

Monitor

Making the health sector
work for patients

NHS adult hearing services in England: exploring how choice is working for patients



About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

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Executive summary

As people get older their hearing typically declines, which can have a major impact on their lives. However, many people do not seek help. Hearing loss becomes harder to manage the longer it is ignored, and is associated with poor mental health, dementia and other long-term conditions. The NHS funds the provision of hearing aids and other services to help people manage age-related hearing loss. It is estimated that of the six million people in the UK who could benefit from using hearing aids only two million have them.

Before 2012, these adult hearing services were generally provided in hospitals. Since 2012, some patients in England with age-related hearing loss have been given the chance to choose their service provider under the ‘any qualified provider’ approach. The approach allows any provider meeting the requirements set by the local commissioner to offer defined services to local patients. Around half of commissioners have taken up the option of using the any qualified provider approach for adult hearing services.

We looked at what has happened since choice was introduced and asked how we could make choice work better for patients in future. This report presents the findings of our research and sets out how the sector could ensure that choice works better for patients.

There were five strands to our research:

1. We commissioned a survey of over 1,200 patients to discover their experiences of adult hearing services, both when they had been given a choice and when they had not.
2. We commissioned interviews with GPs to find out about how they refer people with hearing loss to services and GPs’ experiences of offering choice.
3. We invited views from those with an interest in adult hearing services and received more than 600 responses from individual patients, patient groups, professional bodies, GPs, providers and commissioners about the introduction and impact of choice.
4. We spoke to a broad range of patient groups, commissioners, providers and professional bodies to obtain further information about the impact of choice. Some had submitted evidence to the project and we wanted to follow up particular points raised. We also spoke to some people who had not made a submission to ensure their experiences and views were captured in the project. We also visited a number of providers’ hearing clinics.
5. We looked at academic and policy evidence to develop a full picture of adult hearing services, patient choice and what has happened since the introduction of choice in those services.

We found that where choice has been introduced patients have benefited from improvements in some aspects of service quality. With a few exceptions, hospitals continue to offer adult hearing services, but now there are clinics on the high street, in GP practices and at other community locations. Faster treatment times are also on offer and appointment times may be more flexible. New options for people who may have found it difficult to access care have also emerged, such as providers that specialise in home visits or organisations setting up in areas where patients had previously had to travel long distances to reach the service. These aspects make services easier to access.

We found that choice has prompted many providers to tailor their services to patients' needs. Some providers offer drop-in services, an expanded range of hearing aids, and speciality clinics and support groups.

Both in areas where choice had been introduced and areas where it had not, more than eight in ten patients surveyed were satisfied with their NHS-funded hearing aids, and more than nine in ten said they found their hearing aids beneficial to their lifestyle. Patients were also satisfied with the ongoing support they got from providers with their hearing aids.

Overall, we found that patients liked choosing who provided their care. Seven in ten patients surveyed who were offered a choice found it useful to have a choice. Eight in ten patients that had not been offered a choice said it would have been beneficial to have one. Patients told us that having a choice made them feel more in control and allowed them to choose the service that best suited them. The most popular option among patients surveyed was to be treated in an NHS hospital, but many were interested in other community options too, such as a clinic in the GP surgery or on the high street. Our findings show that choice has led to a diversity of providers, and offering patients a range of options enables them to choose the one that best suits their needs.

However, we found that patients were not always offered a choice, even in areas where choice should have been available. We were disappointed to learn that only one in ten patients surveyed told us they had been offered a choice of hearing service provider. Only one in five patients recalled having a discussion with their GP about which hearing specialist they might go to. Commissioners do not always make information available to either patients or their GPs to enable the patients to choose who provides their care. Some of the GPs interviewed were not aware that patients should be offered a choice of where to go, or were not familiar with the different providers that patients could choose between. Half of patients offered a choice were given no information to help them choose.

Some stakeholders, including some GPs and commissioners, raised concerns that the introduction of choice has had or might have negative consequences for the quality of patient care. While we have not undertaken a clinical assessment of

services or assessed the impact that choice has had on clinical outcomes, the patient survey suggests that people were not being persuaded to have hearing aids unnecessarily. Nor did our patient survey support concerns that many people accessing NHS-funded care are put under pressure to buy hearing aids: fewer than 1% of patients said they had been pressured into buying hearing aids.

For commissioners, the introduction of choice has strengthened the opportunity for them to achieve better value for money. In areas with choice, commissioners have often put in place more robust or higher service specifications that raise expectations of providers. In some cases, commissioners have also established locally determined prices that are 20–25% lower than the national non-mandated tariff. Providers are required to report their service outcomes to commissioners, who can levy penalties for underperformance. Commissioners can use the service outcome data to drive further improvements in services (eg by comparing providers' services to identify best practice and/or by making data available to GPs and patients to help them choose).

The introduction of choice has also made services more transparent. In areas without choice, adult hearing services are often provided as part of a block contract without service outcome reporting requirements, so it can be difficult for commissioners to tell how good services are, or even how many people are being treated and at what cost.

Although choice in hearing services brings patient benefits and can help commissioners get value for money, it also involves difficult trade-offs for commissioners. Unpicking old block contracts, qualifying old and new providers, and putting in place and managing multiple contracts takes time and effort. The process of qualifying providers is intended to be flexible and proportionate, so that commissioners can qualify good providers without being bound up in bureaucracy. In practice, our findings suggest the qualification process can be onerous, inconsistent and unclear for commissioners and providers alike. Moreover, although the price of treatment per patient may go down, overall spending by commissioners on hearing services may increase as more patients who could benefit from adult hearing services have access to them.

We appreciate that commissioners have concerns about the cost of implementing choice, and it is for commissioners to decide how to allocate their time and their budgets. However, in weighing up whether and how to introduce choice in adult hearing services, we urge them to recognise that some of the costs are short term, or would be incurred using other commissioning approaches. There are also opportunities to enhance the benefits for patients from choice, which may increase in the longer term.

Our findings show that choice can make services more accessible for patients, leading to more people getting help. Taking steps to make choice work better for

patients would benefit some of those millions of people with hearing loss who do not have hearing aids. In the longer term, this has the potential to reduce pressures on health and social services that can be attributed to unaddressed hearing loss. Improving access to hearing services may increase total spend on hearing loss, but we expect this to benefit patients.

We have identified a number of practical steps that commissioners can take to help them maximise value from offering patients choice in adult hearing services. These relate to adopting an open and transparent provider qualification process, promoting a level playing field, monitoring services and enforcing providers' contracts, and managing spending on services as well as empowering patients to make informed choices (see section 5).

As sector regulator, Monitor will support commissioners to ensure choice works in the interests of patients in the following ways:

- We will hold several commissioner workshops to share the insights arising from our research and facilitate the sharing of information between commissioners. We will also publish materials for commissioners that set out key principles of well implemented choice in adult hearing services, including tips for commissioners who are thinking about using patient choice and other resources to aid decision-making.
- We will engage with commissioners to consider revision to the service specifications to place an obligation on providers to inform patients, in their promotional and marketing materials, that they may have a choice of other providers available to them.
- We will work with local Healthwatch teams, Action on Hearing Loss, patient groups and other local partners to raise public awareness and understanding of the role of choice, particularly in areas that have introduced a wider choice of providers.
- We will explore ways that providers' service outcome data might be shared practically and cost effectively with patients. We propose a pilot project whereby we will work with a clinical commissioning group to determine how best to communicate providers' reported data to GPs and patients. We will share any findings from this pilot with other commissioners.
- We will review adult hearing services in 12-18 months' time to understand the impact of our work and consider whether further action is needed.

Some of our system partners are also taking action to help patient choice work better for patients (see section 5). NHS England and the Department of Health's (DH) forthcoming 'Action Plan for Hearing Loss' addresses the full range of hearing issues. The action plan will lead to the development of a commissioning framework

for hearing services to provide commissioners with the best possible evidence and resources to shape services. We intend to work with NHS England and DH to help ensure that the insights from our research are made available to commissioners as part of this framework.

We received over 600 submissions from patients (and their carers) and a range of stakeholders including patient groups, commissioners, GPs, NHS and independent sector providers, and others. We are grateful for the time, effort and thought that stakeholders devoted to our project.

We are grateful to all of those that provided their views and we have carefully considered all of the feedback that we received.

We would also like to thank Action on Hearing Loss and Hearing Link for their contributions to the patient survey.

1. Introduction

1.1. What is this project about?

This project looked at how choice is working in NHS-funded adult hearing services in England. For the purpose of the project, we define adult hearing services as services for people with suspected or diagnosed age-related hearing loss, who are typically aged 55 and older.¹

Since 2012, a process called ‘any qualified provider’ has been used to offer choice in adult hearing services in many areas of England. This process allows any provider meeting the qualification requirements specified by a commissioner in a given area to deliver services in that area. As a result, when a patient is referred to the service, they can choose who provides their care from a list of qualified providers in the area. Further information about the process is provided in section 2.1.²

Adult hearing services were one of the first services commissioned using this process and we estimate that about 60% of commissioners now use it for these services.³

The aims of the project were:

- to understand how choice has been working in relation to adult hearing services funded by the NHS
- to understand whether current arrangements serve the interests of patients effectively and whether there is scope for improvement
- to offer insights for commissioners deciding whether and how to introduce choice.

Our project has focused on commissioning of adult hearing services and we have not undertaken a clinical assessment of services or assessed the impact that choice

¹ Other audiology services, such as those for children or adults with non-age-related hearing loss, were not included in the scope of this project.

² Throughout this report we use the terms choice and any qualified provider interchangeably. As part of this project, we have not examined other commissioning approaches that can be used to facilitate choice (eg commissioners contracting with two or three providers of a service and allowing patients to choose between them). These alternative approaches typically limit the number of providers and often require providers to compete on the basis of both quality and price. Under the any qualified provider approach, the intention is that any provider can seek to join the list of providers in an area and there is no limit on the number of providers that can qualify. Providers also compete on the basis of quality (not price) to attract and retain patients.

³ Based on information from the Supply2Health website at December 2013 (which ceased to exist on 1 March 2014), between 87 and 92 (of 152) primary care trusts in England introduced choice to adult hearing services using any qualified provider (between 57% and 61%). Based on our web research and discussions with commissioners, we estimate that 125 of 211 clinical commissioning groups (CCGs) currently commission adult hearing services using any qualified provider (about 60%).

has had on clinical outcomes. Nor have we attempted to quantify the cost effectiveness of hearing aids or adult hearing services.

1.2. Why did we look at choice in adult hearing services?

We launched this project for two reasons: the recommendations of 'A fair playing field' review⁴ and questions raised by the UK's largest hearing loss charity, Action on Hearing Loss.

In 'A fair playing field' we recommended developing the evidence of the risks, costs and benefits of introducing choice, particularly in community-based services. The review suggested that there was a general lack of evidence about these aspects of introducing choice,⁵ which has made it difficult for commissioners to decide whether and how to introduce choice.

Action on Hearing Loss suggested we examine whether choice is working in the best interests of patients.

Adult hearing services were one of the first services commissioned using any qualified provider, and many commissioners now use it for these services. This has provided us with a useful opportunity to explore the impact that choice has had on patients and commissioners. This included comparing patients' and commissioners' experiences in areas where choice has been implemented using the any qualified provider approach and where it has not.

We recognise that choice using any qualified provider has only been in place for about two years (and even less in some commissioners' areas) and that it may be too soon to understand the full impact of choice. However, as discussed later in the report, the findings of our research show there have already been some benefits for patients.

