves and their families. Monitor (now NHS Improvement) guidance on procurement, patient choice and competition regulations can be found at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283505/SubstantiveGuidanceDec2013_0.pdf.

4 Why we need a commissioning framework for hearing services

Approximately one in six people in England experiences hearing loss. The number of people affected is rising as the single biggest cause is age-related loss and older adults are the largest population in need of hearing healthcare. Recent reforms have improved the quality, accessibility, standards and value for money of hearing services, but there are still major challenges in terms of unmet need, variation in quality of and access to services and ensuring outcomes are measured and acted upon.

[The Action Plan on Hearing Loss](#) identified the major public health challenge and set out a case for action to tackle the rising prevalence and personal, social and economic costs of uncorrected hearing loss and the variation in access and quality of services experienced by people with hearing loss. A summary of the case for action is outlined below:

4.1 The prevalence of hearing loss and tinnitus

- Over nine million people across England have hearing loss, that's approximately one in six of the population (1);
- Age-related hearing loss is the single biggest type of hearing loss - this is why hearing loss increases with age. It affects 42 percent of people over 50 years old and 71 percent of people over 70 years old (1);
- Hearing loss is now one of the most common long-term conditions in older people and is the sixth leading cause of years lived with disability in England (2);
- Due to the ageing population, estimates suggest that by 2035 over 13 million people in England will have hearing loss – that's one in five of the population (3);
- One in 1000 children is born and identified with hearing loss of 40 dBHL or greater in both ears and this rises to two in 1000 by age 9 to 16 (4,5);
- 41,377 deaf children receive specialist education support services in England (6);
- The prevalence of glue ear ranges from 10 percent to 30 percent between the ages of one and three (7) and 80 percent of children will have had at least one episode by the age of 10 years (8). In the vast majority of cases hearing loss is temporary and resolves without treatment. In some cases it might cause permanent conductive hearing loss but this is rare;
- In England and Wales at least 22,000 Deaf people use a sign language as their main language;
- It is estimated that between 10 percent and 15 percent of adults will have tinnitus, with 3 percent of adults likely to require a clinical intervention for their tinnitus (9);
- Reported prevalence of tinnitus varies from 12 percent to 36 percent and is more common in children with hearing loss compared to children with normal hearing. Like adults, most children self-manage, but a proportion require further support (10);

- Veterans under the age of 75 are three and a half times more likely to report problems with hearing than the general population of the same age (11);
- 11 percent of veterans that were surveyed reported having problems hearing and six per cent reported tinnitus (11);
- Estimates suggest that over 300,000 ex-service personnel in the UK are living with hearing loss (11).

4.2 The costs of hearing loss

- Unaddressed acquired hearing loss (primarily age-related and noise-induced) in adults has major impacts, leading to communication difficulties, social isolation, depression, reduced quality of life and loss of independence and mobility;
- In babies and children, unmanaged and unsupported hearing loss has a serious impact on all areas of their development, including speech, language and communication, education and social development;
- Evidence now suggests that acquired hearing loss in adults may increase the risk of developing dementia - people with mild hearing loss are twice as likely to develop dementia as people without any hearing loss. The risk increases to three times for those with moderate hearing loss, and people with severe hearing loss are five times as likely to develop dementia (12, 13). Recent research found that hearing loss not only increases the risk of the onset of dementia, but also accelerates the rate of cognitive decline (13, 14);
- Older people with hearing loss are two and a half times more likely to develop depression than those without hearing loss (15) and estimates suggest that children who are deaf have a 40 percent prevalence rate of mental health problems compared to 25 percent in children who are hearing (16);
- It is estimated that 80 percent of older people living in care homes have hearing loss and will need support to maximise their independence and wellbeing. People with unmanaged hearing loss and mental health problems are more likely to go straight to expensive care packages than would be the case if their hearing loss were effectively managed;
- A recent study comparing the health of the signing Deaf community in the UK compared with the general population found that deaf people's health is poorer than that of the general population, with probable under diagnosis and under treatment of chronic conditions putting them at risk of preventable ill health (17);
- A large proportion of people will have hearing loss, along with one or more other long-term conditions (18). Evidence suggests around 30 percent of those reporting severe hearing loss have at least four long-term conditions (19);
- It is estimated that around 12 percent of adults in England aged over 55 have severe hearing loss, blindness or both and around 69 percent of people with both deafness and blindness are reported to have at least four other long-term conditions contributing to the growing burden of ill health in England, particularly among older people (19);
- Hearing loss increases the risk of falls. A recent study found that a mild hearing loss made patients nearly three times as likely to have reported a fall in the prior year. For every 10 dB increase in hearing loss, there was a 1.4 increase in the odds of a fall in the preceding year (20);

- An increased risk of falls and falls related injuries costs the NHS. Fallers use more than four million bed-days, cost the NHS £2.3 billion and incur total costs including social care of £5.6 billion (21). Costs per faller are £1,720, rising to £8,600 for those seeking medical care (22);
- Without proper support, hearing loss increases the costs of both health and social care because people are not able to manage their conditions well and their health outcomes are worse (23);
- Hearing loss contributes to difficulties in accessing services that are costly to the health and social care system, through:
 - reduced communication leading to increased length and number of GP visits
 - more missed appointments
 - increased risks of misdiagnosis and mismanagement of other conditions
 - greater use of hospital and social care services (24, 25);
- Hearing loss often reduces the quality of life of family members and carers (1, 26, 27);
- 30,000 hospital admissions for grommet surgery in children occur annually (28);
- Hearing loss impacts on employment prospects. On average people with hearing loss earn £2,000 less per year and many people leave work early because of their hearing loss(1, 24);
- People with hearing loss are less likely to have a job and recent estimates suggest unemployment due to hearing loss costs the UK economy £24bn (1).

4.3 The benefits of intervening to address hearing loss

- Hearing aids have been shown to improve the quality of life and economic prospects, and reduce loneliness and improve mental health by reducing the psychological and social effects associated with hearing loss (29, 30, 31, 32);
- Newly emerging findings suggest that the rate of cognitive decline decreases with the use of hearing aids which may reduce the risk of developing dementia (33);
- Hearing aids have also been shown to have a positive effect on physical health (34);
- Early intervention and provision of amplification in children is associated with better developmental outcomes including speech, language, and literacy (35);
- Studies from the UK and other countries have shown hearing aids to be a cost effective healthcare intervention per quality-adjusted life years (QALY). Various UK studies have estimated the cost per QALY to be around £1,300 - £1,500 (32, 36);
- Nine out of ten adult hearing aid users benefit from them and use them regularly (37). Follow-up and other support after the initial hearing aid fitting has been shown to improve satisfaction with hearing aids and increase hearing aid use (38, 39);
- Given the impacts of unaddressed hearing loss and the low costs of hearing services, hearing assessments and hearing aids are a cost-effective health care intervention (38, 40).

4.4 The variation in access and quality of services

- Adults with hearing loss wait on average 10 years before they seek help (32, 41) and when they do visit their GP, 30 to 45 percent are not referred on for a hearing assessment (32, 42). This means that there is significant unmet need - for example only around two fifths of people who need hearing aids have them (29, 37, 43);
- As well as unmet need, there is significant variation across England in access to hearing care – including an 11-fold variation in the rate of adult audiology assessments (44, 45);
- Assessment and management pathways vary locally which can have a significant impact on prognosis (46);
- In addition, there is variation in the provision of hearing aids(46);
- Follow-up and ongoing support are inconsistently provided across England and people might not always receive information from their audiologist about other support and equipment that could help them (47, 48);
- Monitor's (now known as NHS Improvement) review in 2015 (48) exploring how choice was working in adult hearing loss services found that only one in ten service users that were surveyed had been offered a choice of hearing service providers;
- Demand for hearing services will continue to rise in line with changing demographics and the introduction of new technologies (45).

CCGs should be aware of the impact of hearing loss and its association with physical health, mental health, dementia, falls and other health issues which remain as policy priorities for the Government and the NHS (49) along with addressing the continuing variation in access and quality of hearing loss services.

This evidence supports the need for a national commissioning framework and CCGs should take account of these findings when commissioning services for people with hearing loss in their local area. The framework will help CCGs respond to these issues by providing guidance on how to use service specifications, clear pathways, tariffs and procurement to commission effective high quality services, and how to measure outcomes and use quality improvement to monitor and improve service provision.

5 What matters to people with hearing loss

It is important that CCGs commission audiology services alongside wider health and public services that deliver what matters to people with deafness and hearing loss. The following points have been identified by people with hearing loss, their families and carers as important for ensuring a good experience and best possible outcomes that matter to the person with hearing loss are achieved².

- Educating and informing to improve prevention, awareness and early diagnosis of hearing loss, promoting the benefits of hearing aids, hearing loss management and reducing the stigma related to having a hearing loss.
- Providing services that are easily accessible and convenient for people with hearing loss, including innovative and flexible services in their communities.
- Ensuring the information and communication needs of people with deafness or hearing loss are met when booking appointments, accessing services and in consultations, with appropriate notes kept up to date in service user records and shared when the person is referred on.
- Delivering high quality services based on evidence of what works and what people with hearing loss want, following best practice guidance and monitoring and improving processes.
- Allowing early and timely access to effective, up to date technology and specialist services where these would lead to the best outcomes for the person with hearing loss.
- Providing clear information on hearing loss, diagnoses and how to get the most from hearing aids in initial fitting consultations, allowing time for questions and concerns to be answered and ensuring there are adequate follow-up processes in place, with aftercare delivered in an easily accessible way that meets the needs of people with hearing loss.
- Providing timely access or signposting to relevant support services, including assistive technologies, lip-reading classes, hearing therapy or counselling, support groups, volunteer support schemes, befriending services and communication support.
- Ensuring audiology provides integrated support that takes into account the links between hearing loss and other conditions, and the wider health or educational needs a child or adult with hearing loss may have.
- Undertaking more research into the causes of and management of hearing loss and tinnitus.

² This information comes from the What Children, Young People, Adults and their Families and Carers Want section of the Department of Health and NHS England Action Plan on Hearing Loss (2015) and other information gathered from surveys of people with hearing loss, namely: Monitor (2014) Research Findings: Monitor's patient survey which fed into its report, NHS adult hearing services in England: exploring how choice is working for patients; Deloitte Access Economics and Action on Hearing Loss (2013) Evaluation Framework for adult hearing services in England; and other analysis of Action on Hearing Loss stakeholder surveys

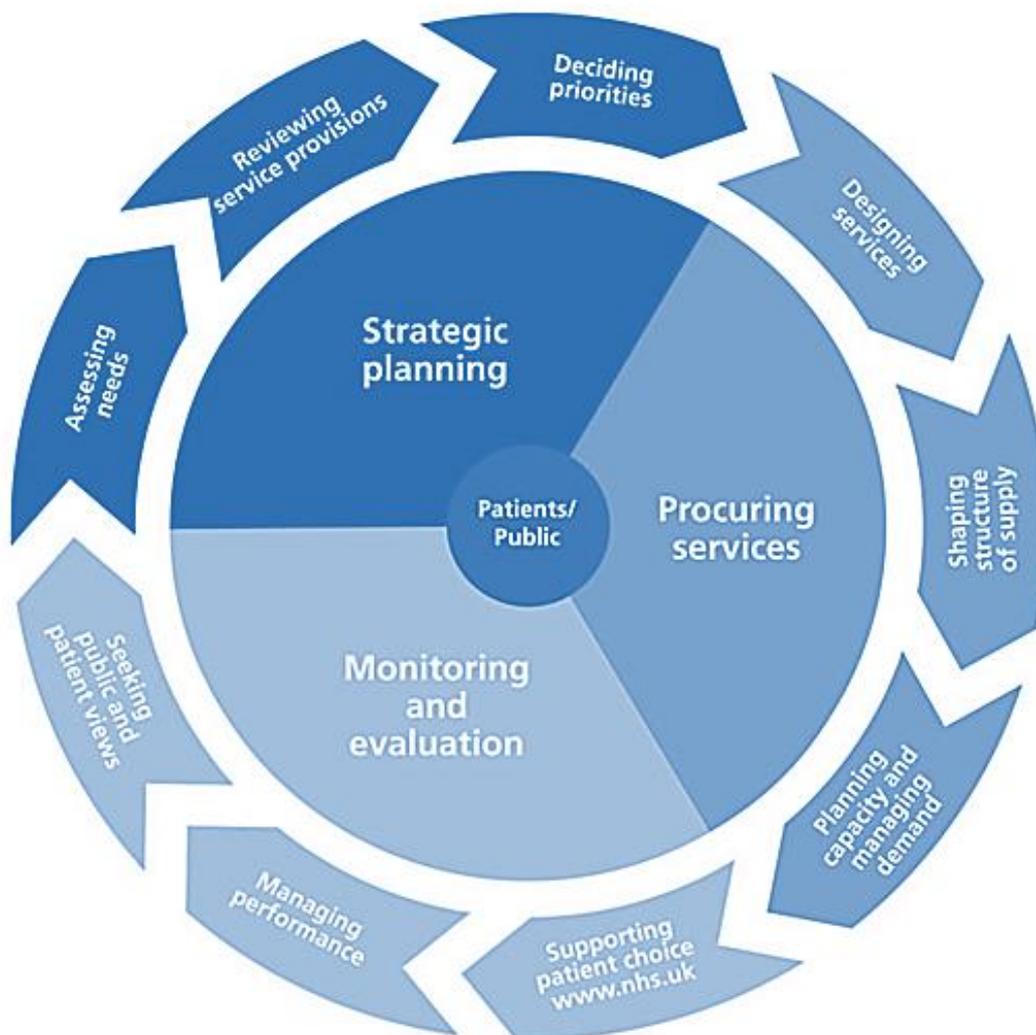
6 Principles for commissioning hearing services

The focus of high quality commissioning is on planning, securing and monitoring services that:

- Are designed and based on the needs and preferences of the populations they serve;
- Promote health and well-being rather than solely treat ill health;
- Drive up quality and deliver better outcomes and value for people, making the most effective use of available resources;
- Are based on collaboration and co-production (50).

This framework sets out best practice guidance and principles for CCGs when commissioning hearing loss services and is structured around the main elements of the commissioning cycle illustrated in Figure 1.

Figure 1: The Commissioning Cycle



6.1 The vision for hearing services

The Hearing Loss and Deafness Alliance³ has developed principles to help inform the commissioning of services to protect and deliver complete hearing wellbeing for individuals and populations. The main themes for the principles are focused on ensuring that commissioning:

- Promotes excellence in outcomes for patients;
- Is clinically and service user led;
- Supports evidence based practice; and
- Facilitates choice and flexibility in provision of services.

