



The Government Response
to the Health Committee Audiology Services
Fifth Report of Session 2006–07

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
July 2007



The Government Response
to the Health Committee Audiology Services
Fifth Report of Session 2006–07

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
July 2007

© Crown copyright 2007

The text in this document (excluding the Royal Arms and departmental logos) may be reproduced free of charge in any format or medium providing that it is reproduced accurately and not used in a misleading context. The material must be acknowledged as Crown copyright and the title of the document specified.

Any enquiries relating to the copyright in this document should be addressed to The Licensing Division, HMSO, St Clements House, 2-16 Colegate, Norwich NR3 1BQ. Fax: 01603 723000 or email: licensing@cabinet-office.x.gsi.gov.uk

Introduction

The House of Commons Health Select Committee (the Committee) published its report into audiology services on 16 May 2007. This Command Paper sets out the Government's response to the conclusions and recommendations in that report.

The Government recognise that the demand for audiology services, and adult hearing services in particular, has increased substantially in recent years and that waits have been too long. The success of the Department of Health's Modernising Hearing Aid Services (MHAS) programme contributed to this by ensuring that all NHS audiology services were able to fit digital hearing aids from April 2005.

Following extensive work with stakeholders, the Department of Health published in March 2007 the national audiology framework, *Improving Access to Audiology Services in England*. The framework sets out the access performance framework for audiology within which local health systems are responsible for improving services. It also explains how local commissioners and providers can use the health reform levers in order to improve quality, efficiency and access to audiology services, and a series of actions that the Department is taking to support this.

THE GOVERNMENT'S RESPONSE TO THE HEALTH SELECT COMMITTEE'S CONCLUSIONS AND RECOMMENDATIONS

- 1. Audiology services improved greatly as a result of the introduction of digital hearing aids and the MHAS programme. However, this led to a surge in demand, not only from new patients but also from those who wished to switch from analogue aids. This increased waiting times which the NHS surprisingly did not anticipate. (Para 41)**

The MHAS programme was indeed a success but did not collect NHS waiting times. At about the same time as the MHAS programme was completing, work was underway in the newly established Physiological Measurement 18 Weeks programme to develop a robust method of measuring diagnostic waiting times for audiology. The NHS began the first systematic (monthly) collection of waiting times for 15 key diagnostic tests, including pure tone audiometry, in January 2006 (and the collection was extended in October 2006 to capture all audiology assessments). The first data, published in April 2006, showed that waits for assessments were too long. Work began with the NHS and wider stakeholders to address this. The national audiology framework was published in March 2007 and is now being implemented.

- 2. Details about the extent of waiting times are unclear because of inadequate data recording and collection. We recommend that comprehensive data be collected and published on all patients waiting for audiology services from GP referral to treatment. The information we have received indicates that some individual trusts have no waiting list while others have waits of over two years. (Paragraph 42)**

As well as the monthly diagnostic data collection referred to above, the NHS carries out a regular (now quarterly) census of waits for all diagnostic tests including all audiology assessments from October 2006. None of this was in place before 2006.

It is also important to understand how long patients wait from when they are referred to when they are treated (for example, by being fitted with a hearing aid). Referral-to-treatment (RTT) waiting times have been collected since January 2007 for those patients on 18 Weeks pathways whose treatment requires them to be admitted. The first data was published on 7 June. More importantly for audiology – because hearing aid fitting does not normally require admission to hospital – will be referral-to-treatment times for non-admitted patients on 18 Weeks pathways. This data has been collected since April 2007 and should be ready for publication later in the summer. Most of the data relevant to audiology will appear as part of Ear, Nose and Throat (ENT) returns.

The 18 Weeks data will not cover referral-to-treatment waits for patients referred directly to audiology departments from primary care. However, following the publication of *Improving Access to Audiology Services in England*, four NHS sites are piloting the collection and submission of an RTT data set and Patient Tracking List (PTL) for all direct-access referrals into audiology. The findings from this pilot will inform a decision on whether to introduce a national data collection of all audiology RTT times.

3. Some PCTs have failed to give audiology services the priority they deserve. The Minister admitted that audiology services had not been seen as a priority, but this still seems to be the case. The publication of the new audiology framework was delayed for almost one year. Its publication eventually coincided almost exactly with the Committee's inquiry. The framework adds little that is new. Already some of the targets in the framework, such as publication of the adult hearing loss model care pathway by March 2007, have not been met. (Paragraph 57)

The NHS Operating Framework for 2007/8, published in December 2006, made special mention of audiology in the context of the 18 Weeks target. It said:

2.10 There are risks to the delivery of [an 18 Week patient pathway] because of the potential for referrals that do not need to be made to consultants – such as referrals direct to audiology departments for simple hearing problems or direct to therapy – to be redirected via consultants in order to bring them into the scope of 18 weeks. PCTs should therefore commission sufficient direct access activity in these areas to substantially reduce waits – for audiology and hearing aid fitting in particular.