1.3. How did we approach the research for this project?

Several sources informed our findings:

- Over the course of summer 2014, we invited views from patients, patient groups, commissioners, GPs, providers of adult hearing services and other

⁴ Monitor. (2013) 'A fair playing field for the benefit of NHS patients', Monitor's independent review for the Secretary of State for Health.

⁵ To our knowledge, there is currently only one research paper on the effects of choice for community-based services, and that relates to the provision of psychological therapies in primary care: Griffiths S, Foster J, Steen S, Pietroni P. University of Chester. 'Mental health's market experiment: commissioning psychological therapies through any qualified provider'. Available at: www.chester.ac.uk/cptpc/research/papers

interested parties. More than 600 responses were submitted to us online and by post. Annex 2 provides information on who responded to us.⁶

- We commissioned a quantitative patient survey of more than 1,200 users of NHS-funded adult hearing services to understand better what effect the introduction of choice has had on patients. The main fieldwork took place in autumn 2014. Interviews took place by phone, face-to-face and online to provide as inclusive a sample as possible. A report containing the findings of the patient survey and a full explanation of the methodology used in the survey is published alongside this report.⁷
- We commissioned 30 interviews with GPs to explore their experiences, views, attitudes and behaviours when referring patients to adult hearing services. The interviews took place in autumn 2014. A report detailing the outcomes of the GP interviews and a full explanation of the methodology used is published alongside this report.⁸
- We spoke to a broad range of stakeholders with an interest in adult hearing services, including patient groups, commissioners, providers and professional bodies.⁹ Some had submitted evidence to the project and we wanted to follow-up on particular points raised. We also spoke to some people who had not made a submission to ensure their experiences and views were captured in the project. We also visited a number of providers' hearing clinics. Annex 2 lists who we spoke to.
- We also looked at academic and policy evidence to develop a full picture of adult hearing services, patient choice and what has happened since the introduction of choice in those services.

⁶ The information received from this source is largely qualitative, and we report it as such throughout this report. We use the terms 'several' and 'many' to indicate how many stakeholders reported a particular view. 'Several' is used to mean two or more stakeholders offered this view, but not the majority. 'Many' means the majority of stakeholders offered this view.

⁷ Accent was commissioned to undertake this work on behalf of Monitor. See Accent. (2015) 'How choice is working in NHS adult hearing services in England' (hereafter 'the patient survey report'). Available from: <https://www.gov.uk/government/publications/nhs-adult-hearing-services-in-england-exploring-how-choice-is-working-for-patients>

⁸ Creative Research was commissioned to undertake this work on behalf of Monitor. See Creative Research (2015), 'Choice in adult hearing services: the GP perspective on age-related hearing loss', (hereafter 'the GP interviews report'). Available from: <https://www.gov.uk/government/publications/nhs-adult-hearing-services-in-england-exploring-how-choice-is-working-for-patients>

⁹ See footnote 6.

1.4. Guide to the report

- Section 2 provides background on the policy that initiated the introduction of choice in adult hearing services. It also provides a description of adult hearing services, including who uses and who provides these services.
- Section 3 provides our findings on how choice has benefited patients.
- Section 4 provides factors which are limiting the effectiveness of choice.
- Section 5 provides ways to improve the effectiveness of introducing choice in adult hearing services.

Alongside this report we have published five annexes:

- Annex 1 provides a list of commissioning areas that have introduced choice for adult hearing services and those that have not.
- Annex 2 provides a list of stakeholders with whom we engaged over the course of this project.
- Annex 3 provides four case studies showing how the introduction of choice has impacted on patients' access to services.
- Annex 4 provides the results of our analysis of commissioner data on waiting times for adult hearing services.
- Annex 5 provides an explanation of Improving Quality in Physiological Services (IQIPS) accreditation.

We have also published reports detailing the methodology and findings of the patient survey and GP interviews alongside this report.

2. Background

2.1. Policy background on choice in community services

Putting people in control of their care by giving them more choice has been a priority for the NHS for a number of years. Patients have the right to a range of choices, including which hospital to go to for elective care.^{10,11}

The government signalled in 2010 that it would take steps to increase the range of services for which patients could choose their provider.¹² The motivations for the policy were to improve:

- outcomes for patients
- the responsiveness of services to patient preferences
- the degree of patient choice and control.¹³

The Department of Health (DH) prioritised eight services, from which commissioners were asked to select at least three in which to implement choice using the any qualified provider approach between April and September 2012:¹⁴

- adult hearing services in the community
- continence services
- direct access diagnostic tests
- leg ulcer and wound healing
- musculoskeletal services for back and neck pain
- podiatry services
- primary care psychological therapies
- wheelchair services.

¹⁰ The NHS Constitution and the Primary Care Trust (Choice of Secondary Care Provider) Directions 2009.

¹¹ The NHS Choice framework provides information about patients' rights to choice in the NHS. DH. (2014) '2014 to 2015: NHS Choice framework'. Available from: www.gov.uk/government/publications/nhs-choice-framework

¹² DH. (2010) 'Equity and excellence: Liberating the NHS'. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf

¹³ DH. (2010) 'Extension of any qualified provider (impact assessment)'. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/216136/dh_128461.pdf

¹⁴ Alternatively, commissioners were allowed to choose other services if, based on the views of service users and potential gains in quality and access, they were considered to be of greater local priority. See DH. (2011) 'Operational guidance to the NHS: Extending patient choice of provider'. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/216137/dh_128462.pdf

DH also published guidance for commissioners on how to implement choice using the any qualified provider approach,¹⁵ setting out the main principles as follows:

- providers qualify and register to provide services through an assurance process that tests providers' fitness to offer NHS-funded services
- commissioners set local pathways and referral protocols that providers must accept
- referring clinicians offer patients a choice of qualified providers
- competition is based on quality, not price
- providers are paid a fixed price determined by a national or local price.¹⁶

DH, working alongside the NHS, also developed a range of support resources for commissioners. The resources included implementation packs with service specifications, currency and pricing information, template questionnaires for qualifying providers, and ongoing commissioner support and training.¹⁷

From 1 April 2013, clinical commissioning groups (CCGs) and NHS England took on responsibility for introducing choice and qualifying providers. Commissioners must consider ways to improve healthcare services, including by enabling patients to choose their provider.¹⁸

The importance of choice has been reiterated in the '[Five Year Forward View](#)', which includes the commitment to "make good on the NHS's longstanding promise to give patients choice over where and how they receive care".¹⁹

2.2. Hearing loss and adult hearing services

In this section, we provide an overview of hearing loss and describe adult hearing services, who uses them, and who provides them. More than half of commissioners now offer patients choice for these services in England.²⁰ Annex 1 lists the commissioning areas that have implemented choice in adult hearing services using the any qualified provider approach.

¹⁵ DH. (2011) 'Operational guidance to the NHS: Extending patient choice of provider'. Available from:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/216137/dh_128462.pdf

¹⁶ See footnote 15.

¹⁷ The implementation pack developed for adult hearing services was: DH. (2012) 'Adult Hearing AQP Implementation Pack' (hereafter 'DH's implementation pack').

¹⁸ Commissioners' procurement decisions must be compliant with the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013.

¹⁹ NHS England. (2014) 'Five Year Forward View', pages 12-13, Available from: www.england.nhs.uk/ourwork/futurenhs/

²⁰ See footnote 3.

What is the prevalence and impact of hearing loss?

More than 10 million people in the UK have some form of hearing loss, and the risk of hearing loss increases with age. This figure is expected to increase to 14.5 million people by 2031.²¹

Hearing loss can lead to communication difficulties, social isolation, and emotional distress and can significantly adversely affect a person's quality of life.²² This appears to affect not only the person with hearing loss, but also those around them such as their partner, family and/or carer.²³

Hearing loss also increases the risk of mental health problems, including depression.²⁴ It is strongly associated with an increased rate of cognitive decline and an increased risk of dementia.²⁵ There is evidence to suggest that people with mild hearing loss are almost twice as likely to develop dementia. The risk for people with moderate hearing loss is three times higher, and for people with severe hearing loss it is almost five times higher.²⁶

Prevention and early diagnosis of hearing loss can significantly reduce the impacts of hearing loss, including social isolation and mental ill health.²⁷

Hearing loss can also reduce a person's ability to manage other health conditions independently. About half of older people in the UK with hearing loss have additional disabilities or long-term health conditions.²⁸

In addition to increasing use of health and social care services, hearing loss can increase unemployment and sick leave rates, and limit opportunities for career progression. The International Longevity Centre UK estimated that, in 2013, due to

²¹ Action on Hearing Loss. (2011) 'Hearing matters'. Available from: www.actiononhearingloss.org.uk/supporting-you/policy-research-and-influencing/research/hearing-matters.aspx

²² See, for example, Ciorba A et al (2012) 'The impact of hearing loss on the quality of life of elderly adults', *Journal of Clinical Interventions in Aging*, 7: 159-63; Dalton DS, Cruickshanks KJ, Klein BEK, et al. (2003) 'The impact of hearing loss on quality of life in older adults', *The Gerontologist*, 43(5): 661-68; Mulrow CD, Aguilar C, Endicott JE, et al. (1990) 'Quality-of-life changes and hearing impairment', *Annals of Internal Medicine*, 113(3): 188-94.

²³ See, for example, Wallhagen MI, Strawbridge WJ, Shema SJ, et al. (2004) 'Impact of Self-Assessed Hearing Loss on a Spouse: A Longitudinal Analysis of Couples', *The Journal of Gerontology*, Series B, Psychological Sciences and Social Sciences, 59B(3):S190-6.

²⁴ See, for example, Saito H et al. (2010), 'Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese', *Journal of the American Geriatrics Society*, 58(1): 93-97.

²⁵ See, for example, Lin FR, Metter EJ, O'Brien RJ, et al. (2011) 'Hearing loss and incident dementia', *Archives of Neurology*, 68(2): 214-20; Lin FR, Yaffe K, Xia J, et al. (2013) 'Hearing loss and cognitive decline in older adults', *JAMA Internal Medicine*, 173(4): 293-99.

²⁶ Lin FR, Metter EJ, O'Brien RJ, et al. (2011) 'Hearing loss and incident dementia', *Archives of Neurology*, 68(2): 214-20.

²⁷ See footnote 21.

²⁸ See footnote 21.

lower employment rates for those with hearing loss than across the rest of the population, the UK economy lost £24.8 billion in potential economic output.²⁹

What are adult hearing services?

We define adult hearing services as services for people with diagnosed or suspected age-related hearing loss, who are typically aged 55 years and older.³⁰ The services form part of a wider group of audiology services,³¹ which are often delivered alongside or are integrated with ear, nose and throat (ENT) services.³²

Patients are usually referred to adult hearing services by their GP.^{33, 34} After referral, an initial assessment by the provider will show whether the patient could benefit from hearing aids. The provider will fit hearing aids if needed. The patient may be offered a follow-up appointment³⁵ and may also contact the provider for aftercare services (eg to have their hearing aids maintained, adjusted, cleaned, or for replacement batteries). Providers may also invite patients for an appointment after a certain period (eg three years)³⁶ to assess whether changes to treatment are needed.

There are currently no National Institute for Health and Care Excellence (NICE) clinical guidelines for managing age-related hearing loss. We understand that NICE is likely to begin development of a clinical guideline for adult-onset hearing loss³⁷ over the next 12 months. This guidance will be followed by a quality standard for adult-onset hearing loss.

²⁹ International Longevity Centre UK. (2014) 'Commission on Hearing Loss: Final Report', page 13. Available from: www.ilcuk.org.uk/index.php/publications/publication_details/commission_on_hearing_loss_final_report

³⁰ We are aware of at least 40 CCGs adopting 55 years and above as the age eligibility threshold to access these services. This is the age eligibility threshold adopted in the service specifications developed by DH to support commissioners implementing choice.