Further details are provided in appendix 4.

6.2 CCGs' responsibilities

CCGs always need to be mindful of their responsibilities to secure services in the best interests of service users and to secure continuous improvement in the quality of services and outcomes for people, including reducing inequalities when accessing services, as set out in various guidance and regulations (51, 52, 53). This commissioning framework aims to help commissioners meet the needs of service users and act in a way that will help them comply with their regulatory responsibilities including the Procurement, Patient Choice and Competition Regulations (51).

The following principles provide a framework to ensure commissioners secure services in the best interests of service users (51):

- To secure the needs of patients who use services and to improve the quality and efficiency of those services, including through providing them in an integrated way;
- To act transparently and proportionately, and to treat providers in a non-discriminatory way;
- To procure services from providers who are most capable of delivering the overall objective and who provide best value for money; and
- To consider ways of improving services, including through services being provided in a more integrated way, enabling providers to compete and allowing service users to choose their provider.

This section of the framework provides information on planning, securing and monitoring hearing services to help CCGs commission services that deliver better outcomes and value for people with hearing loss.

³ The Hearing Loss and Deafness Alliance is a coalition of charities and professional representative groups working together to prevent and reduce the impact of hearing loss and tinnitus, and to promote the inclusion and participation of people who are deaf and hard of hearing in society.

7 Planning hearing services

Strategic commissioning plans should take account of population needs, service performance and emerging best practice or new models of care, as well as required national standards (50). CCGs will need to carry out assessments of population needs and current service provision for hearing loss to plan and commission future service provision. Using all available data and localised information on hearing loss will help to prioritise areas for change and make improvements in quality, outcomes and efficiency.

This section of the framework outlines what CCGs will need to consider in assessing local needs and signposts to the main data sources available on hearing loss.

7.1 Assessing population hearing loss need

A number of sources of information need to be considered in assessing and understanding need. Data including local demographics, service user views and current service impact, need to be triangulated to give best estimates and reflect ongoing population changes.

The purpose of assessing hearing loss need is to determine if sufficient and effective hearing care is currently commissioned for the local population and if population projections will change this needs assessment over future years. An assessment of the need for hearing loss services is necessary to inform short and long-term commissioning decisions and joint strategic needs assessments.

7.1.1 Population prevalence of hearing loss

Estimates of prevalence data on hearing loss for England set out in [Hearing Matters, 2015](#) (1) estimate that over nine million people have a hearing loss of at least 25 dB HL in their better ear. These figures have been estimated by applying the prevalence rates of hearing loss among the adult population reported in the UK National Study of Hearing (53) [to current population estimates](#) and rounded to the nearest 500 (54). Although this data is based on estimates, the UK National Study of Hearing remains the best prevalence data available in the UK (55). It should also be noted that these prevalence figures are based on the threshold of 25 dB HL in the better ear as most of the literature to date has recommended this and CCGs can base their planning assumptions on this threshold. However, the Global Burden of Disease Expert group has recently acknowledged that hearing problems may occur at the 20dB HL threshold and clinicians should take account of this.

Prevalence of hearing loss estimates by age group in England is listed in Table 1 (1):

Table 1 – Estimated number of people with hearing loss by age band in England

Age band	Numbers of people with hearing loss (≥ 25 dB HL in better ear)	Prevalence Percentage
17 – 29	158,000	1.7 percent
30 – 39	199,000	2.80 percent
40 – 49	625, 500	8.20 percent
50 – 59	1,305,000	18.90 percent
60 – 69	2,101,500	35.68 percent
70 – 79	2,395,500	60.31 percent
80+	2,434,500	94 percent
All ages (including below 17 years)	9,235,000	

7.1.2 Local prevalence of hearing loss by CCG and local authority

The estimated number of people with a hearing loss in each CCG and local authority area is available at <https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF-CCG-LA-prevalence-data.zip>. The CCG and local authority prevalence data has been calculated in the same way as the population prevalence by applying the prevalence rates of hearing loss among different age groups in the population, updated to the most recent population statistics (Office for National Statistics (ONS) - mid 2014 data) and rounded to the nearest 500. ONS population projections for 2019 have been used to calculate projected prevalence over the next five years to help CCGs plan services for the future.

Table 2 provides a regional summary of the highest and lowest hearing loss prevalence rates based on 2014 and 2019 estimates by local authority. Table 3 lists the 20 lowest and highest local authority prevalence rates.

Table 2:

	Average 2014 prev rate	Average 2019 prev rate	Min2014 prev rate		Max2014 prev rate		Min2019 prev rate		Max2019 prev rate	
LONDON	12.7%	13.0%	8.1%	Tower Hamlets	18.6%	City of London	8.0%	Tower Hamlets	18.4%	Havering
NORTH WEST	17.3%	18.4%	10.8%	Manchester	23.7%	South Lakeland	11.1%	Manchester	25.6%	South Lakeland
SOUTH EAST	17.8%	19.0%	11.1%	Slough	26.1%	Rother	11.6%	Slough	27.9%	Rother
EAST MIDLANDS	17.7%	19.0%	12.6%	Nottingham	24.0%	East Lindsey	13.0%	Nottingham	25.4%	East Lindsey
EAST	18.0%	19.2%	12.8%	Luton	26.2%	North Norfolk	13.2%	Luton	28.5%	North Norfolk
WEST MIDLANDS	17.2%	18.3%	13.6%	Birmingham	23.7%	Malvern Hills	13.9%	Birmingham	25.4%	Malvern Hills
SOUTH WEST	19.6%	20.8%	13.8%	Bristol, City of	27.7%	West Somerset	13.9%	Bristol, City of	28.5%	West Somerset
NORTH EAST	18.0%	19.2%	14.5%	Newcastle upon Tyne	20.7%	Northumberland	15.4%	Newcastle upon Tyne	22.5%	Northumberland
YORKSHIRE AND THE HUMBER	17.2%	18.2%	14.6%	Bradford	22.8%	Ryedale	15.2%	Bradford	25.0%	Craven
<i>ENGLAND</i>	<i>17.0%</i>	<i>18.0%</i>								

Table 3:

Lowest 20 LA prevalence rates	2014	2019	Highest 20 LA prevalence rates	2014	2019
Tower Hamlets	8.10%	8.00%	West Somerset	27.68%	28.53%
Newham	9.10%	9.26%	Christchurch	26.59%	27.64%
Hackney	9.31%	9.57%	North Norfolk	26.25%	28.52%
Lambeth	9.90%	10.29%	East Dorset	26.08%	27.65%
Southwark	10.08%	10.37%	Rother	26.05%	27.91%
Islington	10.41%	10.72%	East Devon	25.66%	27.31%
Wandsworth	10.73%	11.08%	West Dorset	24.88%	26.99%
Manchester	10.76%	11.08%	Tendring	24.66%	26.03%
Haringey	11.03%	11.47%	Arun	24.29%	25.61%
Slough	11.07%	11.63%	New Forest	24.03%	25.71%
Lewisham	11.30%	11.59%	Dorset	24.03%	25.77%
Barking and Dagenham	11.35%	11.00%	East Lindsey	23.98%	25.44%
Hammersmith and Fulham	11.49%	11.78%	South Lakeland	23.72%	25.64%
Greenwich	11.72%	12.25%	Malvern Hills	23.71%	25.42%
Waltham Forest	11.75%	12.08%	Chichester	23.37%	24.44%
Oxford	12.03%	12.68%	Fylde	23.36%	25.01%
Camden	12.35%	12.79%	Suffolk Coastal	23.24%	25.20%
Hounslow	12.43%	12.66%	South Hams	23.18%	25.27%
Brent	12.47%	13.04%	West Devon	23.04%	24.34%
Nottingham	12.57%	12.97%	Isle of Wight	23.00%	24.60%

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In summary, the tables indicate that:

- Hearing loss prevalence rates range from 8.1 percent (Tower Hamlets) to 27.7 percent (West Somerset) in 2014 with slight increases generally predicted for 2019;
- London overall looks different from the rest of England, with a notably lower prevalence rate of 13 percent in 2019. Mean prevalence rates in other regions range from 17.2 percent to 20.8 percent between 2014 and 2019;
- The South West has the highest prevalence rates (19.6 percent in 2014, and 20.8 percent predicted for 2019) because older populations tend to have higher proportions of the population with some form of hearing loss.

When the 2014 and 2019 estimates of hearing loss prevalence rates are mapped to CCG clusters by theme (NHS England mapping figures)⁴ based on the 2012 population proportions of local authorities to CCGs, the estimated levels of people with hearing loss per CCG in 2014 and predicted figures for 2019 are calculated as follows in Tables 4 and 5.

Table 4:

Estimated levels of people with hearing loss per CCG 2014, and predicted 2019 figures.

CCG Count	Cluster	Total 2014 pop	Total 2014prev	Avg 2014 prev per CCG	Prevalence Rate 2014	Total 2019 pop	Total 2019prev	Avg 2019 prev per CCG	Prevalence Rate 2019
11	Deprived urban areas with younger people and ethnic diversity, particularly Black	3,207,818	373,000	33,909	11.6%	3,405,676	408,500	37,136	12.0%
6	Mixed communities in Inner London	1,335,868	158,500	26,417	11.9%	1,396,171	172,500	28,750	12.4%
18	Deprived urban areas with younger people and ethnic diversity, particularly Asian	4,948,154	628,402	34,911	12.7%	5,231,622	680,817	37,823	13.0%
17	Areas with younger adults and university cities	4,756,004	724,085	42,593	15.2%	4,879,735	774,861	45,580	15.9%
35	Areas with lower deprivation and better health	7,530,159	1,259,381	35,982	16.7%	7,879,645	1,397,638	39,933	17.7%
58	Traditional communities with deprived areas and poorer health	12,371,955	2,145,875	36,998	17.3%	12,641,717	2,327,591	40,131	18.4%
20	Larger CCGs with older populations and more rural areas	11,249,926	2,120,705	106,035	18.9%	11,630,334	2,346,049	117,302	20.2%
44	Smaller CCGs with older populations and more rural areas	8,916,735	1,825,552	41,490	20.5%	9,133,378	2,013,044	45,751	22.0%
209	England	54,316,618	9,235,500	44,189	17.0%	56,198,276	10,121,000	346,655	18.0%

⁴ CCG figures based on mapping Local Authorities to CCG using www.england.nhs.uk/wp-content/uploads/2014/03/Fb-calc-ccg-pop-grth.xlsx&usg=AFQjCNEh6UDHN02m7cyCVE7r609v-9f9_g

Table 5:

Estimated levels of people with hearing loss per CCG 2014, and predicted 2019 figures.

CCG Count	Cluster	Min2014 prev rate	Max2014 prev rate	Min2019 prev rate	Max2019 prev rate
11	Deprived urban areas with younger people and ethnic diversity, particularly Black	9.6%	14.0%	9.8%	14.6%
6	Mixed communities in Inner London	10.4%	13.9%	10.7%	15.2%
18	Deprived urban areas with younger people and ethnic diversity, particularly Asian	8.1%	15.2%	8.0%	15.8%
17	Areas with younger adults and university cities	10.8%	18.6%	11.1%	20.0%
35	Areas with lower deprivation and better health	13.6%	19.4%	14.5%	21.2%
58	Traditional communities with deprived areas and poorer health	14.5%	20.8%	14.9%	22.2%
20	Larger CCGs with older populations and more rural areas	16.5%	22.3%	17.1%	23.5%
44	Smaller CCGs with older populations and more rural areas	17.0%	24.7%	18.2%	26.6%

On average 44,000 people per CCG were estimated to have hearing loss in 2014, rising to 48,000 in 2019, although in the 20 larger CCGs with older populations and more rural areas, the levels are estimated to be 106,000 and 117,000 cases in 2014 and 2019 respectively. As mentioned previously, the South West has the highest prevalence rates (19.6 percent in 2014 and 20.8 percent predicted for 2019).

Total prevalence rises from 9.2 million people with hearing loss in 2014 to 10.1 million in 2019.

CCGs can access prevalence and other local data at www.the-ncha.com/resources/hearing-map/ccgs-england/.⁵ This map aims to address information gaps and help local commissioners and providers work collaboratively to meet local hearing needs.

CCGs can use these local prevalence estimates and statistics to help inform commissioning plans and in joint strategic needs assessments with local authorities to plan anticipated capacity for hearing care services at a local level.

⁵ The Hearing Map is produced by the National Community Hearing Association, a not-for-profit membership organisation for community hearing care.

7.2 Reviewing service activity data

CCGs can use datasets which provide information on the level of NHS funded activity to support service users with hearing loss, for example:

7.2.1 Monthly diagnostics waiting times and activity

Waiting times and activity for 15 key diagnostic tests and procedures including audiology assessments are reported monthly on the [Diagnostics Waiting Times and Activity page](#) of the NHS England website.

7.2.2 Hospital episode statistics (HES)

HES data is available from the [Health and Social Care Information Centre \(now NHS Digital\)](#), and provides information on all NHS admitted patient care, outpatient appointments and accident and emergency attendances in England. Healthcare Resource groups (HRGs) are standard groupings of clinically similar treatments which use common levels of healthcare resource and can help to understand activity in terms of the types of service users cared for and the treatments undertaken. HRGs related to ear treatments can be used to identify activity and costs and help inform the development of local commissioning plans for hearing loss services. Ear related HRGs are listed in appendix 5 for information. Commissioners should be aware that HES data will only provide a partial picture of care provided and does not include data on non-specialist hearing services provided in a community setting.

7.3 Involving and engaging with patients and the public

CCGs will want to ensure they have a good understanding of the types of services the local population want and need by engaging with their local communities, groups protected under the equality act and local and national voluntary and community sector organisations early in the planning process.

Charities and service user groups can help ensure that the needs of people with hearing loss, deafness and tinnitus are at the heart of service developments. In particular they can help feed expertise and experience into the planning process for specific services and help CCGs create a vision for future services and where required, make the case for change to existing hearing services. [The Hearing Loss and Deafness Alliance](#) is a coalition of charities and professional representative groups working in partnership to ensure that the needs of people with hearing loss, deafness and tinnitus are at the heart of service developments. The Alliance can provide advice and access to national and local voluntary, community sector and professional organisations⁶.

Resources are also available to support CCGs to engage their local populations and patients in service design, for example the 'Transforming Participation in Health and Care' guide which is available at www.england.nhs.uk/ourwork/patients/participation/. Particular advice on service user engagement in hearing services is also available

⁶ Where the organisation is also a provider CCGs should ensure they offer all providers an equal opportunity to explain and share how services might benefit potential service users and the local NHS.

through the Improving Quality in Physiological Services (IQIPs) accreditation scheme which is discussed in section 8.