Improving Access to Audiology Services in England, was developed following extensive work with the NHS and other key stakeholders. That the Committee chose to inquire into audiology waits at the same time as the framework was published shows how important we all believe it is to make further progress in this area.

Transforming Adult Hearing Services for Patients with Hearing Difficulty was published on 29 June. This includes model pathways for the delivery of care. Stakeholders were also consulted on an 18w commissioning pathway for patients with hearing impairment on 26 April and this will be available shortly.

A new Audiology Advisory Board met for the first time on 21 June. The Board will review work to date on key deliverables including the development of a workforce toolkit, analysis of cost data to inform a possible tariff for 2008/9 and ideas for quality assessment and service monitoring.

4. **We note the Minister's determination to meet the existing target of providing diagnostic tests for audiology within six weeks by March 2008. This will be difficult.**

The first stage of this target – for all patients to receive diagnostic tests within 13 weeks by March 2007—has already been missed. The Minister told us that “quite a number of people could have their hearing aid fitted literally on the same day as the assessment”, presumably through the use of ‘open-fit’ technology. Whether this can be adopted widely is being investigated and must be confirmed. (Paragraph 58)

Strategic Health Authorities have provided assurance that their activity plans for 2007/8, including plans to procure more from the independent sector, will deliver six-week maximum waits for all diagnostic tests, including audiology assessments, by March 2008. Performance on audiology waits clearly needs to improve and the SHAs are committed to this.

The good practice guidance referred to above references the work and outcomes of NHS pilot sites which have tested the new assess-and-fit technology, and which enables a hearing aid to be fitted on the same day as assessment. An evaluation report of the pilot study will be produced by the Medical Research Council Hearing and Communications group at the University of Manchester.

5. **The exclusion of audiology services from the 18-week target means that patients with hearing problems are waiting for over two years to receive treatment in some areas. This is particularly unacceptable since the hearing aids are so effective. The exclusion has led GPs to have their patients seen quicker by referring them to ENT departments. It is ridiculous that this loophole exists since it can be so easily exploited and increases costs and waiting times for ENT outpatient appointments.**

Waiting times for all audiology patients will remain long if audiology remains outside the 18-week target. It would be difficult to do it immediately, but we recommend that the Department of Health include audiology services within the 18-week target at an early date. Meeting the 18-week target should be possible once the six week target for diagnostic tests for audiology has been achieved. (Paragraph 59)

The 18 Weeks target covers pathways that involve or might involve medical or surgical consultant-led care. To counteract any incentive for patients with simple hearing problems to be referred via ENT, SHAs are committed to achieving the milestone of six-week diagnostic waiting times for all diagnostic tests including audiology assessments. We have no plans to revisit the scope of the 18 Weeks target but have been clear with the NHS that no local health system will be credible in claiming success on 18 Weeks if it does not make excellent progress in tackling long waiting times affecting large numbers of its local population, including those waits that are technically outside the target. Direct-access services should be quicker for patients because they eliminate an unnecessary stage of the pathway.

6. We recommend that the Department undertake a thorough examination of the medium- and long-term demand for digital hearing aids. (Paragraph 91)

This we are doing working closely with SHAs and involving stakeholders.

7. We recommend that audiology departments review the way in which they provide services to patients, identifying the skill mix and the levels of training or experience necessary. Their reviews should also examine the possibility of operating flexible opening hours, telephone follow-up, home visits, the use of Choose and Book and cross-boundary working to increase the numbers of patients seen. The cost of hearing aids could be reduced by bulk purchasing. (Paragraph 93)

We agree, and proven ways of doing this are set out in the good practice guidance published on 29 June.

The cost of digital hearing aids has already been reduced considerably as a result of the national contract developed by the NHS Purchasing and Supply Agency and RNID and held by NHS Supply Chain. The NHS is encouraged to take advantage of the economies of scale achieved by buying hearing aids through this contract.

8. We received evidence about the extent of graduate unemployment. We recommend that the Department examine the situation of recent audiology graduates. (Paragraph 94)

The Department has not collected centrally any data on the number of audiology graduates who might have been unable to secure a post.

We are aware, anecdotally, that a very small number of 2006/07 graduates are currently unemployed. Strategic health authorities and trusts are working proactively to find opportunities for graduates within their overall workforce plans. Graduates are encouraged to be flexible when applying for posts. For example, although there are now several more training institutions than there were just a few years ago, there is not one in every SHA area and graduates will need to continue to be mobile when looking for jobs.