³¹ Audiology services provide diagnosis, treatment and rehabilitation services for children and adults with suspected or diagnosed hearing and/or balance disorders or tinnitus and hearing tests for newborns.

³² ENT services are multidisciplinary consultant-led services that provide diagnosis and medical and surgical management of conditions of the ear, nose, throat and other related parts of the head and neck.

³³ Prior to the referral, the GP should undertake an assessment of the patient presenting with hearing difficulties to confirm the patient should be referred to adult hearing services. Patients presenting with, for example, persistent pain affecting either ear, history of discharge other than wax from either ear, or sudden loss or rapid deterioration of hearing should typically be referred to a consultant-led ENT service.

³⁴ In some areas, patient referrals will be managed by a referral management centre (eg Brighton and Hove CCG, North Norfolk CCG).

³⁵ In some areas, providers are contractually required to provide a follow-up appointment, in others they are not. We are aware of at least 51 CCGs where providers work to service specifications that require follow-up appointments.

³⁶ We are aware of at least 51 CCGs where providers work to service specifications that require review appointments every three years.

³⁷ Adult onset hearing loss is hearing loss which presents in adulthood. The leading cause of adult onset hearing loss is age-related hearing loss, followed by noise-induced hearing loss.

Who uses adult hearing services?

Around half a million referrals are made to adult hearing services in England each year,³⁸ with more people using the services on an ongoing basis for aftercare. The services cost commissioners about £200 million.³⁹

There is evidence to suggest that using hearing aids can improve a person's quality of life by reducing the psychological, social and emotional effects of hearing loss.⁴⁰ Despite the potential benefits, there is evidence to suggest that hearing aids are underused in the UK. The Commission on Hearing Loss reports that of the 6 million people in the UK who could benefit from using hearing aids, only 2 million have hearing aids, of which 30% do not use them.^{41,42} There are academic studies that suggest that between 75% and 80% of people who could benefit from hearing aids are not using them, and that both uptake and continued use can be problematic.⁴³

The low uptake of hearing aids may in part be explained by many adults delaying by 10 to 15 years before consulting a GP or hearing specialist about hearing difficulties. The most commonly cited reason for this delay is a belief that their hearing loss is not bad enough to ask for help; however, some people also report a belief that

³⁸ In 2013, there were more than 495,000 referrals to direct access audiology services (source: NHS England's Direct Access Audiology Data, completed pathways dataset, available from: www.england.nhs.uk/statistics/statistical-work-areas/direct-access-audiology/daa-data/). We understand that most referrals to direct access audiology services are for adults with suspected or diagnosed non-complex hearing loss where a medical referral to an ENT service is not indicated. These will predominantly be patients with age-related hearing loss. (See DH, FAQs 1 & 2: Direct Access Audiology Referral to Treatment Data Collection, available from: www.england.nhs.uk/statistics/statistical-work-areas/direct-access-audiology/).

³⁹ DH. (2010) 'Extension of any qualified provider (impact assessment)', page 13. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/216136/dh_128461.pdf

⁴⁰ Chisolm TH, Johnson CE, Danhauer JL, et al. (2007) 'A systematic review of health-related quality of life and hearing aids: final report of the American Academy of Audiology Task Force on the Health-Related Quality of Life Benefits of Amplification in Adults'. *Journal of The American Academy of Audiology*; 18(2): 151-83.

⁴¹ International Longevity Centre UK. (2014) 'Commission on Hearing Loss: Final Report', page 8. Available at: www.ilcuk.org.uk/index.php/publications/publication_details/commission_on_hearing_loss_final_report

⁴² Studies of use of hearing aids have differing results. For a systematic review of the evidence see: Perez E and Edmonds BA. (2012) 'A systematic review of studies measuring and reporting hearing aid usage in older adults since 1999: A descriptive summary of measurement tools', *PLoS ONE*, 7(3), e31831. Available at: <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0031831>

⁴³ One study estimated that 12% of adults aged 55 to 74 have substantially impaired hearing, and of those, only 3% were found to be receiving intervention through the use of hearing aids (suggesting that 9% of the 12%, or 75%, who might benefit, are not using hearing aids). A further 1% said they did not wear an aid but had tried one. Another study estimated that 10% of adults aged 40 to 69 had significant hearing impairment, while only 2% used a hearing aid, suggesting that 80% of those who could benefit don't use hearing aids. (See: Davis A, Smith P, Ferguson M, et al. (2007) 'Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models'. *Health Technology Assessment*; 11 (42); and Dawes P, Fortnum H, Moore DR, et al. (2014) 'Hearing in middle age: a population snapshot of 40- to 69-year olds in the United Kingdom'. *Ear and Hearing*; 35(3): e44-51.)

nothing can be done to help them. It has also been reported that people express concern about being treated or looked at differently if they wear a hearing aid.⁴⁴

Other factors that may influence how likely someone is to use a hearing aid after having one fitted include hearing sensitivity, appearance, comfort, and access to continuing support such as counselling.⁴⁵

Who provides adult hearing services?

Historically, NHS-funded adult hearing services were typically provided by NHS hospitals. In some areas,⁴⁶ other providers (such as independent and third sector providers) have also played a part.

In 2007, many providers other than NHS hospitals began to provide NHS-funded adult hearing services as part of an initiative to reduce waiting times (see Annex 4).⁴⁷ The role of those and other providers increased after commissioners' decisions to introduce choice for adult hearing services.

NHS hospitals are still the main providers of adult hearing services (we estimate that NHS hospitals serve around 75% of patients who have been referred to adult hearing services),^{48, 49} but the range of providers now includes:

- national independent sector providers (eg Specsavers, Boots Hearingcare and Scrivens Hearing Care)⁵⁰
- regional independent sector providers (eg Regional Hearing Specialists,⁵¹ Amplifon⁵²)

⁴⁴ Action on Hearing Loss. (2011) 'Hearing matters', page 15; and Davis A, Smith P, Ferguson M, et al. (2007) 'Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models'. *Health Technology Assessment*; 11(42): 1-294.

⁴⁵ McCormack A and Fortnum H. (2013) 'Why do people fitted with hearing aids not wear them?' *International Journal of Audiology*; 52: 360-68; Knudsen LV, Oberg M, Nielsen C, et al. (2010) 'Factors influencing help seeking, hearing aid uptake, hearing aid use and satisfaction with hearing aids: A review of the literature'. *Trends in Amplification*; 14(3):127-54.

⁴⁶ For example, in areas now under the responsibility of Hartlepool and Stockton-on-Tees CCG, South Tees CCG, Waltham Forest CCG and Solihull CCG.

⁴⁷ In 2007, DH invested additional resources to reduce waiting times for audiology services. This included procuring additional services from the independent sector. At the time, demand for services had increased with the arrival of digital hearing aids, which placed pressure on existing services and increased waiting times.

⁴⁸ Based on the responses to the patient survey, we estimate that in areas where commissioners introduced choice for adult hearing services, providers other than NHS hospitals serve around 28% of patients using adult hearing services.

⁴⁹ We are aware of three areas where the local NHS hospital stopped providing adult hearing services to the local population following the introduction of choice (Brighton and Hove CCG, Bromley CCG and Solihull CCG).

⁵⁰ Specsavers and Scrivens offer NHS-funded adult hearing services in 110 and 72 CCGs respectively, while Boots offers services in around 20 CCGs. See, for example, www.specsavers.co.uk/hearing/gp

- social enterprises (eg Chime)
- charitable organisations (eg Action for Deafness)⁵³
- GP-led organisations (eg GP Care).⁵⁴

⁵¹ Regional Hearing Specialists offers NHS-funded adult hearing services from multiple locations in Cornwall, Devon, East and West Sussex, Staffordshire, Herefordshire and Shropshire. See: www.nhs.uk/Services/Trusts/HospitalsAndClinics/DefaultView.aspx?id=91551

⁵² Amplifon is a dedicated hearing aid specialist that offers NHS-funded adult hearing services in East Cheshire and Wirral. See: www.amplifon.co.uk/askanexpert/category-4/can-i-get-nhs-hearing-aids-free-of-charge-from-amplifon-rather-than-having-to-go-to-the-hospital

⁵³ Action for Deafness offers NHS adult hearing services in the West Sussex area from seven different clinics. See: <http://actionfordeafness.org.uk/>

⁵⁴ GP Care is a federation of 100 GP practices. The organisation often works in partnership with other local providers such as NHS hospitals, out-of-hours organisations and community service providers to provide the majority of the clinical staff to deliver the services. It offers NHS-funded adult hearing services in Bristol, South Gloucestershire and North East Essex. See: www.gpcare.org.uk/site/nhspatients/audiology/

3. The benefits of choice

Our research has enabled us to identify several ways in which patients benefit from choice in adult hearing services. In this section, we describe those benefits.

3.1. The value of choice for patients

In our patient survey, respondents were asked whether having a choice of provider was valuable to them. Most respondents indicated that choice was of value to them. Between 71% and 79% indicated this in areas where choice had been introduced (results varied depending on whether or not they had been offered a choice).^{55,56} Patients of all age groups surveyed, including those aged 80 years and older, were equally likely to value choice. The same applied across different socioeconomic groups.⁵⁷ This is contrary to the perception that it is younger people and people from higher socioeconomic backgrounds that want choice.⁵⁸

Survey respondents, as well as individual patients who wrote to us, said they value choice because it allows them to choose the service that best suits them and makes them feel in control of their care. Examples of reasons respondents gave for wanting a choice include:

“ Made it easier for me as my local hospital was too far. ”

“ Because some people prefer local venues because public transport links in rural areas may be bad. Also, local clinics may be non-threatening environments compared to a large hospital, having to navigate your way to the audiology department.”

⁵⁵ Proportions vary depending on whether patients had been offered a choice of provider or not. Of those who had been offered a choice of provider, 71% said that the choice had been of some value (saying that the choice was either “very valuable” or “nice to have but not essential”). Of those that had not been offered a choice, 79% indicated that the choice would have been of value (saying that the choice would have been “very useful” or “fairly useful”). (See the patient survey report, pages ii and 16-18.)

⁵⁶ These results are consistent with research by the King’s Fund which found that 75% of people view choice as either “very important” or “important” to them. (See: King’s Fund. (2010) ‘Patient Choice: How patients choose and how providers respond’. Available from: www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Patient-choice-summary-Kings-Fund-Anna_Dixon-Ruth-Robertson-John-Appleby-Peter-Purge-Nancy-Devlin-Helen-Magee-June-2010.pdf.)

⁵⁷ See the patient survey report, pages 16-18.

⁵⁸ A common view among the GPs interviewed was that younger patients and ‘professionals’ were more aware of and interested in choice while older patients were less interested. (See: the GP interviews report, page 43; King’s Fund. (2010) ‘Patient Choice: How patients choose and how providers respond’, Available from: www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Patient-choice-summary-Kings-Fund-Anna_Dixon-Ruth-Robertson-John-Appleby-Peter-Purge-Nancy-Devlin-Helen-Magee-June-2010.pdf.)