7.4 Matching capacity to need

Having assessed local need and demand against commissioned activity and available resources, CCGs should be in a position to understand and address any variance and determine where new service models or additional capacity may be required to meet the service user and population need, or to improve quality and productivity.

8 Securing hearing services that deliver improved outcomes and value

Improving access, choice, quality and outcomes are fundamental aspects of NHS policy (48, 56, 57, 58, 59) and CCGs will be focused on commissioning services that deliver these for their local populations.

This section of the framework provides information to support CCGs with their plans to commission hearing services that deliver the best quality and outcomes within the resources available.

8.1 Focusing on outcomes

The overall aim of moving towards more outcome focused commissioning is to provide services that have a positive impact on those using them in terms of access, choice, quality and other related outcomes that demonstrate benefits and improvements as a result of any treatment or intervention for the service user. The intention is to move away from commissioning services based solely on activity (60).

CCGs need to define what good outcomes look like for hearing services and what measures should be used to demonstrate improvement. The outcomes should be designed with the local population and the users of local hearing services themselves (50, 60). To help with this task the stakeholders involved in the co-production of this framework have agreed some recommended outcomes that CCGs can use and adapt locally to monitor the impact and benefits of hearing services on people who use them. An overview of the outcomes is summarised in Figure 2 below:



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These five outcomes can be readily measured and collected by hearing services using validated outcome tools. CCGs will find them useful in monitoring the impact of the service on service users (for example in terms of how many hearing aids are used or how much the service improves the quality of life of service users) and the level of service quality and improvement across different services. In addition to monitoring these five outcomes across all services, it is recommended that every provider should ensure audiologists develop personalised care plans (audiology services refer to this as an “individual management plan”) with service users to agree and monitor outcomes that are important to them. This personalised care plan could be part of a wider care and support planning discussion and plan that an individual may have, for example if they have a long-term condition and have a care plan or a personal budget (health, social care or in the case of children, education). This should cover the following as defined in the NHS Standard Contract 2016/17:

- Reflects the service user’s goals;
- Helps the service user to manage their physical and mental health and wellbeing, including access to support for self-management;
- Pays proper attention to the service user’s preferences, culture, ethnicity, gender, age and sexuality; and
- Takes account of the needs of any children and carers.

At the time of writing, there are three validated outcome tools available that can be used to collect data on these outcomes. They are the Glasgow Hearing Aid Benefit Profile (GHABP); the Client Oriented Scale of Improvement (COSI) and the International Outcome Inventory for Hearing Aids (IOI-HA). Currently there is no one tool that can be used for all five outcomes but they can be used in combination (see Table 6 below). None of these tools measure ‘reduced social isolation’. In the interim, until a robust validated outcome tool specific to audiological outcomes is developed and in the interest of reducing variation across providers, commissioners should in consultation with their providers agree for all services in their locality to use the same tools. It is recommended these should be the IOI-HA and one other tool either GHABP or COSI.

Table 6 – Measurement of outcomes

Outcome	Method of measurement (for more details see Appendix 7)
Reduced communication difficulties	GHABP/COSI/IOI-HA or other validated tool to show improvement.
Improved quality of life	IOI-HA or other validated tool to show improved enjoyment of life.
Proportion of patients continuing with their choice of hearing aid and or other intervention(s).	GHABP/IOI-HA or other validated tool shows percentage of patients reporting continued use of intervention
Proportion of patients reporting hearing intervention has helped	IOI-HA or other validated tool shows intervention has helped.
Service user satisfaction with their choice of intervention	GHABP/ IOI-HA or other validated tool shows whether the person is satisfied or whether it was worth the trouble.

CCGs should work locally with their providers to agree how to balance the need to benchmark quality and outcomes, with the need to encourage innovation and different approaches to choice in high quality care, including considering the publication of outcomes data to help support service users to choose which service to use.

These outcomes can be tailored to specific services for children and adults, for example adults diagnosed with tinnitus or vestibular related dizziness and balance difficulties as illustrated in appendix 5, and can form the basis of more detailed quality requirements and key performance indicators (KPIs) used alongside service specifications for hearing services which are discussed next.

8.2 Developing service specifications

In addition to setting out planned outcomes to be reported and monitored by the service and commissioners, the purpose of the service specification is to describe the service to be provided, the service user, local population and geography to be covered, acceptance/exclusion criteria, where the service is to be provided and other key requirements.

Service specifications are essential in holding the provider to account for delivering the service as specified and are a useful means of engagement with providers. In its review of how choice was working for adults requiring hearing services in England Monitor (48) found that service specifications for adult hearing services were not always in place. Where they were used with regular reporting of outcome measures and penalties for underperformance they created “*incentives for providers to ensure the desired quality*” (48, p.33), ensured the needs of service users were met and that the service offered good value for money.

In light of these findings and the views of the stakeholders involved in the co-production of this commissioning framework, for hearing services it is specifically recommended that:

- A service specification must always be in place when providers are commissioned to provide hearing services;
- Providers should be paid for the services they provide on the basis of outcomes achieved and should be paid the same amount for delivering the same service;
- Commissioners should consider offering service users a choice of different providers for their hearing services;
- Contracts for hearing services that do not include service specifications and outcome measures should be avoided.

8.2.1 A model service specification for adult hearing services

In 2012, adult hearing services were one of eight services prioritised by the Department of Health to implement choice using the “any qualified provider”, (AQP) approach (61). Since then, over 50 per cent of CCGs have adopted this approach for commissioning hearing services for adults with age-related hearing loss (48). A model service specification template was produced as part of [the Adult Hearing AQP](#)

[Implementation Pack](#), which provided a template for commissioners to use and proposed quality requirements and KPIs expected of qualifying providers. The service specification was not mandatory and could be modified to meet local needs and circumstances, although Monitor found that it was adopted by most commissioners and providers when commissioning to improve choice. In addition, feedback from commissioners and providers suggested that the service specification set out clearly defined expectations and more robust arrangements than previous contract monitoring mechanisms (48).

The model service specification for adults with hearing loss has been reviewed and updated by the stakeholder groups involved in the development of this commissioning framework, using the advice and experience of CCGs and CSUs who have implemented the AQP approach and learnt from their experience. The updated model service specification is available at <https://www.england.nhs.uk/wp-content/uploads/2015/03/HLCF-Service-Spec-CP-CR.docx>. Some key elements of the service specification are highlighted below.

8.2.1.1 Population needs – national/local context and evidence base

CCGs can use the population data for England, local CCG prevalence data referenced in section 7 and rates of diagnosis in each area to help determine local need and demand and if new service models or additional capacity are required to encourage more people to seek help and meet the service user and population need, or to improve quality and productivity.

8.2.1.2 Local defined outcomes and KPIs

The recommended outcomes summarised in Figure 2 can be adapted by CCGs to form the broad outcomes expected of the service. They can also be used to shape the applicable quality requirements and KPIs to monitor performance and improvement, in negotiation with local providers, which will need to be set out in Schedule 4 (Quality Requirements) of the NHS Standard Contract 2016/17. Monitoring performance against outcomes and KPIs can provide data to improve services and support service users to choose between services. Further detail on proposed quality requirements and performance thresholds for hearing services is provided in appendix 7.

Outcomes and quality requirements for tinnitus, vestibular related dizziness and balance disorders and children's services for CCGs commissioning these services can be accessed at <https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF-Proposed-outcome-measures.zip>.

8.2.1.3 Scope

The scope of the model service specification is clearly defined for adults experiencing hearing and communication difficulties who feel they might benefit from a hearing assessment and rehabilitation including the option of trying hearing aids with aftercare and support. The specification does not cover services for people with certain contraindications (set out in Appendix 8). These are illustrated in existing

national guidance published by the British Academy of Audiology (BAA) at http://www.baaudiology.org/index.php/download_file/view/302/178/ and the British Society of Hearing Aid Audiologists (BSHAA) at <http://www.bshaa.com/Publications/BSHAA>. The BAA and BSHAA are jointly developing updated illustrative contraindications. This guidance will be included as soon as it is available.

Age-related hearing loss is the most common cause of hearing loss in adults over the age of 50. Initially, the specified age threshold for adult services quoted in the 2012 AQP specification was 55 years of age to minimise the risk of people with these contraindications being referred inappropriately. The BAA recommends an age threshold of over 50 years to ensure continued mitigation of the risk of inappropriate referrals, whilst BSHAA does not specify a lower age limit within adult services, recommending that all adults can and should be able to access community services unless there is clear evidence that there is a need for specialist services.

CCGs may wish to be flexible on this to enable younger adults access to the service and some have done this. For example, both Solihull CCG and North West London Collaboration of CCGs (comprising 5 CCGs) have expanded the threshold to 18 years of age and collected data demonstrating between 8 to 10 percent improvements in access to the service. Other CCGs are offering open access and self-referral options depending on local demographics. CCGs can include the monitoring of inappropriate referrals in the information schedule between the CCG and provider to assure that people accessing hearing services receive timely and appropriate assessment, diagnosis and intervention. Commissioners may also want to monitor the issue through feedback from GP and Ear Nose and Throat (ENT) services on service users returning into the system with undetected contraindications.

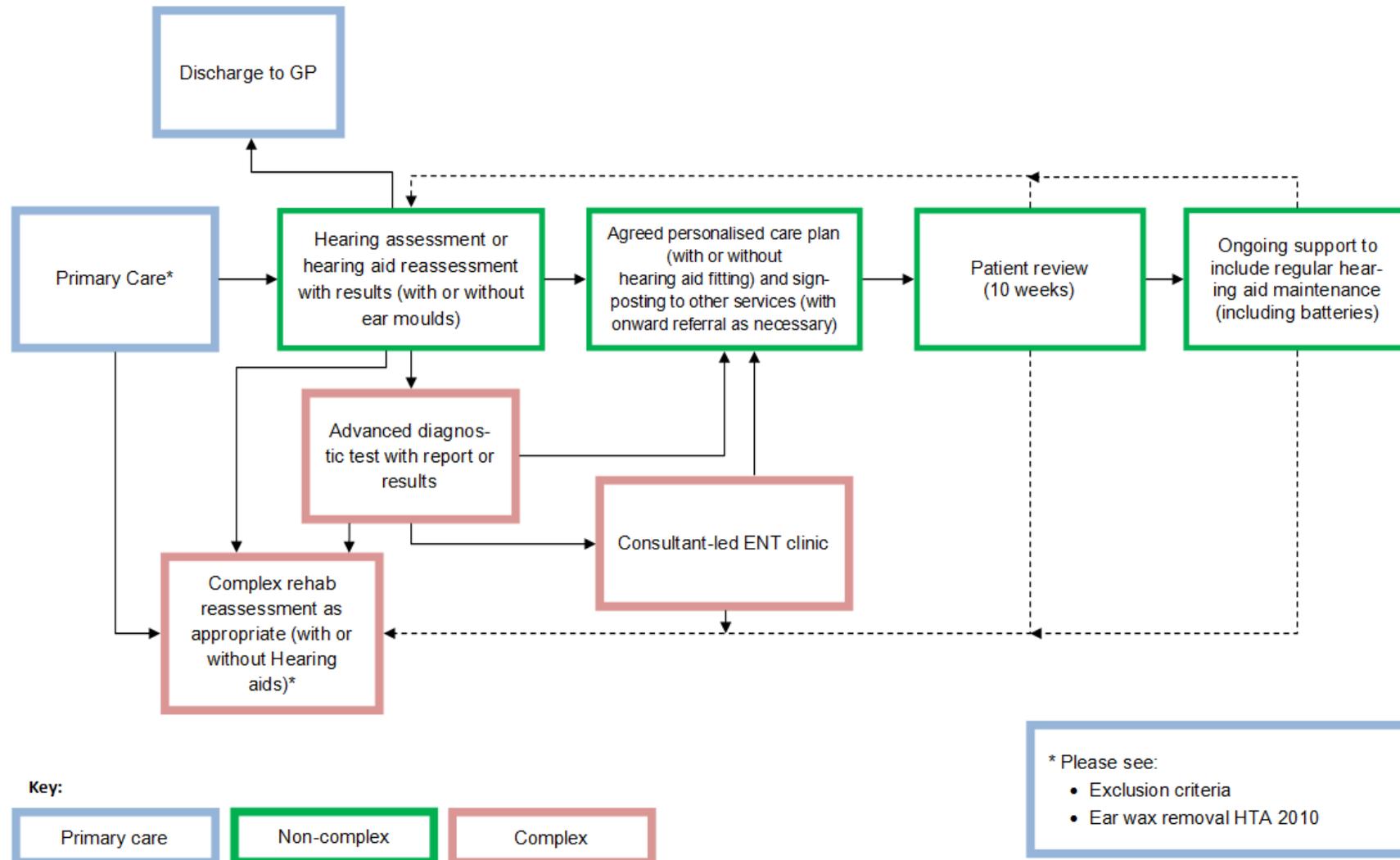
8.2.1.4 Illustrative pathway for adults with hearing loss

The Adult Hearing Service must be seen as part of wider integrated adult health and social care hearing services working in partnership with GPs, primary health care teams, ENT departments, audio-vestibular medicine (AVM) audiology departments, local authorities (including social care and educational services), the voluntary and community sector and independent providers.

As stated previously, this framework and service specification covers hearing services for adults without the contraindications listed in appendix 8. In general it does not cover services for those who may require more specialist medical intervention (for example from ENT services). CCGs together with their local providers should ensure there are clearly defined referral arrangements in place to facilitate timely access to specialist services when required, including assessment for cochlear implants or other devices when required.

A typical pathway for adults with hearing loss is summarised and illustrated in Figure 3 below:

Figure 3:



*CCGs, as with all activity monitoring will benefit from monitoring these services and comparing data with other CCGs with similar demographics to ensure effective use of NHS resources

Adult audiology services include a full hearing assessment, fitting of hearing aid(s) where required, follow-up to ensure the person is benefitting, ongoing aftercare (including hearing aid support, repairs and batteries) and onward referral to further support and equipment from social services and other local services such as support with developing communication skills, support groups, and lip-reading classes and assistive equipment like amplified telephones and doorbells.

If hearing aids are recommended as the preferred intervention, people generally benefit from being offered 1 for each ear (bilateral) (46, 62) unless there are reasons that this is inappropriate. Fitting of bilateral hearing aids is beneficial as many modern hearing aids interact with each other to offer greater improvement in speech discrimination in everyday environments. It is estimated that in people aged 50 and over the bilateral fitting rate might range between 85 percent and 90 percent, it might be lower in younger adults, and higher in older adults because age-related hearing loss is bilateral and slowly progressive.