- 9. Value for money assessment must be carried out. This will be difficult without a tariff. We note that the Department will consider this in 2007. We recommend that the Department produce a national tariff for audiology at an early date.**

We are progressing the commitments made in *Improving Access to Audiology Services in England* to review tariff and benchmark costs. Centrally available procurement and reference costs are being collated and analysed to inform the possible introduction of either an indicative or mandatory audiology tariff for 2008/09.

- 10. The contracts negotiated with the private sector must ensure that patients receive adequate care and follow-up. Services must be monitored and the quality of care must be assessed on the same basis as the quality of care is assessed in the NHS. (Paragraph 96)**

Centrally procured contracts, negotiated with independent sector providers as part of the Independent Sector Treatment Centre Phase 2 Diagnostics procurement which include the provision of audiology services, are structured to ensure that patients receive, as a minimum, the same level of quality of care provided by the NHS.

- 11. We are concerned that older and sometimes vulnerable people might be encouraged to buy more expensive hearing devices than necessary. The Department must ensure that encouragement to patients to 'trade up' to a more expensive hearing aid is limited. (Paragraph 97)**

The Department is responsible for the private provision of audiology services when procured directly, under contract, from the independent sector (IS). Under contracts negotiated as part of the Independent Sector Treatment Centre Phase 2 Diagnostics programme, the hearing devices supplied are paid for by the NHS, and as such are free at the point of delivery for patients. The Department is not responsible for any other private provision of audiology services.

The regulation of the practice of private hearing aid dispensers is currently the responsibility of the Hearing Aid Council.

Where provision of hearing aids is through the NHS we would expect the local provider to assess the needs of each patient on an individual basis and prescribe the most suitable hearing aid available.

Patients receiving hearing aids through the NHS, including any independent sector provision procured for the NHS, are not charged for their aid and are therefore not exposed to any risks in relation to 'trading up'.

- 12. The Department must ensure that the involvement of the private sector does not undermine the NHS's capacity to provide expert audiology services. It must assess the effects of private sector activity on NHS capacity and levels of expertise within audiology departments. We were encouraged that the Department appears to be listening to local commissioners about whether private sector involvement is needed. (Paragraph 98)**

SHAs have generally taken the view that they can achieve the necessary reductions in audiology waiting times by improving existing NHS services (some of which are already provided locally by the independent sector) and with a modest procurement of additional IS capacity. Around 50,000 additional pathways are being procured from the independent sector, through extensions to the existing Phase 2 Diagnostics procurement and additional local procurement. It is for SHAs to determine how this additional capacity relates to any NHS audiology services in the area.

- 13. We recommend that private sector contracts be relatively short-term in the first instance but extendable subject to companies achieving and maintaining high standards of treatment and care. Future contracts should depend upon demand remaining high, as the private sector maintains will be the case. (Paragraph 99)**

Centrally procured contracts negotiated with IS providers as part of the Phase 2 Diagnostics procurement which include the provision of audiology services are set at a five-year term, with an option to extend for a further two years. Providers are subject to ongoing audit, and must meet stringent key performance indicators through the delivery of the contract.

- 14. Decisions on the amount of activity required from the private sector have not been based on evidence, but appear to have been 'plucked out of the air'. The Department should specify criteria for private sector involvement, for example failure to meet the 18-week target once it is in place. The Department should make evidence-based decisions and ensure value for money. (Paragraph 100)**

Procurement decisions are based on the activity assessments provided by SHAs based on local need.

The majority of additional capacity is being produced through local schemes and it is up to SHAs to determine the criteria for these. A pack of supporting information has been provided to SHAs by the DH Commercial Directorate. The Department will work with the local NHS to offer advice and support where required in relation to SHAs seeking to undertake local procurements



Published by TSO (The Stationery Office) and available from:

Online

www.tsoshop.co.uk

Mail, Telephone, Fax & E-mail

TSO

PO Box 29, Norwich, NR3 1GN

Telephone orders/General enquiries: 0870 600 5522

Order through the Parliamentary Hotline *Lo-call* 0845 7 023474

Fax orders: 0870 600 5533

E-mail: book.orders@tso.co.uk

Textphone 0870 240 3701

TSO Shops

123 Kingsway, London, WC2B 6PQ

020 7242 6393 Fax 020 7242 6394

16 Arthur Street, Belfast BT1 4GD

028 9023 8451 Fax 028 9023 5401

71 Lothian Road, Edinburgh EH3 9AZ

0870 606 5566 Fax 0870 606 5588

TSO@Blackwell and other Accredited Agents

ISBN 978-0-10-171402-0



9 780101 714020