- “ It is always good to have a choice. More choice means better service in my opinion. ”
- “ Some places you get a good service, and some places are bad, this way you have a choice to pick from. ”
- “ It is a good idea, as you can pick where you would like to go, it can be near bus routes or the local area, makes getting to the place easy. ”
- “ There are many aspects to hearing rehabilitation of which technology is only one. I would have liked the opportunity to go to a practitioner who is prepared to discuss social, emotional and employment aspects. ”
- “ People can pick the specialist where they want to go, then it’s a really good thing, ensure they feel comfortable and at ease. ”
- “ I feel that choice is better even if I choose to stay with the service I’m with now. ”
- “ I was not satisfied with the service that I received so I moved. ”
- “ I would have been more aware of what was available to me. ”

Source: Patients’ submissions to Monitor and Monitor patient survey responses

When respondents were asked which provider they would choose from a range of options, most (seven in 10) said an NHS hospital would be their first choice. However, people tended to be influenced by what they had already done, usually choosing the option closest to the type of provider that they used previously. About four in ten surveyed said they would choose somewhere in the community (a clinic in the GP’s surgery, a high street hearing specialist, a clinic in their neighbourhood or treatment in their own home).⁵⁹

A significant minority of respondents said they did not value choice. In areas where choice had been introduced, 29% of those who had been offered choice indicated this and 21% of those who had not.⁶⁰ Of these respondents, most simply wanted to be seen at a hospital or at a particular provider, were happy with their current provider, or felt that services were so similar that having a choice made little difference. Only a few had a concern that it would be difficult to make a judgement,

⁵⁹ See the patient survey report, pages 22-23.

⁶⁰ Of those that had chosen their provider, 29% said that having the choice had made “no difference at all”. Of those that had not been offered a choice of provider, 5% indicated that choice was “not at all useful”; 16% said it was “not very useful”. (See the patient survey report, pages 15-17.)

said that it's better to have guidance (5%) or that having too many options is confusing (2%).⁶¹

We also found that patients are not always offered a choice in areas where choice should be available. We were disappointed to learn that as few as 10% of respondents were offered a choice of hearing service provider by their GP.⁶² Nor is information about their options always available to patients or their GPs to help them choose. These aspects limit the benefits for patients, and we discuss them further in section 4.1.

3.2. Choice and improvements in services for patients

Below we provide an overview of our findings on how choice has affected service quality. We also discuss some improvements to services that we have identified in areas where choice has been introduced:

- providers are finding ways to be innovative and responsive to patient needs
- providers are making it easier for patients to access services
- new service specifications have established more robust or higher standards with which providers are expected to comply.

3.2.1. Overview

In general, we found high rates of satisfaction with services among patients surveyed. Both in areas where choice had been introduced and areas where it had not, more than eight in ten respondents were satisfied with their NHS-funded hearing aids.⁶³ about eight in ten said they wore their hearing aids most days for at least two hours a day,⁶⁴ and more than nine in ten said they found their hearing aids beneficial to their lifestyle.⁶⁵

⁶¹ See the patient survey report, page 18.

⁶² See the patient survey report, pages 7-8.

⁶³ In the patient survey, in areas where choice has been introduced, 58% of patients said they were "very satisfied" and 25% said they were "fairly satisfied". In areas where choice has not been introduced, 58% of patients said they were "very satisfied" and 26% said they were "fairly satisfied". (See the patient survey report, page 45.)

⁶⁴ In the patient survey, in areas where choice has been introduced, 62% of patients said they wore their hearing aids "most days for more than 8 hours a day" and 19% said they wore their hearing aids "most days for between 2 and 8 hours a day". In areas where choice has not been introduced, 64% of patients said they wore their hearing aids "most days for more than 8 hours a day" and 21% said they wore their hearing aids "most days for between 2 and 8 hours a day". (See the patient survey report, page 49.)

⁶⁵ In the patient survey, in areas where choice has been introduced, 70% of patients said their hearing aids were "very beneficial" and 22% said they were "fairly beneficial". In areas where choice has not been introduced, 72% of patients said their hearing aids were "very beneficial" and 20% said they were "fairly beneficial". (See the patient survey report, page 51.)

Some stakeholders, including GPs and commissioners, raised concerns that the introduction of choice has had or might have negative consequences for the quality of patient care.⁶⁶ These concerns included: the quality of aftercare, providers giving hearing aids to people who did not need them or giving two hearing aids when one would suffice,⁶⁷ the range of hearing aids on offer, and people accessing NHS-funded care being put under pressure to use hearing aids they had to pay for. While we have not undertaken a clinical assessment of services or assessed the impact that choice has had on clinical outcomes, the results of the patient survey and other evidence we reviewed provide some insight on the issues raised.

The patient survey results do not suggest that new providers offer poor quality aftercare; 90% of respondents in areas where choice has been introduced and who are using a provider other than a hospital said that they were satisfied with the ongoing support offered by that provider. This was slightly lower than at NHS hospitals located in areas with choice, but not significantly so (90% vs 92%).⁶⁸ Overall, providers' ongoing support was slightly better in areas where choice had been introduced than where it had not (91% vs 88%, or about 3% better), but not significantly so.⁶⁹

The patient survey also suggests that people are not being persuaded by new providers to have hearing aids unnecessarily. One in ten respondents said that the provider had assessed that they did not need hearing aids, and this proportion was higher at out-of-hospital providers.⁷⁰

On the issue of whether patients should be issued one or two hearing aids, we understand that hearing loss presentation, lifestyle and individual preference all need to be taken into account when deciding whether to fit one or two hearing aids, and that there can be good reasons for issuing two hearing aids.⁷¹

In terms of the range of hearing aids offered, in our patient survey only one in four of those who needed hearing aids said they were shown a selection of hearing aids. However, there was little difference between areas where choice had and had not been introduced. Patients' satisfaction with the range of hearing aids shown was also similar in areas where choice had been introduced and where it had not (82% vs

⁶⁶ A range of patient groups, GPs, providers and commissioners raised questions about service quality in areas where choice has been introduced. See also the GP interviews report, pages 58-61.

⁶⁷ GPs' interviews suggest that some GPs had concerns about providers dispensing two hearing aids rather than one. See the GP interviews report, page 59.

⁶⁸ See the patient survey report, pages 58-59.

⁶⁹ See the patient survey report, page 58.

⁷⁰ See patient survey report, page 36.

⁷¹ Action on Hearing Loss. 'Bilateral hearing aids: policy statement'. Available from: www.actiononhearingloss.org.uk/~media/Documents/Policy%20research%20and%20influencing/Policy/Consultation%20responses/Policy%20statements/Health%20and%20social%20care/Bilateral_PDF.ashx

83%).⁷² We also note that providers often work to service specifications requiring NHS-funded hearing aids to be of a minimum technical specification⁷³ (see also section 4.6).

While the patient survey did identify a few people accessing NHS-funded care who said they felt under pressure to adopt hearing aids they had to pay for, the numbers affected appear to be small (less than 1% of respondents needing hearing aids).⁷⁴ They were also identified both in areas where choice has and has not been introduced, and at all types of providers.⁷⁵ We note that, although the numbers are small, providers often work to service specifications that are supposed to prevent this from happening.⁷⁶ This is relevant to contract enforcement, which we discuss further in section 4.6.

Our patient survey did not offer insights on other concerns raised by stakeholders. For example, concerns that patients with more complex conditions requiring referral to a consultant-led ENT service may not always be detected by some providers of adult hearing services or that delays may be caused by multiple referrals when patients with more complex conditions are sent back to the GP for suitable onward referral. Patients with more complex conditions were out of scope for the patient survey.

3.2.2. Choice and incentives to improve service quality

We explained in section 2.2 that historically adult hearing services in England were provided by NHS hospitals and the introduction of choice has led to an increased range of providers. Here we set out our findings on how new and existing providers have responded to choice in adult hearing services.

‘Choose and book’⁷⁷ data showed us that, on average, there are four providers in areas where choice has been introduced (see Table 1). By comparison, there are two providers, on average, in areas where choice has not been introduced.⁷⁸

⁷² See the patient survey report, pages 38-39.

⁷³ See, for example, DH’s implementation pack, Section 1, page 17.

⁷⁴ See the patient survey report, page 40.

⁷⁵ Only six people who were shown hearing aids they had to pay for felt pressured to purchase those. Two out of the six were in areas where choice had not been introduced, and three out of the six attended an NHS hospital. (See the patient survey report, page 40.)

⁷⁶ Service specifications may require providers not to encourage patients to privately purchase more expensive hearing aids than is necessary and to deal with requests for information about privately prescribed hearing aids outside of NHS-funded appointments. (See DH’s implementation pack, page 15.)

⁷⁷ Choose and Book is a national electronic referral service that gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. See: www.chooseandbook.nhs.uk/

⁷⁸ More than one provider may be present in areas where choice using any qualified provider has not been applied. Historically, there may have been two or more hospitals in the area offering adult hearing services and patients may have been able to choose between them. Alternatively,

Table 1: Number of providers per CCG⁷⁹

Number of providers			
Area	Average	Minimum	Maximum
AQP	4	1 ⁸⁰	10
Non-AQP	2	1	5

Source: Referral data from 'Choose and book'⁸¹ using a sample of 191 CCGs (117 from areas where choice has been introduced and 74 from areas where it has not). Averages have been rounded to the nearest integer.

New providers in specific areas include national and regional independent sector providers, social enterprises, charitable organisations, GP-led providers, and NHS hospitals operating from community clinics. New providers that emerged in some areas were already providers of adult hearing services in other areas (eg Specsavers, NHS hospitals). Others were established providers of related services, such as hearing and optical services for private patients (eg Scrivens, Boots, Amplifon). Providers have established clinics in various settings, including on the high street, in GP practices, and in other community locations. Often providers had limited local presence before they started offering their services to NHS patients so had to invest to establish and mobilise their services for NHS patients.

Providers that were new to particular areas told us they have had to differentiate themselves to attract NHS patients. For example, we are aware of providers establishing themselves in locations where services were previously lacking (see section 3.2.3 and Annex 4). We are aware of some providers targeting patients who in the past may have found it difficult to access services (eg a provider told us that it was catering for people in residential care homes). We identified examples of providers differentiating themselves in other ways:⁸²

- offering extended opening times⁸³
- extending the range of hearing aids offered to patients (eg in-the-ear hearing aids and hearing aids that match patients' skin tone)

commissioners may have commissioned services from multiple providers, including independent sector providers. Commissioners might do this so patients have access to a range of different sites, but patients do not have a choice of provider and providers do not compete to attract patients.

⁷⁹ Note that not all providers may be reflected in the data. The Choose and book data allowed us to identify providers, within a CCG, who received at least one patient referral using Choose and book over the period under examination. If a provider did not receive a referral via Choose and book over the period, then it will not be reflected in the data and not included in our analysis.

⁸⁰ Using the Choose and book data, we identified 11 CCG areas where any qualified provider had been used but there was only one provider. For the reasons stated in footnote 79, the data is likely to overestimate the number of areas with only one provider.

⁸¹ Choose and book, Daily Booking Reports, available from:
www.chooseandbook.nhs.uk/staff/bau/reports/daily

⁸² We recognise that many of these initiatives may exist outside areas where choice has been introduced.

⁸³ For example, providers on the high street opening on a Saturday.

- tailoring aftercare to patients' needs and preferences (eg offering a drop-in service, allowing patients to order batteries and other supplies over the phone or online, delivering supplies to a patient's home free of charge)
- offering other support such as group training for new users of hearing aids and their families.

The majority of GPs interviewed acknowledged that choice had the potential to deliver or was delivering benefits to patients.⁸⁴ Some also commented that choice appeared to be driving improvements to NHS provider's services, particularly in terms of shorter waiting times and more clinics in the community.⁸⁵ This is consistent with what some patient groups told us.

“ I think that's [patient choice] made them [the NHS] up their game and provide a better service, quick access and [be] more responsive to the patients”

A GP's response in interview with Creative Research⁸⁶

“ The hospital had to step up its game re waiting times and the products they provide”

A GP's submission to Monitor

“ Waiting times are much better via private providers, which has in turn improved NHS providers”

A GP's submission to Monitor

3.2.3. Choice and access to services

In this section we set out our findings on the impact that choice has had on patients' access to services, including service location, opening times, waiting times, and reaching patient groups that can find access difficult.