Referral and management pathways vary locally with some CCGs beginning to commission different models of care as a result of the policy drives to develop more integrated services out of acute hospital settings in the community and the flexibility through the NHS Standard Contract 2016/2017 to have longer term contracts. A number of examples are highlighted in the case studies presented in Section 10 of this framework. CCGs should monitor referral pathways to ensure they are working effectively, service users are getting the support and onward referrals (for example to social services) they need and that they are being appropriately referred.

8.2.1.5 Applicable service standards

As is usual practice, hearing services should follow published best practice guidelines and standards. In particular, alongside monitoring KPIs, outcomes and service user feedback, it is important for all services to demonstrate that they meet clearly defined quality standards, and are delivering high quality services for service users by achieving United Kingdom Accreditation Service (UKAS) accreditation.

The UKAS Improving Quality in Physiological Services (IQIPS) scheme is a professionally led programme of accreditation that includes audiology services. With UKAS accreditation, hearing services can assure commissioners and service users that they meet a range of clearly defined quality standards, developed by the Royal College of Physicians in conjunction with professional bodies and service users. To date the model service specification has set out the expectations in terms of accreditation as follows:

- The provider will be expected to undertake a quality audit such as the United Kingdom Accreditation Service (UKAS) IQIPS-Self Assessment and Improvement Tool (SAIT) before delivering NHS services under the contract and continue using the quality audit on a regular basis;
- The provider will be expected to be working towards UKAS IQIPS accreditation standards and achieving accreditation.

Some CCGs are asking for further assurance of accreditation, for example, the North West London Collaboration of CCGs has asked for the following in addition to the above:

- Any existing provider that is not accredited must submit a statement of progress from UKAS who has been appointed by the Royal College of Physicians to manage and deliver the UKAS IQIPS assessment and accreditation scheme.

The general consensus of the stakeholder groups involved in the development of this commissioning framework is that accreditation of audiology services should be a requirement for providing hearing services and that the current specification in relation to this should be strengthened. Commissioners should ensure that audiology services participate in, and maintain accreditation to defined quality standards operating under the umbrella of the UKAS IQIPS Accreditation Scheme. In particular:

- The provider will be expected to have completed the IQIPS SAIT and registered an application for accreditation with UKAS; and
- Accreditation status should be achieved within the duration of the contract.

Since the publication of the model service specification in 2012, all organisations that provide NHS or adult social care must follow the new Accessible Information Standard by law by 31 July 2016. The purpose of the Accessible Information Standard is to ensure that disabled people have access to information that they can understand and any communication support they might need. This includes making sure people can get information in different formats if they need it and supporting people's communication needs, for example by offering a range of contact methods, ensuring staff have training on hearing loss and hearing aids, and providing a British Sign Language (BSL) interpreter, deafblind manual interpreter or an advocate where this is needed.

[The Accessible Information Specification](#) sets out the requirements CCGs must meet which includes ensuring that commissioning and procurement processes enable and support implementation and compliance with the standard and that CCGs monitor assurance of compliance with the standard. CCGs must take account of these requirements in their commissioning of hearing services and service specifications.

8.2.1.6 Exit arrangements to manage contract expiry or termination

The AQP approach for hearing services has been shown to have many potential benefits, and commissioners will wish to give it serious consideration. Experience from the first round of AQP hearing service contracts has, however, shown some potential for misunderstandings between commissioners and providers as an unintended consequence of the three year pathway tariff approach, particularly where some providers have chosen to exit the market as their contracts expire.

In a contract with a three-year duration there is a risk that the commissioner may assume that the provider must continue to accept new referrals up to the end of the third year of the contract, but must then also provide aftercare for a diminishing number of patients for a further period of nearly three years. By contrast, the provider

may assume that its responsibility to provide aftercare simply ceases at the point at which the contract expires at the end of the third year.

To avoid this kind of confusion, especially where a pathway tariff is adopted involving some element of payment in advance, it is vital that commissioners make the proposed arrangements clear as part of their procurement process and in local contract documentation. This can be achieved by inclusion of a schedule (Schedule 21) setting out “exit arrangements” (including arrangements for recovery of elements of the pathway tariff at expiry or termination of the contract.)

Even where a pathway payment approach is not adopted, it is worth putting in place, at the outset of the contract, clear exit arrangements describing the process for managing service users who have not completed their care pathway at the point at which the contract expires or is terminated. If the original provider has decided to leave the market, the parties will need to agree a succession plan to transfer users of the service to a new provider or providers – and again, agreement up front of clear exit arrangements will minimise the risk of disagreement about who should bear any associated costs (relating to reassessment or administration, for example).

As well as ensuring financial clarity for both commissioner and provider, taking the proactive steps outlined above will help to ensure safe and timely continuity of service for service users

8.3 Procurement options

Effective procurement is an integral part of the commissioning cycle (63) and is essential in commissioning improved services and outcomes for local service users and ensuring value for money (64).

In determining their approach to procurement CCGs should be mindful of the requirements of the Procurement, Patient Choice and Competition Regulations (51) and of the Public Contract Regulations 2015 (53). The AQP model is one approach which can be considered and has been used by over 50 percent of CCGs in recent years (48).

CCGs could also consider the use of personal health budgets to increase the level of control that people have, and this approach could be particularly beneficial to individuals where they already receive personal budgets for other parts of their health or social care. This approach would be in line with the NHS Mandate’s expectation that by 2020, [50,000 to 100, 000 people should be benefitting from personal health budgets](#). Published in May 2016, the [Integrated Personal Commissioning Emerging Framework](#) provides a model for the effective integration of care and support around the needs of individuals with more complex needs, and this could include hearing services.

In addition, commissioners should be flexible to ensure the best service is commissioned, for example by commissioning components of the pathway separately, or commissioning aftercare and support services in an integrated way between health and social services. The case studies in section 10 provide examples of this.

8.4 Pricing and tariff

8.4.1 Setting a price

There is no nationally mandated currency or price for hearing services, but the 2016/17 National Tariff Payment System (NTPS) (65) sets out principles and rules which govern the agreement of local prices, including:

- The approach must be in the best interests of service users;
- The approach must promote transparency to improve accountability and encourage the sharing of best practice; and
- The provider and commissioner(s) must engage constructively with each other when trying to agree local payment approaches.

Within these principles and rules, CCGs are able to determine how they wish to structure payments to providers for hearing loss services, setting this out as part of their procurement process.

CCGs should use the best possible information to arrive at a price for hearing services. Useful sources of information include:

- Non-mandatory prices for adult hearing services set out for reference in the NTPS 2016/17 and below for information;
- 2012 AQP pricing guidance (see appendix 9);
- Other CCGs.

Description	Tariff (£)
Audiology hearing aid assessment only	53
Pathway for hearing aid assessment, fitting of one hearing aid device, cost of one device and first follow up	268
Pathway for hearing aid assessment, fitting of two hearing aid devices, cost of two devices and first follow up	370
Hearing aid aftercare (repairs)	25

It is important to note that the 2016/17 non-mandatory tariff and the 2011/12 AQP pricing guidance reflect different packages of care. In particular, the AQP price included a full three years of aftercare following fitting of a device.

Monitor (now NHS Improvement) estimated that locally determined prices adopted by commissioners were about 20 percent to 25 percent lower than the national non-mandated tariff for adult hearing services, and that this could allow commissioners to treat more patients for the same spend and/or release additional funds that commissioners can spend on meeting other patients' needs (48). In addition, there is evidence of some CCGs setting prices significantly lower than both the non-mandatory tariff and AQP pricing guidance - for example, seven CCGs in Birmingham, Solihull and the Black Country are out to market with a tariff that is approximately 20 percent less than the 2012 AQP tariff.

CCGs can use this information to agree local prices with providers whilst ensuring tariffs are high enough to deliver good quality pathways of care based on evidence and good practice.

8.4.2 Structuring payment

The 2012 AQP pricing guidance (see Appendix 9) was broadly based on the 2011/12 non-mandatory tariff model, with some additional component inclusions. A key feature of the non-mandatory prices and the 2012 approach was that it involved payment up-front on a pathway basis for assessment, fitting and aftercare.

Where this approach is taken, CCGs should be sure to include a financial recovery schedule in their local contract, setting out what proportion of the pathway payment is to be re-paid by the provider, at expiry or termination of the contract, reflecting the extent to which the full pathway has not yet been delivered for each individual service user. This can be included under Schedule 21 of the NHS Standard Contract (Exit Arrangements).

Where they choose to adopt an AQP approach, commissioners should take steps to ensure that contracts for hearing services are consistent in terms of quality standards and payment.

Commissioners must use the NHS Standard Contract to commission hearing services and this will ensure consistency of nationally specified terms and conditions, but other local terms of contracts awarded under an AQP process must also be consistent across the range of approved providers.

It is also important that, where procurement has been carried out on an AQP basis, CCGs put in place referral pathways to ensure appropriate service users are referred only into the AQP providers, not to other providers. If, for instance, an acute provider has chosen not to seek accreditation to provide hearing services under an open AQP arrangement, the commissioner should not permit it to provide those same services under its main acute services contract, potentially at a different price and to different quality standards. In such a situation, the commissioner should ensure that it terminates the relevant services at the acute provider and that referrals are directed to approved AQP providers.

Where the CCG commissions a service for complex hearing services from the acute sector, the CCG and the acute provider should agree a service definition. This should include the agreed definition of the complex services and the agreed quality and monitoring standards. The definition and service pathway should be made available to service users and referrers to support service users to access the most appropriate service. Complex services should include a clear basis on which service users are returned into the non-specialist care pathway and can benefit fully from the choices available.

8.5 A model service specification for children's services

Alongside education and social care, children's audiology services form part of a wider context and care pathways at a local level, which are commissioned by NHS

England, area teams and CCGs and may be provided by the same local providers, other local providers, or by alternative specialist services. CCGs should be knowledgeable of the local networks involved in providing audiology services for children, and in particular what arrangements are in place for transition to adult hearing services.

A comprehensive model service specification for children's audiology services has been co-produced by Leeds South and East CCG, the National Deaf Children's Society and the British Academy of Audiology for those CCGs involved in commissioning these services and can be adapted to suit local circumstances. The service specification can be accessed at <https://www.england.nhs.uk/wp-content/uploads/2016/07/P37-CYP-Service-Specification-Template.pdf>.

8.6 Hearing services for armed forces / veterans

Serving personnel have their primary care needs, including audiology services provided from within Defence Medical Services commissioned by the Ministry of Defence. However, acute hospital care is provided in the NHS and commissioned by NHS England's Armed Forces team. CCGs need to be aware of the special arrangements in place for armed forces veterans who lose their hearing as a result of military service. The Veterans Hearing Fund (VHF), funded by the Government and provided by the Royal British Legion, ensures that post-discharge support with hearing loss is continued where that support is not otherwise available through statutory sources.

The VHF may fund:

- In-the-ear (ITE) devices, typically not available in the NHS;
- Hearing aids or adaptations which do not require surgery;
- Bluetooth or other peripheral devices, for example directional microphones;
- Therapies or training courses, such as lip-reading;
- Reasonable travel and accommodation costs associated with the above, (where not funded)

All interventions must be endorsed by an audiologist who, as part of their assessment, confirms that the intervention is not something which could be funded by the NHS or other statutory sources.

The VHF helps to provide continuity of hearing care and support for veterans where variations in local CCG commissioning policies may have had an impact on the care they receive.

The VHF Charities that are part of the Confederation of British Service Charities Organisation (COBSEO) will signpost to each other, and NHS audiology services, GPs and related community services have received notification of this offer.

The VHF can be accessed by [a two stage application process](#) that assesses eligibility and the interventions required.

9 Incentivising and monitoring for quality improvement

It is essential that CCGs use the formal processes, incentives and sanctions set out in the NHS Standard Contract 2016/17 to set high standards for providers and assure that commissioned hearing services deliver the expected outcomes and quality for people with hearing loss, alongside expenditure and activity levels.

The NHS Standard Contract 2016/17 allows for local agreement of quality requirements and recommends that a small number of outcome indicators and KPIs which really add value are likely to be more effective than too many.

The NHS Operational Standards for Audiology assessments and Direct Access Audiology Referral to Treatment (RTT) times that are collected and published monthly by CCGs must be referenced in Schedule 6A of the NHS shorter-form Contract 2016/17. Schedule 4 of the NHS shorter-form Contract 2016/17 Particulars covers Operational Standards and National Quality Requirements, and audiology RTTs are included under reference E.B.4.

As discussed in section 8.1, five readily measurable outcomes have been identified as part of the production of this framework, and the intention is to move away from commissioning services based solely on activity to commissioning based on outcomes.

Using evidence and good practice guidance, CCGs can consider which outcomes and KPIs detailed in appendix 7 to incentivise and whether increasing the thresholds of some outcomes and KPIs would result in further quality improvements for service users. Performance against outcomes and KPIs should be independently audited to ensure objective quality assurance.

Five KPIs were originally incentivised in the 2012 AQP Implementation Pack including:

- 90 percent of service users referred to the service should be assessed within 16 working days of receipt of referral;
- 90 percent of service users requiring a hearing aid fitting should be seen within 20 working days of the assessment;
- 90 percent of follow-up appointments should be within 10 weeks of the hearing aid fitting;
- 90 percent of service users should be able to access aftercare within two working days of a request;
- 95 percent of responses received from service users sampled via a service user survey should report overall satisfaction with the service.

Achievement of these KPIs resulted in 20 percent of the total value of the annual delivered activity being retained based on a weighting of 4 percent per outcome, the sanction being a reduction of 4 percent per outcome if not achieved.

Some CCGs have retained this scheme and incentivised the achievement of the outcomes through a CQUIN operating at the same percentage levels. Others have retained the scheme and incentivised outcomes as well as, or instead of KPIs. The

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North West London Collaboration of CCGs for example, has specified achievement of the following:

- Availability of aftercare seven days a week in all localities;
- The number and percent of service users still wearing their hearing aids after first follow up, 12, and 24 months;
- The number and percent of those service users reporting overall satisfaction with their hearing after first follow up, 12, and 24 months;
- The number and percent of those service users reporting overall satisfaction with their service provider after first follow up, 12, and 24 months;
- The number and percent of those customers reporting a benefit of having their hearing aids

An additional requirement is to provide an annual Patient Improvement report detailing steps being taken to further enhance the overall experience of the service user within the service.