Hearing clinics can be easier for patients to get to

As set out in section 3.2.2, the introduction of choice has allowed a range of out-of-hospital services to emerge. Hearing clinics have opened on the high street, in GP practices and in other community locations.

Many patient groups, GPs and commissioners told us that moving adult hearing services out of hospital and into the community can make it easier for patients to access services. The results of the patient survey are consistent with this finding. In the patient survey, hospitals were seen as less easy to access overall and

⁸⁴ See the GP interviews report, page 69.

⁸⁵ See the GP interviews report, page 70.

⁸⁶ See the GP interviews report, page 70.

significantly less easy to access than a clinic in a GP practice. In areas where choice has been introduced, 82% of respondents surveyed attending an out-of-hospital provider said the location was “very easy” to get to. This compares with 64% of those attending a hospital.⁸⁷

In the patient survey, respondents in areas where choice had been introduced were more likely to suggest that services were easier to get to services than in areas where choice had not been introduced, but not significantly⁸⁸ so.⁸⁹ We might expect this to be even greater, if more patients were able to exercise their choice. As noted in section 3.1 (and discussed further in section 4.1), we found that patients were not always being offered a choice or given information to help them choose, even in areas where choice should have been available. Having a location that is easy to get to was one of the main reasons respondents gave for choosing their provider.⁹⁰ As the introduction of choice has increased the diversity of providers and opportunity for patients to select a conveniently located service, if more patients were empowered to choose who provides their care, we expect patients would find it even easier to get to services in areas where choice was available.

To examine the impact that the introduction of choice can have on patients’ ability to access services we undertook four case studies. We looked at four different areas of England to compare how the accessibility of services has changed as a result of choice being introduced.⁹¹ We chose these areas on the basis that robust information on providers’ sites was readily available and that the areas included examples of urban and rural populations in different parts of England.

In three of the four areas, our analysis suggests that the number of patients with easy access to at least one provider had increased, and that the number of patients able to choose between two or more easily accessible providers had also increased. This was the case even in an area where the local NHS hospital stopped providing adult hearing services to the local population when choice was introduced. In the fourth area, patients had been able to choose between three providers since before

⁸⁷ See the patient survey report, page 32.

⁸⁸ When comparing patient survey results between areas where choice has been introduced and those where it has not, we use the word “significant” to refer to the statistical accuracy of the differences between groups of patients with a certain confidence level, no matter how large or small the difference is. In our report the differences between subgroups are statistically significant at a 95% confidence level (which is the level of confidence conventionally required to affirm that a result is “statistically significant”). When the differences are not statistically significant (ie it is not possible to affirm that the difference is real) we specify that the difference is “not significant”.

⁸⁹ In our patient survey, 69% of patients found the location “very easy” to get to in areas where choice had been introduced compared to 64% in areas where it had not. (See the patient survey report, page 32.)

⁹⁰ In our patient survey, in areas where choice had been introduced, 35% of patients said that “easy to get to” was one of the main reasons for choice of hearing specialist. 36% said “GP’s recommendation” was the main reason for them. (See the patient survey report, page 22.)

⁹¹ The areas were: North Norfolk, South Norfolk and Norwich CCGs, Brighton and Hove CCG, Oxfordshire CCG, and South Tees and Hartlepool and Stockton-on-Tees CCGs.

any qualified provider was implemented in 2012. Once commissioners removed the limit on the number of providers, a provider of domiciliary services started to provide services, which would improve access. See Annex 3 for our analysis.

Of the four case studies, access improved most significantly for patients in the North Norfolk, South Norfolk and Norwich CCGs' areas. Before choice was introduced, there were four providers operating from five sites. After choice was introduced, there were six organisations operating from 32 sites,⁹² and a domiciliary care provider.⁹³ Figure 1 shows the location of all the GP practices in the area (as a proxy for patients' location) and illustrates their proximity to providers' sites both before and after the introduction of choice.⁹⁴ Our analysis shows that the proportion of GP practices (as a proxy for patients' location) within a 20-minute drive of a provider's site has increased from around half to over 90% following the introduction of patient choice. This one example of what can happen does not recognise the presence of the new provider of domiciliary care in the area, which we would expect to further improve the overall accessibility of the service, especially for housebound patients.

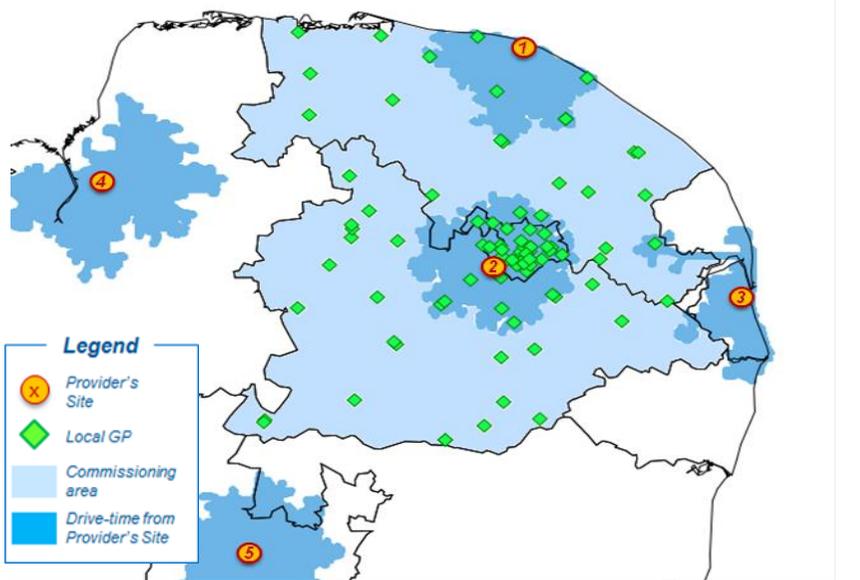
⁹² We note that some of these sites may offer appointments only on particular days of the week.

⁹³ We understand that the CCGs sought to qualify further providers in the summer of 2014 and two additional providers are likely to be available to patients in the future.

⁹⁴ In the figure, GP practices are depicted as green diamonds and providers' sites as orange dots.

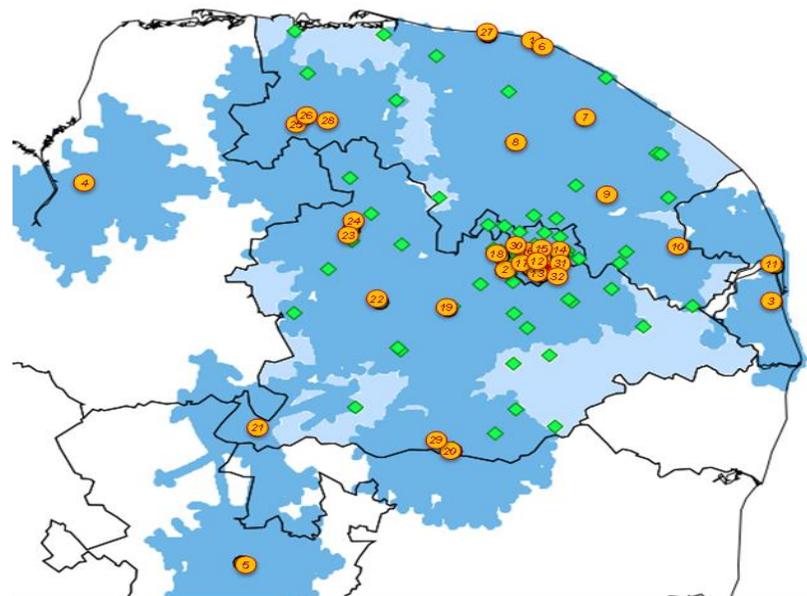
Figure 1: North Norfolk, South Norfolk and Norwich CCGs – accessibility before and after patient choice was introduced (GP practices within a 20-minute drive away of providers’ sites)

Before the introduction of patient choice



<i>Providers before patient choice</i>	<i>Id</i>
Norfolk and Norwich University Hospitals NHS FT	1,2
James Paget University Hospitals NHS FT	3
The Queen Elizabeth Hospital Kings Lynn NHS FT	4
West Suffolk NHS FT	5

After the introduction of patient choice



<i>Providers after patient choice</i>	<i>Id</i>
Norfolk and Norwich University Hospitals NHS FT	1,2
James Paget University Hospitals NHS FT	3
The Queen Elizabeth Hospital Kings Lynn NHS FT	4,24,25
West Suffolk NHS FT	5
Specsavers	6,11,18,20, 21,26,27
Scrivens	7,8,9,10,12,13,14,15,16,17,19. 22.23,28,29,30,31,32

Source: Monitor analysis.

The timing of appointments can be more flexible and convenient for patients

The results of our patient survey suggest that patients' appointments were generally a weekday between 10am and 5pm. Providers were slightly more likely to see patients outside these times in areas where choice had been introduced than in areas where it has not, but not significantly so.⁹⁵ Weekend appointments were rare but significantly more likely in areas where choice had been introduced than in areas where it had not (3% versus 1%), and also where the appointment was at a particular high street provider (11%).⁹⁶

In the patient survey, respondents were slightly more likely to view the timing of appointments as convenient in areas where choice had been introduced than in areas where it has not, but not significantly so.⁹⁷ Convenient opening hours was one of the main reasons patients gave for choosing their hearing provider in the survey.⁹⁸ Given that the introduction of choice has increased the diversity of providers and opportunity for patients to select a provider with more convenient appointment times, if more patients were empowered to exercise their choice, we expect patients would find their appointments even more convenient in areas where choice was available.

Patients can be assessed and fitted with hearing aids more quickly

Our patient survey results suggest that the maximum acceptable waiting time for assessment is around five to six weeks; beyond that point more patients find the wait too long than find it acceptable.⁹⁹ The patient survey suggests that the introduction of choice and new providers means that patients can be treated faster. In areas where choice has been introduced, 68% of respondents attending an out-of-hospital provider were seen within two weeks of being referred, and almost all (99%) were seen within six weeks. Those respondents who attended a hospital experienced the longest waits, with 16% of respondents waiting longer than six weeks and 4% waiting three months or more.¹⁰⁰

Overall, those surveyed were slightly more likely to have a first assessment within 6 weeks in areas where choice has been introduced than in areas where choice had not, but not significantly so.¹⁰¹ Of those that had another appointment to get their hearing aids fitted, the appointment was more likely to happen within a week in areas

⁹⁵ In the patient survey, 33% of patients' appointments were outside of 10am-5pm on a weekday in areas where choice has been introduced (compared with 30% in areas where choice has not been introduced). (See the patient survey report, page 29.)

⁹⁶ See patient survey report, pages 28-29.

⁹⁷ In the patient survey, 74% found the date and time of their appointment "very convenient" in areas where choice has been introduced compared with 70% in areas where choice has not been introduced. A high street provider's appointments were rated particularly highly, with 82% rating them as "very convenient". (See the patient survey report, pages 29-30.)

⁹⁸ See the patient survey report, page 22.

⁹⁹ See the patient survey report, page 28.

¹⁰⁰ See the patient survey report, page 26.

¹⁰¹ 88% vs 85%; see the patient survey report, page 26.

where choice has been introduced than areas where it has not, but not significantly so.¹⁰² Respondents were also slightly more likely to be satisfied with the length of wait in areas where choice had been introduced than where it had not, but not significantly so.¹⁰³ How quickly they could get an appointment was one of the main reasons patients gave for choosing their provider in the survey.¹⁰⁴ Given that the introduction of choice has increased the diversity of providers and opportunity for patients to select a provider with faster waiting times, if more patients were empowered to exercise their choice, we expect patients would be even more satisfied with the length of wait in areas where choice was available.

We also analysed commissioners' waiting time data to see what impact choice has had on waiting times. Full details of our analysis and results are in Annex 4. Based on this analysis, we found that, similar to the patient survey results, patients have enjoyed slightly quicker treatment in areas where choice has been introduced than in areas where it has not.¹⁰⁵

Consistent with the patient survey results, our analysis also shows that introducing choice can be an effective way to reduce waiting times. We found that in areas with choice and an average waiting time of six weeks or more, average waiting times fell by nearly two weeks between April 2013 and July 2014. This is a 70% greater reduction than in areas with similar waits but where choice had not been introduced. Further details are in Annex 4.

It is worth noting that waiting times are generally very good in England. In the vast majority of CCG areas¹⁰⁶ patients have to wait, on average, six weeks or less for assessment and treatment.

Some new providers are catering for people who can find it difficult to access services

We explained in section 3.2.1 that some new providers are targeting patient groups who have found it difficult to access services in the past for mobility or other reasons (eg housebound patients, residents in care homes). In our view, this can improve access for these groups.

¹⁰² 38% vs 27%; see the patient survey report, page 38.

¹⁰³ Patients were slightly more likely to view the length of wait for their first appointment as acceptable in areas where choice has been introduced compared to areas where it has not (92% vs 89% of patients). (See the patient survey report, page 27.)

¹⁰⁴ See the patient survey report, page 22.

¹⁰⁵ We found that waiting times were on average 7% lower over the period April 2013 to July 2014 in areas where choice has been introduced.

¹⁰⁶ In about 90% of CCG areas. This figure is based on Monitor's analysis of figures from NHS England's Direct Access Audiology Data. (See: NHS England, Direct Access Audiology data, Incomplete pathways. Available from: www.england.nhs.uk/statistics/statistical-work-areas/direct-access-audiology/daa-data/.)

Improving access can benefit patients

Patient groups and providers told us that moving services out of hospital and into the community offers patients a more comfortable and friendly environment. They told us that this could reduce stigma and adjust patients' perceptions of hearing loss. One provider added that the stigma around optometry and sight loss has been reduced in a similar way. Patient groups and providers also told us that improving patients' access to services has increased awareness of adult hearing services. We expect that having services on the high street and elsewhere in the community can help make them more visible, which will improve general awareness of hearing loss and the services available.

As described in section 2.2, hearing loss can significantly affect both patients and those around them, and there is evidence to suggest that hearing aids are underused in the UK. In our view, improving access to adult hearing services will lead to more people being aware of the service and getting treated which will produce direct benefits.

Making access to services easier not only improves patients' access to hearing assessments and hearing aids, it also improves access to follow-up appointments and aftercare. This may increase patients' willingness to use these aspects of the service, and we note there is evidence to suggest that follow-up appointments and aftercare can affect the extent to which patients benefit from their hearing aids.^{107,108}

In the long term, improved access could also lead to savings for commissioners and the wider system by reducing pressures on health and social services (as consequences of untreated hearing loss). We recognise, however, that in the short term commissioners' total spend can increase, especially if there has previously been low levels of patients' awareness and/or high levels of unmet demand for services. We discuss this further in section 4.7.

3.2.4. New service specifications and quality expectations

The DH's implementation pack for adult hearing services contained service specifications for the services (the 'national service specifications'), which included a

¹⁰⁷ In the patient survey, patients' satisfaction with their hearing aids was correlated with whether they were offered a follow up appointment. Significantly more of those who were offered a follow-up appointment were ultimately very satisfied with their hearing aids than those who were not offered a follow-up appointment (68% very satisfied compared to 46%). (See the patient survey report, page 46.)

¹⁰⁸ The Commission on Hearing Loss reports that follow-up appointments and appropriate aftercare are critical to ensuring people make the most of their hearing aids, and calls for timely follow-up and accessible aftercare to become routine in all instances across the UK. (See International Longevity Centre UK. (2014) 'Commission on Hearing Loss: Final Report', page 29, Available from: www.ilcuk.org.uk/index.php/publications/publication_details/commission_on_hearing_loss_final_report.)

list of quality requirements and key performance indicators (KPIs) expected of qualifying providers.¹⁰⁹

The pack was not mandatory for commissioners, who could also refine the national service specifications to meet local needs.¹¹⁰ Information made available by commissioners and providers suggests that the national service specifications were largely adopted when introducing choice.¹¹¹ Some commissioners made minor modifications to suit local needs.¹¹² In addition, we identified at least one CCG that had decided not to introduce choice to adult hearing services but had adopted the new service specifications when contracting with their providers of adult hearing services.

The pack specified key service outcomes which providers had to measure, record and report periodically to commissioners. These included the following targets:

- 90% of patients referred to the service should be assessed within 16 working days of receipt of referral
- 90% of patients requiring hearing aid fitting should be seen within 20 working days of the assessment
- 90% of follow-up appointments should be within 10 weeks of fitting
- 90% of patients should be able to access aftercare within 2 working days of a request
- 95% of responses received from patients sampled via a service user survey should report overall satisfaction with the service.¹¹³

The pack also proposed that failure to meet some of these service outcomes could result in a financial penalty.

Commissioners and providers told us that the specifications put in place set out higher requirements on providers or were more explicit than the arrangements previously in place. Before, service specifications were not always in place or when in place, they often lacked clarity. For example, the new specifications clarified

¹⁰⁹ DH's implementation pack, Section B, Part 1.

¹¹⁰ Preface of the DH's implementation pack.

¹¹¹ We are aware of at least 51 CCGs who have adopted the specifications

¹¹² For example, a number have modified the minimum age requirement, changing the specifications from 55 years+ either to 18 years+, 50 years+ or 60 years+ (eg Canterbury and Coastal CCG, Ashford CCG, South Kent Coast CCG, North Norfolk CCG, and Bristol CCG). In some cases, commissioners used patient engagement to identify how to vary the specifications to suit local circumstances (eg Shropshire CCG).

¹¹³ The national service specifications envisaged providers undertaking their own surveys to understand service users' experiences. The specifications also envisaged providers surveying local GPs to seek their views and experiences of services. (See DH's implementation pack, Section 1, Appendix 5.)

obligations to provide follow-up appointments and aftercare services. As discussed in section 3.2.3, there is evidence that follow-up appointments and aftercare are correlated with how much patients are likely to benefit from their hearing aids.

In our view, the service specifications, combined with regular reporting of outcome measures and penalties for underperformance, create incentives for providers to ensure the desired quality. They can also help commissioners ensure that adult hearing services offer good value for money and that the needs of patients are met.

3.3. Choice and the price per patient¹¹⁴

As outlined in section 2.1, under the any qualified provider approach, commissioners were expected to establish a locally determined price before inviting applications from providers to qualify. To help commissioners achieve this, DH's implementation pack included guide prices. For example, DH's guide price for a three-year pathway of care¹¹⁵ was £294 for a patient needing one hearing aid and £388 for a patient needing two hearing aids.¹¹⁶ DH's guide prices were based broadly on the national non-mandated tariff for adult hearing services prevailing at the time. That price had been established as part of Payment by Results and had been used previously by some commissioners to inform local pricing for the service. To establish its guide price, DH made some changes to reflect the new service specifications and applied a 10% reduction. Commissioners were free to adjust DH's guide prices to suit local circumstances.¹¹⁷

Information from commissioners and providers suggests that in establishing locally determined prices, some commissioners originally adopted DH's guide prices. In other areas, commissioners modified the tariff and paid a price either below or above the guide prices, with submissions suggesting a variation of +/- 2%. Some commissioners changed the structure of the guide prices and bundled their payments while others broke the price down by specific activity (eg rather than

¹¹⁴ As explained in section 4.7, commissioners have seen an increase in their total spending on adult hearing services following the introduction of choice. In this section we examine the change in the price per patient. We view this as the relevant cost comparator since this is not sensitive to changes in the numbers of patients being treated.

¹¹⁵ The three-year care pathway was expected to cover: an appointment to assess the person's hearing, the fitting and cost of hearing aids (one or two, as required), a follow-up appointment a few weeks after the fitting to see how the person is getting on with their hearing aids, three years of aftercare, and an offer of a review appointment at the end of the third year to assess whether any changes to treatment are needed. Patients were expected to be able to ask for a review appointment earlier than three years, if they failed to manage their hearing aids or if there was a suspected significant change in their hearing. (See DH's implementation pack, Section 1, Section B, Part 1.)

¹¹⁶ Prices were set out in Section 2 of DH's implementation pack.

¹¹⁷ For example, the guide prices did not include any Commissioning for Quality and Innovation (CQUIN) payment and it was suggested that local prices might reflect local rent and staff. (See DH's implementation pack, Section 2, pages 40-43.)

bundling aftercare with other aspects of the service, some paid for each aftercare contact while others paid a single price for a year of aftercare).

We estimate that the locally determined prices adopted by commissioners have been about 20% to 25% lower than the national non-mandated tariff.¹¹⁸ This can allow commissioners to treat more patients for the same spend and/or release additional funds that commissioners can spend on meeting other patients' needs.

We recognise that commissioners might have achieved similar outcomes by negotiating prices with the providers in their area without introducing choice. However, our research identified few examples of this happening in areas where choice had not been introduced in adult hearing services.

In areas where choice had not been introduced, we found that commissioners often agree to pay a fixed amount for a range of different services under a block contract. Payment will therefore be bundled for a range of services and cannot be linked directly to the cost of individual services or the number of patients treated. In such cases commissioners will not necessarily know how much they are paying for adult hearing services or levels of activity, and at least one commissioner acknowledged this. In other research, we identified the lack of data as a wider issue in the commissioning of community services and some commissioners are in the process of moving away from block contracts.¹¹⁹

Although not widespread, in areas where choice has not been introduced we did identify other examples where commissioners had:

- negotiated prices based on the national non-mandated tariff
- used competitive tenders to determine the price
- negotiated a price based on the locally determined price set by neighbouring commissioners who had introduced choice.

These examples suggest that it is possible to achieve greater transparency in pricing without introducing choice, although we note we found limited examples of this happening in practice.

¹¹⁸ Some providers also told us that some commissioners decided not to pay an additional market forces factor (or MFF), which would represent a further reduction in price. Providers of healthcare in different geographical locations are likely to face different costs associated with their location. The MFF is an index reflecting local cost differences and is used to adjust the national tariffs to the geographical location of the providers. This means that prices at local level are adjusted so that providers in different parts of the country are neither advantaged nor disadvantaged by the relative level of these costs. MFF is calculated with the lowest cost location being one and everything else being more than one which means prices are always adjusted upward if the MFF is applied.

¹¹⁹ Monitor. (2015) 'Commissioning better community services for NHS patients'. Available from: www.gov.uk/government/publications/improving-community-services.

With respect to the use of competitive tenders to agree a price, one winning provider reported that in its opinion such tenders were often heavily focused on price competition and did not allow providers to demonstrate the quality of the service for patients.

3.4. Commissioners' access to service-level data

As set out in section 3.2.4, the introduction of choice has typically led to service specifications that were underpinned by a set of quality requirements, KPIs and other outcome measures, on which providers are required to collect data on and report to commissioners.

Many commissioners and providers responding to the project told us providers do report on KPIs, although we observed differences in the frequency with which some of this information was requested by different commissioners. Some commissioners noted that it had taken time to develop suitable reporting arrangements with providers. A few commissioners noted that not all providers had reported data.

One commissioner told us that having access to this information is important as it can enable commissioners to secure the needs of patients, and improve the quality and efficiency of services.