CCGs could also consider using CQUINS or other local incentives to monitor and improve the earlier identification and diagnosis of hearing loss (reducing unmet need), effective triaging and referral, or other areas they want to improve locally through any relevant providers. Further guidance on using national and local CQUINS is available at www.england.nhs.uk/wp-content/uploads/2016/03/cquin-guidance-16-17-v3.pdf.

A range of other data sources can be used to gauge the quality and success of the service, as well as monitoring the delivery of outcomes. These include service user feedback on complaints and compliments, incident reports, unannounced site visits to review the service in action and other mechanisms such as review meetings with the provider and regular engagement with local Healthwatch organisations and other partners.

Providers with UKAS accreditation for IQIPS give commissioners assurance that their hearing services are delivering high quality services for service users, and meet a range of clearly defined quality standards. UKAS accreditation should therefore be used by commissioners as a benchmark indicator to compare hearing services.

Working with other commissioners in the local area to benchmark and share information and experience of commissioning services from the same provider will help identify where quality and cost improvements can be made and increase collective bargaining power to secure better access, choice, quality and outcomes for people with hearing loss.

10 Commissioning models – case studies

This section of the framework highlights examples of what some CCGs⁷ are doing to commission different models of hearing care that offer more seamless and integrated services, mainly out of the acute hospital setting in the community which are more convenient and closer to home for people with hearing loss. The case studies presented here have not been independently evaluated and some are at an early stage of implementation, however they provide wider learning to both commissioners and providers wishing to review and redesign hearing services for their local populations.

North East Essex CCG has procured a single “lead” provider who is accountable for the provision of a number of community services, including hearing care, as part of a “Care Closer to Home” bundle. The aim is to simplify the care system for services users, clinicians, health professionals and others, enabling referral to a single, integrated provider of care closer to home services, rather than multiple providers. Moving planned care from acute hospitals to community settings where it is safe to do so and ensuring that people are treated in the right place, at the right time, helps to reduce costly activity taking place in the acute sector unnecessarily whilst improving the experience for service users and carers.

**A Lead, Integrated
Provider for Hearing
Care Closer to Home**

**North East Essex
CCG**

The benefits to service users with suspected or diagnosed hearing loss include:

- More of a focus on prevention and early intervention, reducing avoidable hearing loss and providing rapid access to locally based ‘one stop’ clinics and online testing;
- Enhanced integration with the wider care closer to home services, particularly for patients with co-morbidities or who are frail;
- Better information and support for people adjusting to hearing loss and using hearing aids, including active follow-up, strong voluntary sector partnerships and support from volunteer health partners.

In addition to the “Care Closer to Home” service, a provider commissioned by North East Essex CCG through this service has partnered with a volunteer-led community based service provider, on a sub-contractual basis, to deliver comprehensive hearing aftercare support through drop-in sessions at community based locations, care homes and home visits. This easily accessible service is provided by trained volunteers and improves the experience of service users by offering more timely and convenient support closer to home, avoiding travelling times to the nearest hospital and reducing the need for appointments whilst freeing up audiology capacity and reducing waiting times. It also helps reduce the number of visits for hearing aid maintenance to GP practices and health centres

**Volunteer Led Hearing
Aftercare Support**

**North East Essex
CCG**

⁷ For further information CCG contact details are available on request

contributing to overall cost savings in the system. The flexible and convenient support offered ensures people make the most of their hearing aids and continue to be able to communicate with friends and family, remain socially active and manage their own hearing loss and wider health, thereby reducing the need for other health and social care services.

Community-based aftercare support significantly reduces the burden on audiology departments, contributing to significant cost savings for the system, as well as reducing unnecessary GP appointments and other health and social care interventions resulting from basic needs not being met.

North, East and West Devon CCG commissions a complete package of audiology services from a social enterprise organisation in the community. The audiology

**Fully Integrated
Specialist Hearing
Care Service**

**North, East & West
Devon
CCG**

service accepts referrals direct from health professionals in primary care and hospital consultants for all aspects of hearing care for adults and children. This ranges from babies of a few days old and their families to the elderly. The service includes diagnosis of, quantification of degree, and rehabilitation of hearing loss, tinnitus or balance impairment. The service model provides support and diagnostic testing for ENT clinics for adults and children, and provides on a direct referral basis and supports ENT, with a range of both routine and specialist services.

North West London Collaboration of CCGs commissions a domiciliary hearing care service which is designed for people who find it difficult to get to their local high street or hospital audiology department. Service users benefit from having a hearing

**Domiciliary Hearing
Care Service**

**North West London
Collaboration of CCGs**

examination in their own home and aids can be tuned in to their environment and twinned to equipment such as telephones and televisions. Carers and relatives can be present and there is no need for the person to undertake what could be a painful and difficult transfer to another facility. The service provides hearing care and ongoing support at home, meaning reduced inequalities in access for this group. They also no longer have to travel to hospital for non-medical hearing care unless they choose to, and this reduces the risks associated with this vulnerable group of people travelling to and from hospital.

West Hampshire CCG has commissioned a redesigned pathway of hearing care for adults in the local area. The pathway was co-produced with ENT doctors and audiologists and has been designed around the needs of service users ensuring each individual gets access to the right care, from the right place at the right time. The new pathway allows all audiology providers to refer directly into ENT and provides ENT with a streamlined way to offer service users a choice of community audiology. This results in a more integrated model of care and when a

**Redesign of Hearing
Care Pathway**

West Hampshire CCG

person needs input from both ENT and audiology (which is generally less than 20 percent of cases) at least two GP visits are saved per person. The pathway facilitates direct access to ENT to rule out or treat a medical condition and then people can have their hearing needs met on a routine, and often less costly, community hearing care pathway. In the past such service users would be classified as complex because of their medical condition despite their audiology needs being no more or less complex than people with age-related hearing loss. Consequently, waiting times have reduced for people with other forms of hearing loss, so they now have access to the same responsive and local service as people with age-related hearing loss providing a more equitable system of hearing care for all.

The redesigned direct access hearing care service commissioned by Coventry and Rugby CCG provides services for people aged 19 years and above. It removes the

**Redesigned Direct
Access Hearing Care
Service for 19+ years**

**Coventry and Rugby
CCG**

need to see a GP for a referral and also removes the current restrictions related to contraindications (specified in the 2012 AQP Implementation Pack) and ENT acute outpatients' appointments. The service is accessible, provides wax removal, which was only previously available in the acute service, has effective outcome measures, improves patient experience and enables acute and community services to operate alongside each other.

Aintree University Hospital NHS Foundation Trust provides a "one-stop" multi-disciplinary clinic to provide streamlined services for balance and tinnitus patients. In the new streamlined model highly experienced physiotherapists and audiologists with extended roles have their own clinics. The person is examined, investigated (radiological imaging and blood tests can be arranged), diagnosed and treatment started in "one-stop" audiology and physiotherapy led clinics. Many people require

**One Stop Model for
Tinnitus and Balance**

just one visit, but for those with long-term chronic conditions the treatment plan can be formulated at the first visit, thus reducing referral to treatment time and reducing the number of hospital visits for the person. Anyone that requires surgical intervention, or has results that need further investigation is fast tracked to the appropriate consultant-led clinic. Complex cases are discussed at multi-disciplinary team meetings to ensure that all cases are managed appropriately. Support groups for tinnitus and balance disorders have also been set up to complement these clinics.

11 Moving forward

This framework is intended to help raise the profile of the need for effective commissioning of hearing services both nationally and locally and support CCGs to do this by providing some practical tips on how to do it. The framework will help CCGs commission hearing services that offer more person-centred, integrated services, closer to home and deliver better outcomes and value for people with hearing loss.

NHS England has produced this framework as part of its commitment in the Action Plan on Hearing Loss to improve hearing services in England and to build on Monitor's review of adult hearing services. In parallel the National Institute of Health and Care Excellence (NICE) is developing a guideline on the assessment and management of adult-onset hearing loss which is expected to be published in May 2018. The NICE guideline will then be used to develop a quality standard for adult-onset hearing loss which will set evidence based standards that CCGs can use to support commissioning for quality improvement within this framework.

The framework will be revised when new regulations and guidance are released, such as the NICE guideline or when new data, tools or resources are available to help CCGs commission hearing services. The principles of commissioning to improve services, outcomes and value for money for service users and the NHS will remain.

Acknowledgements

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British Society of Audiology
British Society of Hearing Aid Audiologists
British Tinnitus Association
CHIME Social Enterprise
Coventry and Rugby CCG
Hearing Aid Manufacturers Association
Hearing Loss and Deafness Alliance
Leeds South and East CCG
National Community Hearing Association
National Deaf Children's Society
NHS Hammersmith & Fulham Clinical Commissioning Group
NHS Improvement
North East Essex CCG
North East London CSU
North East and West Devon CCG
North West London Collaboration of CCGs
Public Health England, NHS Newborn Hearing Screening Programme
Scrivens Opticians & Hearing Care
Solihull CCG
South CSU
The Outside Clinic
West Hampshire CCG

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Appendix 1 – Membership of Stakeholder Groups involved in Co-Production of Commissioning Framework

Commissioning framework working group:

Organisation	Name	Role
NHS England	Fiona Thow	Clinical Adviser to CSO
NHS England	Sonia Fleming	Hearing Loss Project Lead
NHS England	Charlie Podschies	Programme Coordinator
NHS England	Ruth Thomsen	Audiology Clinical Expertise
Primary Care Commissioning	Cathy Regan	Associate Consultant & Programme Adviser
NHS Improvement	David Furness	Senior Policy Adviser
Hearing Loss and Deafness Alliance	Brian Lamb	Chair
CCG	Doug Middleton	Chief Operating Officer, Solihull CCG
CCG	Sarah Esson	Business Delivery Manager, Planned Care, North East Essex CCG
CCG	Julie Scrivens	Head of Planned Care & Mental Health NHS Hammersmith & Fulham Clinical Commissioning Group
CCG	Kathryn Hodgson	ENT Programme Manager, North West London Collaboration of CCGs
CCG	Raffaele Cioffi	Central Contracts Officer, North West London Collaboration of CCGs
CSU	Bernhard Crede	Senior Contracts Manager, North East London CSU

Adult services content group

Organisation	Name	Role
Hearing Loss and Deafness Alliance	Brian Lamb	Chair
Independent Consultant	Professor Adrian Davies	Subject Expert
Action on Hearing Loss	Chris Wood	Health Policy Manager
Action on Deafness	Jane Shaw	Chief Executive Officer
British Tinnitus Association	David Stockdale	Chief Executive Officer
British Academy of Audiology	Jagjit Sethi	President
British Academy of Audiology	Rosemary Monk	Board Director for Service Quality
British Society of Audiology	Helen Pryce-Cazalet	
National Community Hearing Association	Harjit Sandhu	Director of Policy
British Society of Hearing Aid Audiologists	David Welbourn	Chief Executive
British Hearing Aid Manufacturers Association	Trevor Andrews	Managing Director

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Children’s services content group

Organisation	Name	Role
National Deaf Children’s Society	Susan Daniels	Chief Executive
National Deaf Children’s Society	Vicki Kirwin	Audiology Manager
Public Health England	Jane Hibbert	Programme Manager – NHS Newborn Hearing Screening Programme
British Academy of Audiology	Jagjit Sethi	President

Commissioning framework advisory group (In addition to the above stakeholders):

Organisation	Name	Role
NHS England	Richard Swarbick	National Lead Armed Forces & MoD Transition and AF Networks
NHS England	Andy Bacon	Lead (Asst Head) Armed Forces
NHS England	Forrest Frankovitch	Head of Analysis (Patients and Information, Medical and Nursing Directorates)
NHS England	Michele Davis	Accountable Commissioner for Ear Surgery
NHS England	Kevin Holton	Deputy Director Patient Experience
Department of Health	Michael Swaffield	Autism Policy Lead
Department of Health	Shiraz Sethna	Mental Health and Policy Team
Rightcare	Professor Muir Gray	Population Health Expert
CCGs	Gill Pickering Eastern Cheshire CCG	Primary Care Applications Manager
CCGs	Jayne Andrews Calderdale and Greater Huddersfield CCGs	Contracts Officer
CCGs	Jane Chapman Stafford & Surrounds CCG	Priorities Commissioner
CSUs	Matthew James North of England CSU	Commissioning Manager - Service Planning and Reform
UK Council on Deafness	Jim Edwards	Chair
Royal British Legion	Daniel Elser	Head of Grants & Social Policy
Deaf Connect (Northamptonshire)	Joanna Steer	Chief Executive Officer
Elizabeth Foundation	Julie Hughes	Chief Executive

Appendix 2 – What is Hearing Loss?

Hearing loss can either be sensorineural, or conductive, or mixed (a combination of both types). It can be congenital or acquired (gradual or sudden onset), and in some cases it can fluctuate over time.

2.1 Types of Hearing Loss

Sensorineural hearing loss

Sensorineural hearing loss is caused by damage to the inner ear, such as the hair cells in the cochlea, sometimes damage to the auditory nerve, or both. More than 90 percent of hearing loss in adults is sensorineural (1). In children the prevalence of hearing loss is between 0.1 and 0.3 percent but sensorineural hearing loss is rare.

Sensorineural hearing loss not only changes our ability to hear quiet sounds, but it also reduces the quality of the sound that is heard, meaning that individuals with this type of hearing loss will often struggle to understand speech. Once hair cells become damaged, they will remain damaged for the rest of a person's life. Sensorineural hearing loss is therefore irreversible and cannot be cured. This type of hearing loss is sometimes referred to as sensory, cochlear, neural or inner ear hearing loss.

The leading cause of sensorineural hearing loss is the ageing process (age-related hearing loss, or presbycusis). Other – less common - causes include:

- Regular and prolonged exposure to loud sounds;
- Acoustic trauma or impulsive noise damage (explosions, gun shots at close range);
- Genetics;
- Ototoxic drugs – some antibiotics and medicines used to treat life-threatening infection, diseases or cancers are harmful to the cochlea and/or hearing nerve;
- Illness or infectious diseases such as meningitis, rubella, congenital cytomegalovirus (CMV);
- Complications at birth such as lack of oxygen or severe jaundice
- Injury to the head;
- Benign tumours on the auditory nerve.

Conductive hearing loss

This is due to a mechanical blockage, damage to, or abnormality in the structure that prevents sound vibrations from passing freely through the outer or middle ear. Sounds become quieter, although not usually distorted. A conductive hearing loss can either be temporary or permanent, and may be corrected with medical management, or minor surgery.