At the most basic level, data on activity enables commissioners to reconcile their spending with activity levels and improves commissioners' understanding of how their budget is being spent. It also allows commissioners to forecast their expenditure more accurately so they can get the most from their budget. Data on both activity and service outcomes offers additional insight into the extent to which patients' needs are being met from current service provision and scope for service improvements. It also allows commissioners to understand whether the services they purchase from each provider represents value for money. This is because this information enables commissioners to compare providers receiving the same price using standardised performance measures.

It would seem to us that the new service specifications have given commissioners an opportunity to improve their access to service-level data. In our view, improving commissioners' access to data can benefit patients. As noted, we identified in other research that, historically, commissioners of community services have struggled because of limited available data and limited ways to benchmark services.¹²⁰

¹²⁰ Monitor. (2015) 'Commissioning better community services for NHS patients', page 25. Available from: www.gov.uk/government/publications/improving-community-services. In that report, we say that: "almost a quarter of commissioners responding to our questionnaire mentioned a lack of robust data as a barrier to improving how community services work for patients. Commissioners said they find deficiencies in data needed to measure healthcare outcomes for patients, data to benchmark activity and outcomes in their area against other areas, and cost data that would help them evaluate value for money or develop new currencies and payment mechanisms."

To maximise the value of these data, all service providers need to supply the data and they need to do so in as consistent and comparable format as possible. Suitable reporting arrangements need to be put in place with providers, and these need to be followed through by commissioners. We discuss this further in section 4.6 on contract monitoring and enforcement.

One commissioner suggested that the existing set of KPIs could be improved by including a range of outcome-based measures (eg KPIs that measure improvement in patient hearing acuity, patients being able to use their hearing aids independently, etc). The commissioner said they were exploring this possibility further. We note that Action on Hearing Loss has developed an evaluation framework which includes research into what outcomes might be used.¹²¹

We recognise that commissioners could implement reporting requirements and obtain some benefit without introducing choice. However, we expect greater benefits may be achieved where choice is used. For example, if commissioners have multiple providers operating in their own area, they can compare service outcomes in their own area without having to rely on national benchmarking or benchmarking across CCGs.

¹²¹ Action on Hearing Loss. (2013) 'Evaluation framework for adult hearing services in England'. Available from: www.actiononhearingloss.org.uk/evaluationframework

4. Factors limiting the effectiveness of choice

In the previous section, we described ways that patients benefit in areas where choice has been introduced in adult hearing services. However, in our view, patients could benefit more than they do. Here we describe factors that limit the effectiveness, and therefore the benefits, of choice for patients. These relate to:

- empowering patients
 - patients not being enabled to make choices
 - patients not being directed to other complementary services or equipment for those with hearing loss
- the commissioning process
 - the provider qualification process being burdensome
 - arrangements not necessarily promoting a level playing field
 - time and effort spent on managing multiple contracts
 - contracts not being monitored or enforced
 - increased budgetary pressures on commissioners.

In section 5, we set out what can be done by commissioners, GPs, patient groups and providers to address these issues.

4.1. Patients' ability to make choices

Our research highlighted four important ways in which choice is not working well:

- patients are not aware that they have a choice
- many GPs do not tell patients that they have a choice
- patients do not have information to compare services
- patients are not always able to change their provider if dissatisfied.

We describe these in this section. Our patient survey suggests that the combination of these factors means that in practice only 5% of respondents are able to make an informed choice of provider.¹²²

¹²² We arrive at a 5% estimate on the basis that: 10% were offered a choice by their GP and about 50% had information to help them choose. (See the patient survey report, page 8 and 13.)

4.1.1. Patients' awareness of choice

In areas where choice has been introduced, fewer than one in four respondents surveyed were aware they could choose their provider before visiting their GP.¹²³ The low awareness of choice among patients is consistent with what patient groups told us. Most respondents surveyed became aware of their right to choose from friends or family (58%); 13% were made aware by a provider of adult hearing services.¹²⁴

4.1.2. GPs' promotion of choice

If patients are unaware of their ability to choose, they will not be able to exercise a choice unless their GP offers them a choice at the point of referral.¹²⁵ We were disappointed to learn that very few patients were actually offered choice.

In the patient survey, only one in five said they discussed which service provider they might go to and one in ten patients reported having been offered a choice of provider by their GP. The problem was worse for older patients. Just one in 20 respondents older than 80 reported having been offered a choice of provider by their GP.^{126, 127}

The results of the GP interviews suggest that some GPs may be unaware that commissioners have introduced choice and that patients are entitled to choose their provider.¹²⁸ Some GPs explained that they referred patients based on familiarity with a particular provider and/or feedback received on a particular provider.¹²⁹

The results of the GP interviews suggest that GP may not be offering patients a choice of provider as they feel they do not have enough time in a consultation to discuss choice.¹³⁰ Some GPs also noted that sometimes patients present with other complaints and hearing loss only arises later in the consultation and that this could have implications for how much time they had available to discuss the issue.¹³¹

The GP interviews also suggest that GPs are often unable to identify most providers in their area.¹³² As a result, those GPs offering patients a choice of provider rarely

¹²³ See the patient survey report, page 11.

¹²⁴ See the patient survey report, page 12.

¹²⁵ Or in places where there is a referral management centre, the referral management centre offers them a choice.

¹²⁶ See the patient survey report, page 9.

¹²⁷ For 9% of patients surveyed, the initial referral was handled via a referral management centre rather than through the GP. In such cases, patients were more likely to have a discussion of which hearing specialist they might go to, but there was no higher likelihood of being offered a choice (only 11% of those whose referral was handled by a referral management centre said they were offered a choice of provider). (See the patient survey report, pages 8–9.)

¹²⁸ See the GP interviews report, pages 2, 48–49, and 66.

¹²⁹ See the GP interviews report, pages 2 and 32–41.

¹³⁰ See the GP interviews report, pages 23 and 40.

¹³¹ See the GP interviews report, page 17.

¹³² See the GP interviews report, pages 2 and 29–31.

inform patients about all the providers available to patients in the area.¹³³ This is consistent with the patient survey results. For example, the respondents surveyed and the GPs interviewed expressed an interest in having a domiciliary service available to them but the GPs were often unaware even if this service was in fact already available in their area (eg from the Outside Clinic).¹³⁴

The GP interviews suggest that GPs' knowledge of providers' service quality was extremely limited and usually based on anecdotal feedback from their patients.¹³⁵ Unless they had heard anything to the contrary, the GPs interviewed sometimes assumed that the quality of service would be the same across all providers.¹³⁶

As noted at section 3.1, a common view among the GPs interviewed was that younger and professional patients are more interested in choosing their provider, but this is not in line with the results of our patient survey. The survey results suggest that those older than 80 value choice just as much as those in the younger age groups surveyed, and that those on lower incomes also see choice as equally valuable to those on higher incomes.¹³⁷

4.1.3. Patient access to information

In our view, for choice to deliver improved quality and efficiency, patients need to be able to make informed choices. To achieve this, it is important that patients are able to choose between providers on the basis of comparable information about the quality of the services offered. Of the small number of patients surveyed that were offered a choice, more than half reported having no information to help them choose. Patient groups, in their submissions to us, also told us that patients often do not have sufficient information to choose the provider that best suits them.

Although the national service specifications have given commissioners an opportunity to collect data on services outcomes (see section 3.4), we are not aware of this data being made publicly available to help patients or GPs make choices based on quality.

Some sources list hearing aid services available in local areas and allow patients to review providers of hearing services (eg NHS Choices and a tool on the Action on Hearing Loss website called 'locate and rate'). However, these sources do not contain important information on service features (such as waiting times, the range of hearing aids offered, quality of aftercare) or service outcomes (such as patients' satisfaction or continued usage of hearing aids).

¹³³ For example, of the patients that were offered a choice, most recall being offered just two options despite there being, on average, four providers to choose from. (See the patient survey report, pages 9-10.)

¹³⁴ See the GP interviews report, page 47; the patient survey report, page 23.

¹³⁵ See the GP interviews report, page 50.

¹³⁶ See the GP interviews report, page 51.

¹³⁷ See the patient survey report, pages 16-17.

The lack of comparable information about the quality of services offered means that patients are uninformed and unable to choose the service that suits them best. This limits the extent to which choice benefits patients.

4.1.4. Patient ability to change their provider

The national service specifications included arrangements for commissioners to recover a percentage of the tariff paid to providers if any part of the three-year aftercare or review pathway was not delivered (eg if a patient switched their provider because they were dissatisfied with the service).¹³⁸ Such arrangements can strengthen providers' incentives to deliver good aftercare.

We identified some evidence of patients changing their provider in practice. In areas where choice has been introduced, 8% of respondents surveyed had changed provider.¹³⁹

The survey results also suggest that some patients are sometimes unable to switch in areas where choice has been introduced: 3% of respondents surveyed, who considered themselves either fairly satisfied or dissatisfied with their existing services, said they had attempted to switch their provider but had not been able to; 5% said they had considered but had not tried to switch. Most did not try to switch because they were happy with their current provider, but others mentioned that they were not aware they could switch, they did not have enough information, or they expected the process to be too difficult.¹⁴⁰

Commissioners and providers told us that for a number of reasons it can be difficult for patients to switch. First, different providers often dispense different manufacturers' hearing aids. A provider may be unable to service another provider's hearing aids and so may be unable to provide aftercare to patients who have switched from that provider (unless the provider dispenses new hearing aids). Second, several commissioners told us that they had concerns about paying twice if patients switched provider, so they discouraged switching. Another told us that they required patients to contact the CCG in order to switch and each request was dealt with on a case-by-case basis. A commissioner may have to pay twice if, for the reasons explained above, providers have to dispense new hearing aids to patients who switch and/or the commissioner is unable to reclaim payments made to the patient's original provider for aftercare.¹⁴¹

¹³⁸ The implementation pack included guidance on amounts that should be recovered from providers for 'incomplete pathways' (ie defined as the aftercare and third-year review following assessment, supply, fitting and follow-up of the appliance/s). (See DH's implementation pack, Section 2, page 43.)

¹³⁹ See the patient survey report, page 25.

¹⁴⁰ See the patient survey report, page 25.

¹⁴¹ As discussed in section 3.3 commissioners typically pay providers at the assessment/fitting stage which includes payment for three years of aftercare.

The national services specifications required providers to assess patients at the end of three years and to discharge them back to their GP.¹⁴² One commissioner told us they were keen for patients to be discharged to their GP because this enforces choice and ensures patients get a service that meets their needs. Another commissioner said they are considering changing the way patients are discharged to their GP after the three-year pathway, because of the burden this places on GPs.

4.2. Signposting to other support services

A range of additional services and equipment is available to patients with hearing loss. These include hearing therapy, lip-reading classes, local support groups for the hard of hearing, and equipment such as flashing smoke alarms and door bells, and amplified telephones.

These services and devices can help patients manage their hearing loss by improving communication, social integration and ability to cope with hearing loss (including psychological impact). The services can also help deliver care in an integrated way which may make patients more likely to continue wearing their hearing aids and manage their condition more effectively.

While commissioners require providers to signpost patients to these services and devices in many areas where choice has been introduced,¹⁴³ our patient survey showed that most patients were not told about complementary services or devices.¹⁴⁴ Only one in ten respondents surveyed said they were provided with information¹⁴⁵ and about 15% said they had another service or device to help them with their hearing loss. This perception of a lack of signposting is consistent with what hearing loss charities told us.

Some respondents surveyed said that they were already familiar with these services and devices or did not need them.¹⁴⁶ Interviewed GPs and providers said that they do not always signpost other services or devices that they do not see as relevant to patients with mild to moderate hearing loss.¹⁴⁷ Providers also said that it can be

¹⁴² DH's implementation pack, Section 1, Section B, pages 19-20.