Conductive hearing loss is caused by:

- Impacted wax;
- Perforated ear drum;
- Middle ear fluid (otitis media with effusion or “glue ear”);

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- Absent or underdeveloped outer and/or middle ear structures (microtia or atresia);
- Fixation of one of the middle ear bones (such as otosclerosis).

Estimates suggest that approximately 8 percent of hearing loss has a conductive cause (2). Temporary conductive hearing loss is the most common form of hearing loss during childhood. 80 percent of children will experience otitis media with effusion (“glue ear”) by the age of 10 years (3) but the hearing loss associated with this condition usually resolves over several weeks or months. However if it does not resolve it can lead to educational, behavioural and language problems (4) Sometimes it might also result in permanent conductive hearing loss. This is why effective management in primary care by the GP, and onward referral to ear, nose and throat (ENT) services and/ or the child’s paediatrician where appropriate, is critical. It is most common in pre-school children affecting them during early periods of language development and between the ages of one and three years the prevalence is 10 percent to 30 percent (5).

Ear wax causes a temporary conductive hearing loss that affects around 2.3 million people in the UK each year seriously enough to warrant intervention (6). Research suggests that an estimated four million ears are being syringed annually within the UK placing a significant impact on resources in primary care. General Practitioners (GPs) have reported seeing on average nine people a month requesting removal of ear wax (7). Ear wax may affect between two and five percent of adults and over 10 percent of children (8). It is very important that a clear local pathway is developed and understood to deal with ear wax before audiological assessment is undertaken, as visits to audiology, prior to wax being checked and removed, are a significant source of inappropriate referrals.

Tinnitus

Tinnitus is the term used to describe hearing a sound in one ear, both ears or the head where there is no external sound source. This may be heard as a ringing, humming or buzzing as examples and some people hear two or more sounds at a time. It is often associated with:

- Age-related hearing loss;
- Inner ear damage caused by repeated exposure to loud noises;
- An earwax build-up;
- A middle ear infection;
- Ménière's disease – a condition that also causes hearing loss and vertigo (a spinning sensation);
- Otosclerosis – an inherited condition where an abnormal bone growth in the middle ear causes hearing loss.

Between 10 and 15 percent of adults may have tinnitus, with around 3 percent requiring a clinical intervention (9). Tinnitus can be exacerbated by anxiety or stress. It can occur with hearing loss or in people with no hearing loss, and it can lead to depression and other mental health issues, as well as affecting relationships with others and the ability to sleep, concentrate and work. Hearing aids, information, tinnitus retraining therapy, cognitive behavioural therapy and other specialist support

are among the services that can provide help for people with tinnitus, which are usually accessed in audiology departments after referral from the GP (10). Reported prevalence of tinnitus in children varies from 12 percent to 36 percent and is more common in children with hearing loss compared to children with normal hearing. Most children with tinnitus do not find it distressing and self-manage, but a proportion require further support from audiology services alongside other services such as psychological support (11).

Dizziness and Balance Disorders

Some dizziness and balance disorders are associated with poor hearing (12) as well as other inner ear, brain, metabolic and cardiovascular or thoracic problems. Prevalence increases with age, with these disorders being some of the most common complaints reported to GPs by older patients (13). Almost 1 in 4 adults under 65 are estimated to have problems with dizziness and balance (14) whilst around 15 percent of children are reported to be affected by dizziness (15). Up to 70 percent of children with permanent hearing loss have a balance disorder (16).

Inner ear disorders can also cause imbalance and dizziness in the absence of hearing loss, and conditions such as vestibular migraine (17) and benign positional paroxysmal vertigo (BPPV) (18), comprise approximately 50 percent of cases of imbalance and dizziness occurring in the community each year.

Where dizziness and balance disorders are associated with inner ear problems, diagnostic testing and vestibular rehabilitation is provided by audiology services which may be incorporated into a multidisciplinary balance service with links to other departments such as ear, nose and throat (ENT), neurology, cardiology, care of the elderly, physiotherapy, migraine clinics, and psychology (19).

Deafness

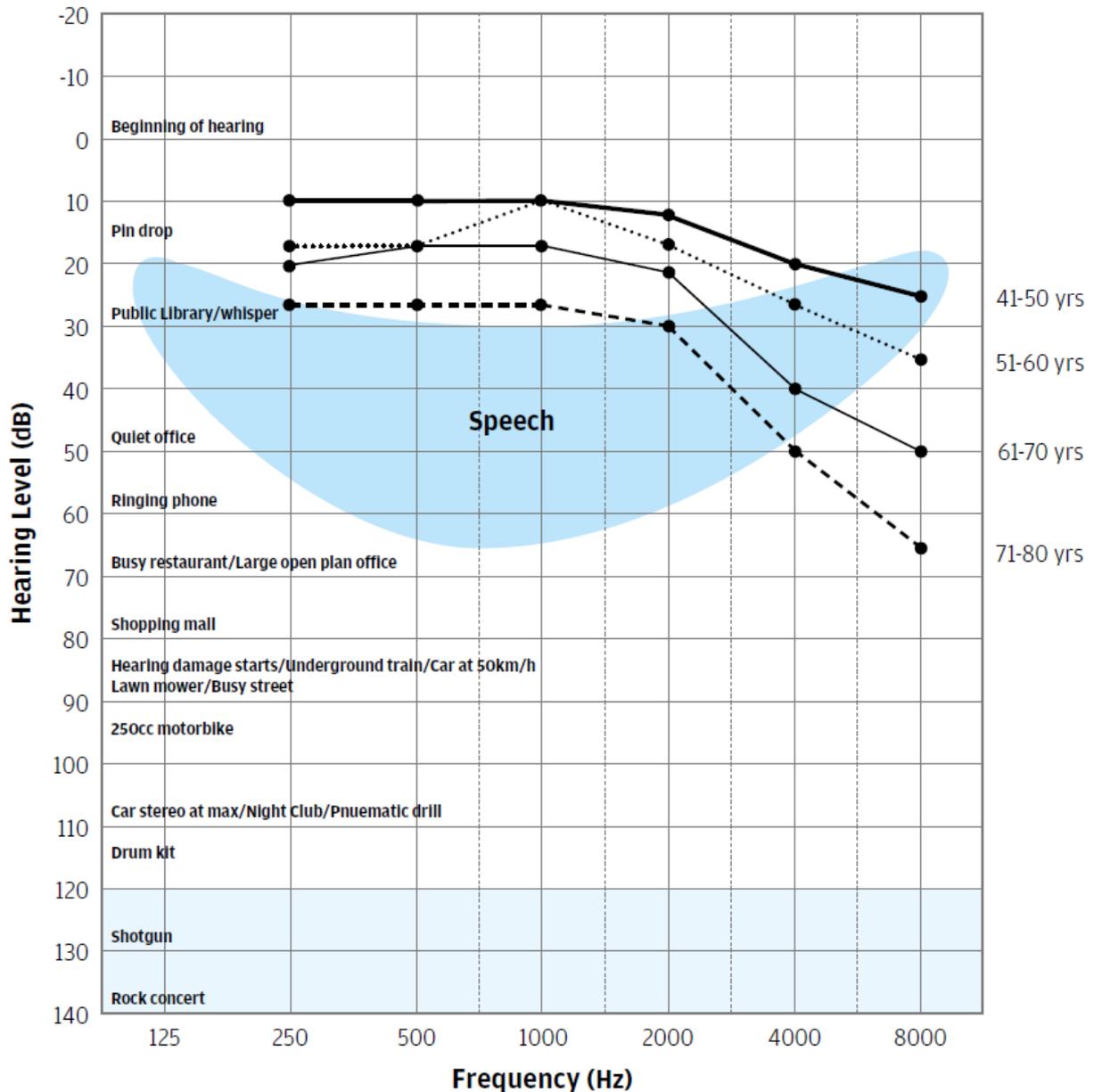
Many people who are severely or profoundly deaf from birth use sign languages such as British Sign Language (BSL) and may consider themselves part of the Deaf community, with a shared history, culture and language. Based on the 2011 census, it is estimated that at least 22,000 people across England and Wales use a sign language as their main language, although this is likely to be an underestimate (10). Those who develop hearing loss or become deaf later in life are unlikely to use sign languages.

2.2 Measurement of Hearing Loss

Hearing loss is measured in terms of the sound level (in decibels or dB) that someone can hear at a given frequency (pitch). Hearing loss is tested across the range of speech frequencies, usually between 0.25 and 8kHz. If a person has good hearing across all these frequencies they are considered to have normal hearing. Many people will have a hearing loss at some frequencies, with normal hearing at other frequencies. For example, when people start to develop age-related hearing loss this usually first affects higher frequencies (20) reducing their ability to hear the consonant sounds from speech, female and children's voices, which can therefore affect understanding of speech and family relationships.

Figure 1 shows an example of an audiogram showing sensitivity to high frequency tones declining with age. (21)

Figure 1:



Hearing tests are usually carried out by an audiologist in soundproofed rooms and can determine whether someone has sensorineural, conductive or mixed hearing loss. The results are recorded on an audiogram which reflects the hearing loss in frequencies and decibels. Other clinical examinations and tests are also used, such as otoscopy, uncomfortable loudness levels and tympanometry to help confirm the type and cause of hearing loss, and to assess if onward referral to medical colleagues and specialists is required. A range of other tests can also be used to determine the impact of the hearing loss on conversation and engagement in normal life activities, for example speech in noise.

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The average of hearing losses in the better ear at the full range of frequencies gives the average hearing level in dBHL (decibels of hearing loss). Table 1 shows the typical predicted impacts of different levels of hearing loss as cited by the Global Burden of Disease Expert Group. It is important to note that the impact on each person will vary depending on which frequencies are most affected, their lifestyle, education or employment setting, any other needs such as any co-morbidities, learning difficulties, use of English as second language and so on. These explanations are therefore only a rough guide and should not be used on their own to determine who receives support.

Table 1: The impact of different decibel levels of hearing loss on Adults (22)

Better ear average hearing level in decibels of hearing loss (dB HL)	Hearing in a quiet environment	Hearing in a noisy environment
20-34 dBHL	Does not have problems hearing what is said	May have real difficulty following/ taking part in a conversation
35-49 dBHL	May have difficulty hearing a normal voice	Has difficulty hearing and taking part in conversation
50-64 dBHL	Can hear loud speech	Has great difficulty hearing and taking part in conversation
65-79 dBHL	Can hear loud speech directly in one's ear	Has very great difficulty hearing and taking part in conversation
80-94 dBHL	Has great difficulty hearing	Cannot hear any speech
Unilateral hearing loss: Up to 20 dBHL in the better ear; at least 35 dBHL in the worse ear	Does not have problems unless sound is near poorer hearing ear	May have real difficulty following/ taking part in a conversation

2.3 Presentation in Adults and Children

Adults may find they do not notice a hearing loss as it first develops, even if it is already impacting on their ability to communicate, their health or their quality of life. Their brain can often fill in the gaps of missing speech information they do not hear using their understanding of language and context. Under these circumstances, hearing requires increased concentration and can be both exhausting and stressful. Early symptoms can arise from stresses of increased misunderstanding, and contribute to the tendency to withdraw and become isolated. Later it may be a family

member that notices a hearing loss before the individual concerned when they do not respond appropriately and it is common for adults to present later. Adults with hearing loss wait on average ten years before they seek help, and many people who could benefit from hearing aids don't have them, so GPs and other health and social care professionals should regularly check people's hearing as they get older (10, 23) to encourage people to seek help, and to ensure they get a prompt referral on to audiology services. Guidance on referral is available from the British Academy of Audiology at http://www.baaudiology.org/index.php/download_file/view/302/178/, and professional practice guidance from the British Society of Hearing Aid Audiologists can be found at <http://www.bshaa.com/Publications/BSHAA>.

CCGs should plan to ensure services tackle unmet need and ensure that GPs are aware of the evidence and national guidance, as well as local referral pathways.

In children, even a slight reduction in hearing may have an impact on their development since they do not have the language base or understanding to fill in the missing gaps. Hearing difficulties in children impact on all areas of their development including speech, language and communication, education and social development. They may miss out on new vocabulary, concepts, and incidental listening and learning on a daily basis. Most children with hearing loss should be identified through the New Born Hearing Screening Programme.

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Appendix 3 – Commissioning Audiology Services

Audiology is a healthcare science encompassing hearing, tinnitus and balance and is predominantly provided by NHS healthcare science staff and hearing aid dispensers in conjunction with many partners. In the UK, it has developed with combined functions as a diagnostic and treatment discipline and is a cost effective use of knowledge and skills. In general, use of the term audiology refers to audiology departments and hearing care providers and “audiologist” refers to audiologists, clinical scientists and Hearing Aid Dispensers (HADs)⁸.

Audiology services provide assessment, diagnosis, intervention and rehabilitation services for children and adults with suspected or diagnosed hearing, tinnitus and balance disorders. These services are sometimes integrated with ENT services or wider primary care.

3.1 Commissioning Paediatric Audiology Services

CCGs are generally responsible for commissioning the following services for children (1):

- Assessment, diagnosis and management of children up to 18 years including those with unilateral hearing loss, glue ear and auditory neuropathy spectrum disorder; and
- Insertion of grommets for glue ear.

Local authorities commission school entry hearing screening as part of their responsibilities in commissioning The Healthy Child programme (2).

NHS England commissions the Newborn Hearing Screening programme, the mental health service for deaf children and adolescents and specialist audiology services for children that are part of a paediatric hearing aid service, including:

- Differential audiological diagnosis;
- Etiological investigations (including radiology and genetics) and medical assessment (including vestibular assessment);
- Hearing aid and frequency modulated hearing aid provision;
- Cochlear implant assessment and provision of cochlear implants;
- Transitional arrangements to adult services;
- Outreach support to education.

3.2 Commissioning Adult Audiology Services

CCGs commission audiology services for adults over 18 years of age. People aged 50 and over usually access these services directly after having their hearing checked and getting a referral from their GP or another health professional. Some CCGs have enabled younger adults to access these services and others are implementing self – referral options to increase ease of access and convenience for service users.

⁸ HAD is a protected title for audiologists who are subject to statutory professional regulation by the Health Care Professions Council.

Adult audiology services include: a full hearing assessment; rehabilitation therapy and on-going support; fitting of hearing aid(s) where required; follow-up to ensure the person is benefitting; ongoing aftercare (including hearing aid support, repairs and batteries); and onward referral to further support and equipment from social services and other local services such as support groups and lipreading classes. Services may also include assessment, diagnosis, intervention and rehabilitation for tinnitus and balance disorders.

Research has shown inconsistencies in the way these services are provided, and that many health and social care professionals such as GPs and care home staff are not identifying or referring people who may have hearing loss (3).

The majority of adult audiology services are still provided by NHS hospitals although the range of providers has expanded over the years (particularly through the Any Qualified Provider (AQP) scheme for adult hearing loss) to include: national and regional independent sector providers, charitable organisations; social enterprises and GP – led organisations

In addition to services described in this appendix, CCGs will also fund ear care via the ENT mandated tariffs for example; if audiology support is provided within consultant- led clinics these costs will usually be covered by the ENT tariff. There are some specialist hearing services, for example bone conduction hearing implants, cochlear implantation services, middle ear implantable hearing aid services and auditory brainstem implants which are commissioned by NHS England and generally provided by NHS hospitals.

3.3 Commissioning Audiology Services for Armed Forces / Veterans

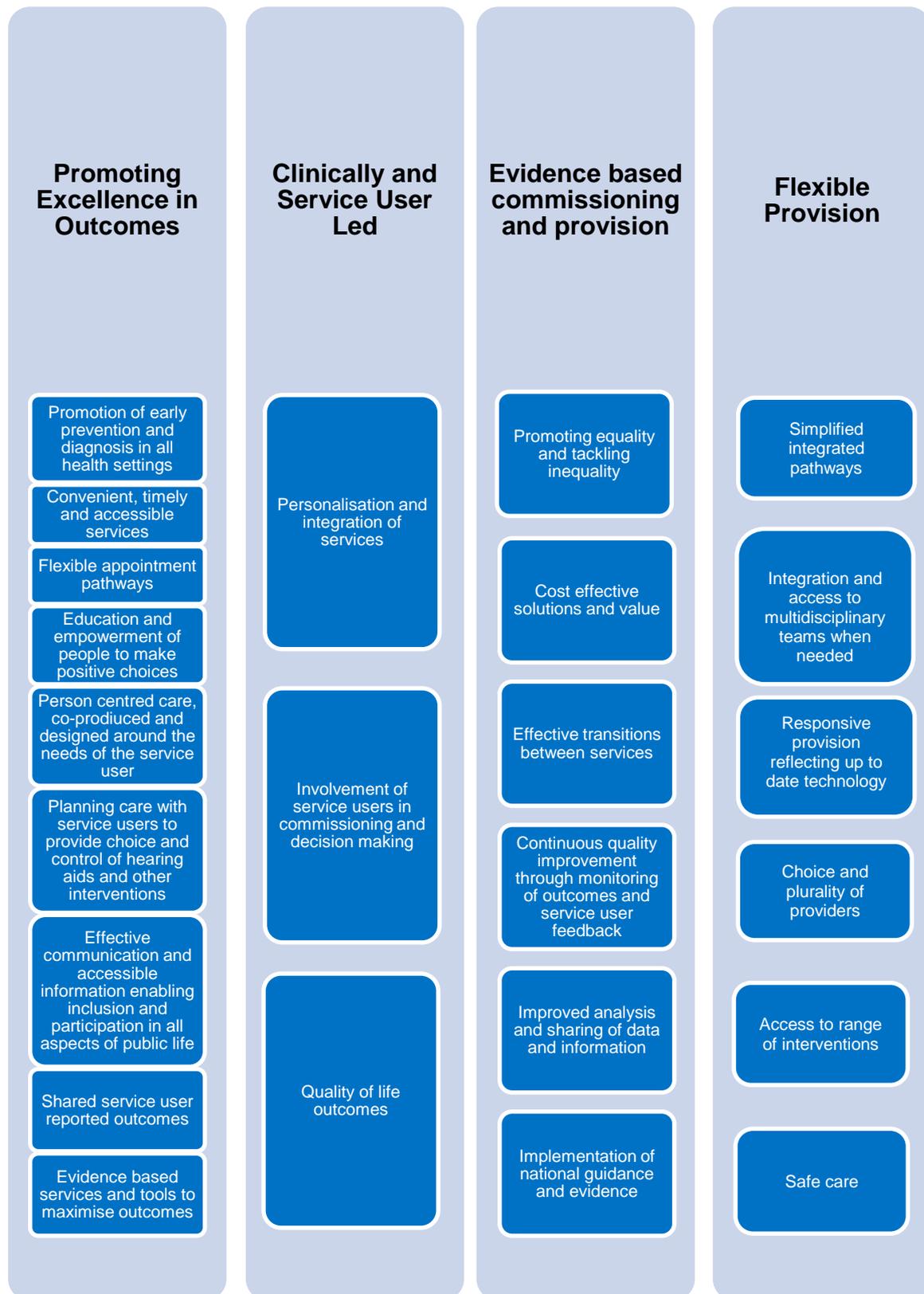
CCGs will need to take into account the veteran status of service users with service related hearing loss. They have the right to access care the same as any other member of the public and may have received treatment before discharge from the Ministry of Defence, Defence Medical Services. There are specific compensation arrangements for those who lose their hearing due to service and separate Government-financed funding for enhanced hearing loss services (to complement NHS /CCG commissioned services) coordinated by the Royal British Legion (an outline of this is available in section 8.6 of this framework where a web link can also be found). It is important therefore that veterans are identified in the system, so that they can benefit from their entitlements after discharge from the service.

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Appendix 4 – Hearing Loss and Deafness Alliance Principles for Commissioning Hearing Loss Services



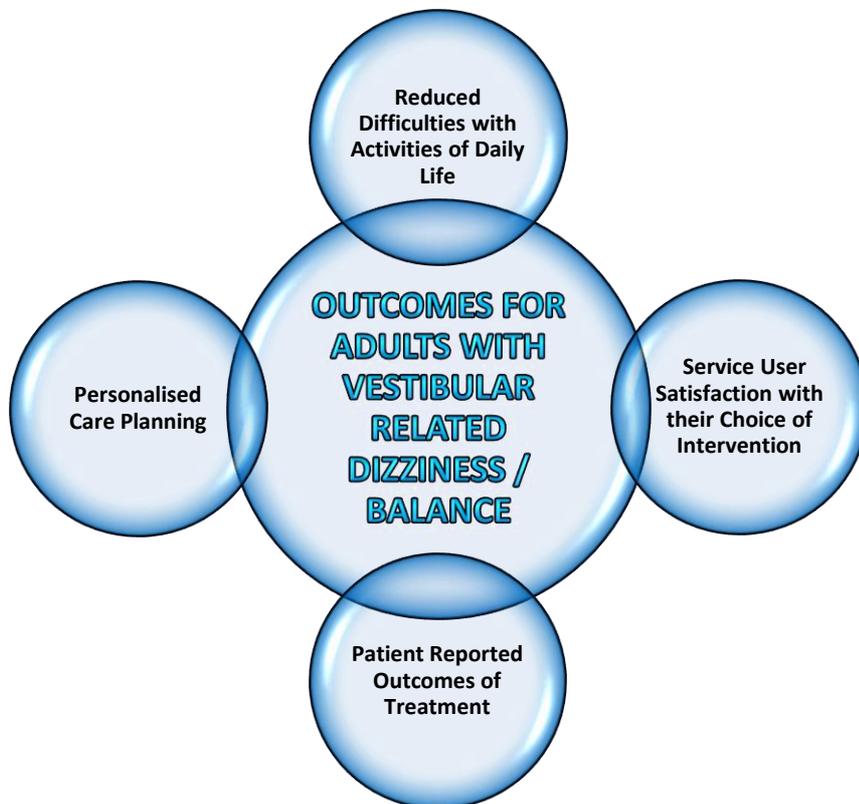
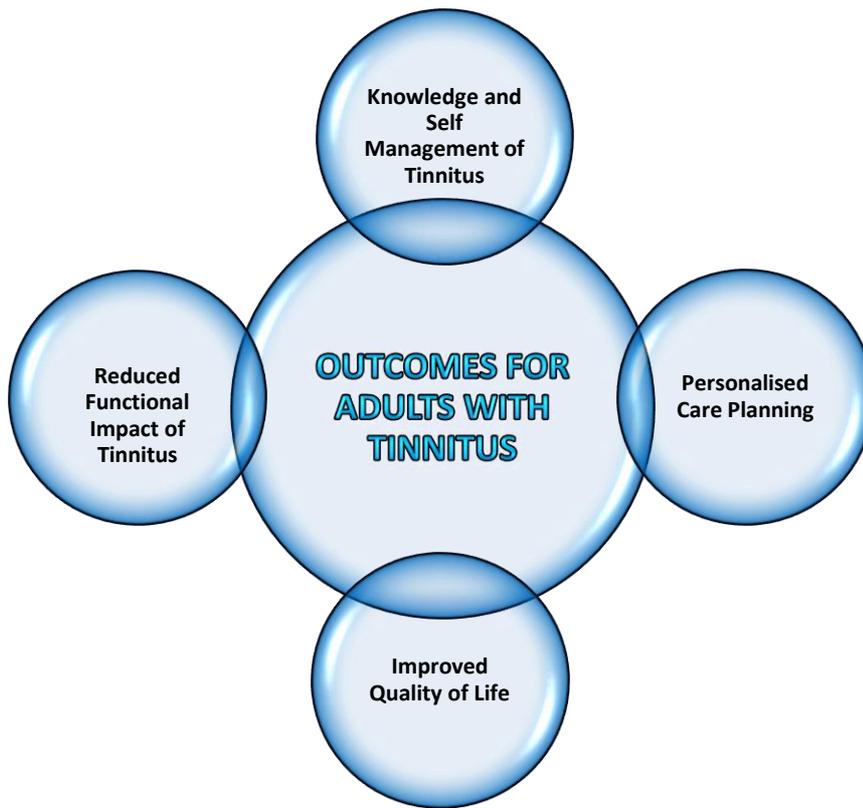
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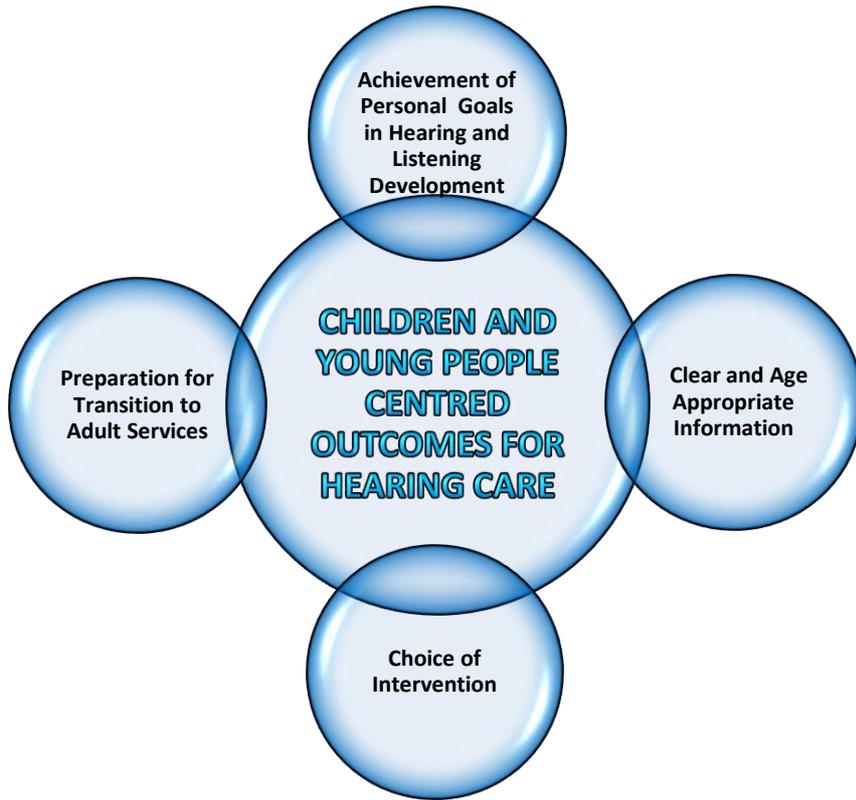
Appendix 5 – Ear Related Healthcare Resource Groups (HRGs)

(Admitted Patient Care and Outpatient Attendances)

HRG Code	HRG Name
CZ08S	Minor Ear Procedures 18 years and under with CC
CZ08T	Minor Ear Procedures 18 years and under without CC
CZ08V	Minor Ear Procedures 19 years and over with CC
CZ08Y	Minor Ear Procedures 19 years and over without CC
CZ09U	Intermediate Ear Procedures 18 years and under
CZ09V	Intermediate Ear Procedures 19 years and over with CC
CZ09Y	Intermediate Ear Procedures 19 years and over without CC
CZ10U	Major Ear Procedures 18 years and under
CZ10V	Major Ear Procedures 19 years and over with CC
CZ10Y	Major Ear Procedures 19 years and over without CC
CZ11Z	Complex Major Ear Procedures
CZ21V	Minor Head, Neck and Ear Disorders 19 years and over with CC
CZ21Y	Minor Head, Neck and Ear Disorders 19 years and over without CC
CZ22W	Intermediate Head, Neck and Ear Disorders 19 years and over with Major CC
CZ22X	Intermediate Head, Neck and Ear Disorders 19 years and over with Intermediate CC
CZ22Y	Intermediate Head, Neck and Ear Disorders 19 years and over without CC
CZ23W	Major Head, Neck and Ear Disorders 19 years and over with Major CC
CZ23X	Major Head, Neck and Ear Disorders 19 years and over with Intermediate CC
CZ23Y	Major Head, Neck and Ear Disorders 19 years and over without CC
CZ240	Complex/Major Head, Neck and Ear Disorders with Major CC
CZ24P	Complex/Major Head, Neck and Ear Disorders with Intermediate CC
CZ24Q	Complex/Major Head, Neck and Ear Disorders without CC
CZ25A	Unilateral cochlear implant
CZ25B	Bilateral cochlear implant
CZ27Z	Fixture for bone anchored hearing aids
CZ28Z	Fitting of bone anchored hearing aids

Appendix 6 – Outcomes for other Hearing Care Services





Appendix 7 – Recommended Outcomes and KPIs for Adult Hearing Loss

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
Recommended Outcomes:					
Outcome 1 Improvement in service user disability, and/or difficulty in communication (reduced communication difficulties)	90 percent	Validated service user reported outcome tools such as Glasgow Hearing Aid Benefit Profile (GHABP)/ Client Oriented Scale of Improvement (COSI) and International Outcome Inventory for Hearing Aids (IOI-HA)	To be defined locally	Monthly Performance Report	Adult Hearing Service
Outcome 2 Improvement in service user reported quality of life	90 percent	Validated service user reported outcome tools such as Glasgow Hearing Aid Benefit Profile (GHABP)/ Client Oriented Scale of Improvement (COSI) and International Outcome Inventory for Hearing Aids (IOI-HA)	To be defined locally	Monthly Performance Report	Adult Hearing Service
Outcome 3 Percentage of service users reporting continued use of their choice of hearing aid and or other intervention(s).	90 percent	Review of Service Quality Performance Reports	To be defined locally	Monthly Performance Report	Adult Hearing Service
Outcome 4 Percentage of service users reporting benefits from their choice of intervention	90 percent	Validated service user reported outcome tools such as Glasgow Hearing Aid Benefit Profile (GHABP)/ Client Oriented Scale of Improvement (COSI) and International Outcome Inventory for Hearing Aids (IOI-HA)	To be defined locally	Monthly Performance Report	Adult Hearing Service

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Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
Outcome 5 Percentage of service users reporting satisfaction with their choice of intervention	90 percent	Validated service user reported outcome tools such as Glasgow Hearing Aid Benefit Profile (GHABP)/ Client Oriented Scale of Improvement (COSI) and International Outcome Inventory for Hearing Aids (IOI-HA)	To be defined locally	Quarterly and accumulative annual report to include an analysis of number of patients discharged and surveyed, number of responses received, % of those satisfied or very satisfied with service.	Adult Hearing Service
Recommended KPIs (incorporating key outcomes above)					
Referral to Assessment Time Assessments to be completed within 16 working days following receipt of referral, unless patient requests otherwise	(90 – 98 percent)	Review of Service Quality Performance Reports	Sanction	Monthly	Adult Hearing Service
Assessment to Fitting Time Hearing aids to be fitted within 20 working days following assessment, unless patient requests otherwise Note: Some CCGs are specifying outcomes for one stop assess and fit services	(90 – 98 percent) 85 percent	Review of Service Quality Performance Reports	Sanction	Monthly	Adult Hearing Service
Fitting to Follow Up Time Appointments are offered within 10 weeks from fitting, unless there are clear, documented, clinical reasons to do otherwise, or the patient chooses to wait beyond this period	(90-98 percent)	Review of Service Quality Performance Reports	Sanction	Monthly	Adult Hearing Service

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Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
Quicker Follow Up Where patients request this, a quicker follow-up is offered within 5 working days	90 percent	Review of Service Quality Performance Reports	To be defined locally	Monthly	Adult Hearing Service
Objective Measurements (e.g. REM) - Patients undergo objective measurement at first fitting where clinically appropriate (exceptions reported in IMP)	95 percent	Review of Service Quality Performance Reports	To be defined locally	Monthly	Adult Hearing Service
Additional Follow Up Where required, additional face to face follow-ups are offered within 7 working days of non-face to face follow-up	90 percent	Review of Service Quality Performance Reports	To be defined locally	Monthly	Adult Hearing Service
AfterCare Aftercare is available (face to face or non-face to face) within 2 working days of patient request	(90 – 98 percent)	Review of Service Quality Performance Reports	Sanction	Monthly	Adult Hearing Service
Information Sharing Patient records and associated letters/reports completed and sent to GP within 5 working days of hearing assessment/ fitting/ follow-up	95 percent	Review of Service Quality Performance Reports	To be defined locally	Monthly	Adult Hearing Service
Service User Experience Standardised patient questionnaire to be issued at discharge points. 95% of responses received from service	95 percent	Review of Service Quality Performance Reports	Sanction	Quarterly and accumulative annual report to include an analysis of number of patients discharged	Adult Hearing Service

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Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
users sampled should report overall satisfaction with service				and surveyed, number of responses received, % of those satisfied or very satisfied with service.	
<p>Peer Satisfaction of Service</p> <p>Percentage of GPs satisfied with service</p> <p>(A minimum of one GP satisfaction survey will be designed and sent to all referring GPs)</p>	95 percent	GP questionnaires	To be defined locally	Quarterly and accumulative report to include an analysis of completed user questionnaires, demonstrating % of those satisfied or very satisfied with service.	Adult Hearing Service
<p>Service Improvement</p> <p>Service user questionnaires and peer satisfaction surveys to capture areas for improvements.</p>	100 percent of recommendations made and agreed with Commissioner s are addressed	Service User Questionnaires	To be defined locally	Annual report to demonstrate recommendations and actions taken to address areas of service improvement	Adult Hearing Service
<p>Reducing Inequalities</p> <p>Patient questionnaire demonstrates a high satisfaction rate from all protected characteristic groups (PCGs)</p>	95 percent	Service User Questionnaires	To be defined locally	Accumulative annual service user questionnaire report analysis to include number of patients surveyed, number of these in PCGs, response rates, response rates for PCGs, % of these specifying overall satisfaction	Adult Hearing Service
Reducing Barriers*	100 percent	Provider provides	To be defined	Provider provides	Adult Hearing

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Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
An integrated patient pathway, which facilitates signposting to wider communication/social support services (where appropriate)		demonstrable evidence of % patients who receive information about these support services validated through service user questionnaires	locally	demonstrable evidence of % patients who receive information about these support services	Service
Personalised Care Planning All service users have an individual management plan (IMP) produced jointly with users, their family and carers	100 percent	Review of audit data to demonstrate that all service users have a completed IMP and service user satisfaction survey	To be defined locally	Quarterly	Adult Hearing Service
Increased choice and control of when and where treatment is delivered (time and place) 95% of service users sampled should report satisfaction with amount of choice and control	95 percent	Patient questionnaire to monitor satisfaction with amount of choice and control offered	To be defined locally	Monthly performance report for activity and quarterly report for survey	Adult Hearing Service
Increased uptake of hearing aids and proportion of patients continuing to wear hearing aids Percentage of patients still wearing hearing aids at review stage (after first follow up, 12, and 24 months)	90 percent of patients fitted with a hearing aid should be continuing to wear the aid(s) at review	As above	To be defined locally	Monthly Performance Report	Adult Hearing Service
Reduced social isolation and consequent mental health Improvement in GHABP/COSI/IOI-HA outcome measure after hearing aid fitted	90 percent	Use of validated tool	To be defined locally	Monthly Performance Report	Adult Hearing Service
Improved quality of life	90 percent	Validated service user reported outcome tools such as Glasgow Hearing Aid Benefit Profile (GHABP)/	To be defined locally	Monthly Performance Report	Adult Hearing Service

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Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
		Client Oriented Scale of Improvement (COSI) and International Outcome Inventory for Hearing Aids (IOI-HA			

* National Service Specification proposed CQUIN for five service outcomes (KPIs). 20 percent of the total value for annual delivered activity will be subject to the achievement of the above key service outcomes. Each outcome will be weighted equally. Sanctions will be applied on the individual indicator failed in accordance with weighting i.e. 1 indicator failed is a sanction of 4 percent reduction; 5 indicators failed is a sanction of 20 percent reduction. Some CCGs are now applying this to other specific outcome measures e.g. the number and % of individuals still using hearing aids at specified time periods.

*Reducing barriers': This should include monitoring and reducing wrong referrals and ensuring people are signposted or referred to other support and equipment services

Appendix 8 – Contraindications for Referral to Routine Adult Hearing Services

The Adult Hearing Service is for adults experiencing hearing and communication difficulties who feel they might benefit from a hearing assessment and rehabilitation including the option of trying hearing aids with onward aftercare and support. Local commissioners may wish to vary this in agreement with local clinicians and services, where appropriate, to enable younger adults to access the service.

The referral criteria are based on the BAA 2016 draft guidelines for the *Direct Referral of Adults with Hearing Difficulty to Audiology Services*⁹ which are out for consultation at the time of writing and BSHAA Protocol and Criteria for Referral for Medical or other Specialist Opinion (2011). The BAA and BSHAA are jointly developing updated illustrative contraindications. This guidance will be included as soon as it is available.

The Provider will need to have systems in place to accommodate service users who:

- Have sight loss/dual sensory loss;
- Have learning disabilities;
- Require domiciliary care – the Provider should provide all parts of the service at the patient's domicile (including residential or nursing homes) where this is requested in writing by a GP.

People with learning disabilities and some requiring domiciliary care may require special test facilities and techniques. It should be the responsibility of the referring clinician and provider to manage between them the appropriateness of referral/treatment according to a person's needs and not automatically exclude them from this service because they have a degree of learning disability or require domiciliary care.

Commissioners should seek assurance that providers have the necessary qualifications, skills and equipment to accommodate these client groups.

Routine adult hearing services for hearing loss may be provided to people as long as they do not meet the contra-indications as detailed below:

The following contraindications apply:

- Children under the age of 18 years;

History:

- Persistent pain affecting either ear (defined as pain in or around the ear lasting more than 7 days in the last 90 days and which has not resolved as a result of prescribed treatment);
- History of discharge (other than wax) from either ear within the last 90 days, which has not responded to prescribed treatment, or which is recurrent;

⁹ The consultation involves key professional groups and societies including for example: the British Society of Audiology, ENT UK, Royal College of General Practitioners, National Community Hearing Association, British Association of Audiovestibular Physicians, British Society of Hearing Aid Audiologists.

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- Sudden loss or sudden deterioration of hearing (sudden=within 72 hours in which case refer via locally agreed urgent care pathways). Due to the variety of causes of sudden hearing loss, the treatment timescale should be decided locally by the medical team. Prompt treatment may increase the likelihood of recovery;
- Rapid loss or rapid deterioration of hearing (rapid=90 days or less);
- Fluctuating hearing loss, other than associated with colds;
- Unilateral or asymmetrical, or pulsatile or distressing tinnitus lasting more than 5 minutes at a time;
- Troublesome, tinnitus which may lead to sleep disturbance or be associated with symptoms of anxiety or depression;
- Abnormal auditory perceptions (dysacusis);
- Vertigo which has not fully resolved or which is recurrent. (Vertigo is classically described as a hallucination of movement, but here includes any dizziness or imbalance that may indicate otological, neurological or medical conditions. Examples include spinning, swaying or floating sensations and veering to the side when walking).
- Normal peripheral hearing but with abnormal difficulty hearing in noisy backgrounds; possibly having problems with sound localization, or difficulty following complex auditory directions;
- Altered sensation or numbness in the face or observed facial droop.

Ear examination:

- Complete or partial obstruction of the external auditory canal preventing full examination of the eardrum. If any wax is obscuring the view of the eardrum, the GP surgery should arrange wax removal before referring the patient to Audiology
- Abnormal appearance of the outer ear and/or the eardrum (examples include: inflammation of the external auditory canal, perforated eardrum, active discharge, eardrum retraction, growths, swelling of the outer ear or blood in the ear canal).

Audiometry:

- Conductive hearing loss, defined as 25 dB or greater air-bone gap present at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz;
- Unilateral or asymmetrical sensorineural hearing loss, defined as a difference between the left and right bone conduction thresholds of 20 dB or greater at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz;
- Evidence of deterioration of hearing by comparison with an audiogram taken in the last 24 months, defined as a deterioration of 15 dB or more in air conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.

References:

Draft Guidelines for the Direct Referral of Adults with Hearing Difficulty to Audiology Services, British Academy of Audiology (2016)
BSHAA Protocol and Criteria for Referral for Medical or other Specialist Opinion (2011)

Appendix 9 – AQP Currency Model 2011/12

The currency model was broadly based on the 2011/12 non-mandatory tariff model, with some additional component inclusions as per the pathway in the specification. A 10 percent reduction was applied to the 2011/12 non-mandatory tariffs, as existing providers (locally and elsewhere) were either delivering the service to reduced costs from the non-mandatory tariff or had agreed that it was achievable.

20 percent of the total value for annual delivered activity was subject to the achievement of key service outcomes. Each outcome was weighted equally. Sanction was applied on the individual indicator failed in accordance with weighting i.e. 1 indicator failed was a sanction of 4 percent reduction; 5 indicators failed was a sanction of 20 percent reduction.

The prices in the model were exclusive of CQUIN. Local commissioners could determine which goals/indicators to include under a CQUIN scheme. Suggestions included moving one or more of the quality requirement indicators into CQUIN (e.g. service improvement) or using CQUIN to enhance the thresholds of one or more quality requirement indicators (e.g. aim for 100 percent).

Whilst the tariffs (2 and 3) included the three year aftercare and third year review, tariffs were paid after the follow-up. A recovery schedule was recommended to allow NHS commissioning organisations to then reclaim a percentage of the tariff if any part of the three year aftercare and review pathway was undelivered.

The 2011/12 currency model is illustrated below:

Tariff	Basis of Contract	Price
1	Assessment only	£49
2	Assessment, fitting of 1 aid, cost of 1 aid, follow-up, 3 years aftercare and 3rd year review	£294
3	Assessment, fitting of 2 aids, cost of 2 aids, follow-up, 3 years aftercare and 3rd year review	£388
4	Annual aftercare and review (after 3rd year review, where hearing needs have not changed and re-assessment into the pathway is not required)	£23
5	Replacement hearing aid (due to mechanical failure outside of warranty during a period of annual aftercare following the 3rd year review)	£68

- Provision of batteries was included within the above tariffs

The Financial Recovery Model proposed is outlined in Table 1 below:

An incomplete pathway was defined as the aftercare and third year review following assessment, supply, fitting and follow-up of the appliance/s.

Funding for replacement/lost aids was built into the agreement between commissioner and provider.

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Table 1: Financial Recovery Model

Basis of Contract	Proposed Tariff Excluding CQUIN @ 2.5%	% Tariff recovery for incomplete pathway during 1st year of care following the fitting and follow-up (2.3.4)	% Tariff recovery for incomplete pathway during 2nd year of care following the fitting and follow-up (2.3.4)	% Tariff recovery for incomplete pathway during 3rd year of care following the fitting and follow-up (2.3.4)	Value of tariff recovery for incomplete pathway during 1st year of care following the fitting and follow-up (2.3.4)	Value of tariff recovery for incomplete pathway during 2nd year of care following the fitting and follow-up (2.3.4)	Value of tariff recovery for incomplete pathway during 3rd year of care following the fitting and follow-up (2.3.4)
Assessment only	£49.00	N/A	N/A	N/A	N/A	N/A	N/A
Assessment, fitting of 1 aid, cost of 1 aid, 1st follow-up, 3 years aftercare and review	£294.00	20.00%	13.00%	6.50%	£58.80	£38.22	£19.11
Assessment, fitting of 2 aids, cost of 2 aids, 1st follow-up, 3 years aftercare and review	£388.00	15.00%	10.00%	5.00%	£58.20	£38.80	£19.40
Annual aftercare and review (after 3 years)	£23.00	N/A	N/A	N/A	N/A	N/A	N/A

References:

Section 4 – Why we need and National Commissioning Framework for Hearing Loss

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