¹⁴³ The service specifications developed by DH to support choice required providers to signpost relevant services for patients at particular stages of the care pathway, including at the time of fitting. We found that commissioners have largely adopted these service specifications (see section 3.2.4), including the requirement to signpost relevant services.

¹⁴⁴ See the patient survey report, pages 53-54.

¹⁴⁵ This was most likely to be about free equipment or social groups for the hard of hearing. (See the patient survey report, page 53.)

¹⁴⁶ In areas where choice has been introduced, 10% of patients were not told about these services or devices but said they were already familiar with them or did not need them. (See the patient survey report, page 54.) Similarly, some patients who wrote to us felt they were unlikely to benefit from these complementary services or equipment because of the mildness of their hearing loss.

¹⁴⁷ The GP interviews also suggest that GPs generally do not know much about other services or devices that can help those with hearing loss available in their area, and felt that others on the patient journey were better placed to provide this information. (See the GP interviews report, pages 26-28.)

difficult to identify all the other services available locally, and that significant investment is needed to build awareness and knowledge of those services.

It appears to us that lack of signposting is a widespread issue. The patient survey results suggest it was present in both the areas where choice has been introduced and where it has not (although providers were less likely to signpost in areas where choice has been introduced¹⁴⁸). There was also very little difference in the level of information given by different types of provider.¹⁴⁹

4.3. The provider qualification process

Providers and commissioners raised four main concerns about the provider qualification process:

- it can be burdensome,
- it can favour some providers over others,
- the requirements on providers between qualification and mobilisation can be unclear and protracted,
- it is not always clear when new qualification opportunities will arise.

If the provider qualification process does not work well then commissioners may not be attracting all of the providers well placed to deliver quality services. The process may also impose unnecessary costs on both providers and commissioners.

4.3.1. The burden of the process on providers and commissioners

Several providers and commissioners told us that the provider qualification process was resource intensive, although several said they were unable to quantify the cost of the qualification process.

Providers were concerned about:

- a lack of understanding of the service being procured among those commissioning the service and handling the qualification process
- the questions asked sometimes not giving providers sufficient opportunity to show the quality of their services or not seeming relevant
- several requests being made by the same commissioner for the same information

¹⁴⁸ 81% of patients in areas where choice has been introduced were not told about other services or equipment, compared with 76% in areas where choice has not been introduced. (See the patient survey report, page 54.)

¹⁴⁹ See the patient survey report, page 53.

- the approach to assessing applications varying between areas
- the additional accreditation process, which requires significant investment, being inconsistently applied and enforced.

For accreditation, in areas where choice has been introduced, many providers told us they were required to obtain the Improving Quality in Physiological Diagnostic Service programme (IQIPS) accreditation¹⁵⁰ (more information about IQIPS can be found in Annex 5). Providers told us that the IQIPS application process could take up to 12 months and cost up to £17,000. However, there appears to be some inconsistency in how commissioners enforce this requirement.

Some providers who have achieved IQIPS accreditation told us that they are dissatisfied that other providers have not obtained accreditation, and that commissioners have not sought to remedy this situation. Some commissioners said that they had required those that had yet to qualify to work towards accreditation and that progress was followed-up at regular intervals. We were told that providers could experience delays in getting their applications processed, but the body responsible for accrediting providers suggested to us that there was no backlog of applications.

4.3.2. Favouring some providers over others

Some smaller providers told us that the qualification process could be overwhelming and particularly difficult for them. Those providers told us they often find the NHS language and the number of forms to be completed intimidating and disproportionate. They may also lack the resources and experience of participating in such a process and can struggle to meet the financial requirements.

We also identified cases where providers were required to have premises already established in the local area to qualify rather than being given an option to explain how they intended to establish themselves in the area and by when. This, in our view, could favour existing providers.

4.3.3. The mobilisation process

Some providers told us that the process between qualification and when providers can start providing services (ie before providers are able to mobilise) could be unclear and drawn out. This is because the length of time for issuing contracts can be unclear,¹⁵¹ commissioners may impose further requirements on providers once qualified, and some lack the support to be able to navigate NHS systems (eg how to

¹⁵⁰ This was intended as a less onerous requirement than Care Quality Commission registration.

¹⁵¹ For example, one provider experienced periods of between 2 and 12 months between qualification and mobilisation in different areas; another provider qualified more than 18 months ago but has not yet had the opportunity to enter a contract with the commissioner.

be added to Choose and book, the national electronic referral service). Some providers argued that as a result they can often face additional costs.

Some commissioners expressed concern that providers sometimes decide not to mobilise after qualifying. Providers told us that the number of patients they expect to treat was an important factor in their decision to mobilise. One provider said that the number of patients they could expect to treat could be difficult to judge before knowing how many and which other providers had qualified and decided to mobilise.

4.3.4. New qualification opportunities

Some providers told us that it was often unclear when new opportunities to qualify might arise. Typically, commissioners will have run an initial qualification process and awarded contracts for a fixed period (eg three years), but their position on accepting new providers during that period varies and can be unclear. Some commissioners said that they did not accept new applications; while others have run additional processes to qualify new providers or respond to requests from prospective providers on a continuing basis.

4.4. Level playing field for providers

In this section we consider the implications of commissioners establishing different contracting arrangements with different providers when introducing choice. The intention of introducing choice using the any qualified provider approach was that providers applied to qualify on the basis that they agreed to meet certain quality requirements, deliver services to commissioners' service specifications and meet commissioners' reporting requirements. In return, providers would be paid according to a locally determined price. Each aspect was to be specified in provider qualification documents at the start of the process. Once qualified, providers would then seek to retain and/or attract patients on the basis of the quality of their services.¹⁵² The intention was that competition between providers should focus on service quality, not price. On that basis, in an area where choice has been introduced, we would expect all qualifying providers in that area to be working to the same service specification and to be subject to the same locally determined price.

We understand that in some areas commissioners have not always taken this approach. Providers told us that this was occurring, and we identified at least two cases where providers were working to different service specifications and/or payment arrangements.¹⁵³ We discuss the implications of this below.

¹⁵² In other words, the extension of patient choice was intended to facilitate competition between providers on the basis of quality not price (see section 2.1).

¹⁵³ We were told that local determined prices exist alongside block contracts and cost and volume contracts in a further 20 areas. However, in a number of these cases the different prices were in payment for different services, for example, for more and less complex audiology services.

4.4.1. Working to different service specifications

Providers working to different service specifications may limit the effectiveness of choice and therefore the benefits for patients in two ways. First, because service specifications represent minimum service entitlements for patients,¹⁵⁴ providers working to different specifications will imply that patients are entitled to different minimum levels of service depending on the provider they choose. In the absence of readily accessible information on providers' quality of service, patients may not be aware of this. As noted in section 4.1, we found that information on providers' service quality is not readily accessible to patients or GPs.

Second, some providers may not face any or comparable reporting requirements, KPIs or penalties for underperformance compared to others. As set out in section 3.4, introducing choice offered commissioners an opportunity to collect a comprehensive set of provider data, to assess and compare providers' services and outcomes, and to drive service improvements for patients. Not requiring all providers to meet the KPIs or report data seems a missed opportunity to achieve better outcomes for patients.

4.4.2. Working to different payment arrangements

We found that commissioners' contracting arrangements may lead to some providers operating under a block contract or a cost and volume contract, while others work to the locally determined price. Working to different payment arrangements in this way may impact on providers' incentives to improve their service quality and may influence their decisions on whether or not to provide services.

Where a commissioner's contracting arrangements lead to a block contract existing alongside the locally determined price, GPs may have an incentive or the commissioner may instruct GPs to refer patients to the provider on the block contract. This is because the commissioner may be able to save money if referrals are made to the provider under a block contract instead of another (ie because they avoid paying the other providers). The GP interviews show this can occur in practice.¹⁵⁵ As a result, the provider on the block contract may be referred patients regardless of its service quality, so it will have reduced incentives to improve its service quality to attract patients.^{156, 157} If referrals to the providers not on a block

¹⁵⁴ Service specifications establish minimum service quality requirements. The providers' actual service quality may be higher than the minimum required.

¹⁵⁵ The interviews suggest that GPs do take CCG budgets into account when referring patients, and there were mentions of CCGs encouraging GPs to refer to providers with the lowest price. See the GP interviews report, page 48.

¹⁵⁶ This is not to say that the provider has no incentive to retain or improve service quality. Regulatory requirements and professional ethics may also create incentives for providers.

¹⁵⁷ Paying a provider under a block contract can also weaken the provider's incentive to improve service quality. A block contract is essentially a guaranteed payment to the provider. This can

contract are (or are perceived to be) substantially affected, this may cause them to withdraw their services from the area or may reduce their willingness to enter in the first place.¹⁵⁸

Where some providers are operating under a cost and volume contract, arrangements may lead to some providers being paid higher prices for the provision of adult hearing services than others. In a similar way as in the presence of a block contract, GPs may have an incentive to, or the commissioner may instruct GPs to, refer patients to the provider with the lowest price (so the commissioner can save money which can be used for other services and patients). This means that the lowest paid provider will receive referrals that are not wholly related to its service quality, so it may have reduced incentives to improve service quality to attract patients. If referrals to other providers are affected, this may also induce those providers to withdraw their services from the area or may reduce their willingness to enter in the first place.

Accordingly, providers working to different payment arrangements may limit the effectiveness of choice as an incentive to improving quality and therefore the benefits to patients.

4.4.3. Arrangements for VAT

We also found that there appears to be some confusion among providers and commissioners due to different approaches to VAT. Some commissioners appear to allow providers to charge VAT on top of the locally determined price while others do not.

In areas where CCGs include VAT in the locally determined price, all things being equal, the amount effectively paid to non-NHS providers is lower than the one for NHS providers of adult hearing services. This is because non-NHS providers have to pay the VAT charge within the locally determined price while NHS providers do not. This can affect the non-NHS providers' revenues for delivering adult hearing services, and hence their incentive and ability to provide the service.

4.5. Managing multiple contracts

By introducing choice, commissioners created an opportunity for all providers willing and able to meet a set of criteria within a framework specified by commissioners to provide adult hearing. Providers have taken this opportunity and as a result many commissioners have seen an increase in the number of providers of adult hearing services. As set out in section 3.2, our research suggests that the extension of

make the provider indifferent to the number of patients it treats, and the provider will have less of an incentive to improve its service quality to attract patients.

¹⁵⁸ We are aware of providers deciding not to mobilise despite having been qualified by commissioners.

choice in adult hearing services has typically resulted in an average of four providers within a CCG's area, although some areas have up to ten providers.

Commissioners contract separately with each qualified provider. Several commissioners told us that putting contracts in place with a large number of providers and managing these contracts can take considerable time and resources. Some felt that the effort involved is disproportionately high and significantly different from other types of contract management, so is an important disadvantage to introducing patient choice with new providers.

“ *The procurement resulted in more contractors than we would have appointed under a normal procurement. This created a large demand on commissioner resources in putting all of the contracts together. A lot more time is also required for monitoring the contracts compared to the value of the contracts* ”

A CCG's submission to Monitor

The degree of effort required to manage multiple contracts for adult hearing services seems to us to be driven by two main factors:

- the amount of time and effort required to establish the necessary reporting systems: we understand that under previous arrangements, providers were not required to collect these data, and it has taken some of them time to develop suitable reporting systems
- the amount of time it takes to follow up issues raised by or about particular providers (eg if GPs raise concerns or there are patient complaints about the quality of services).

The first point is a transitional (one-off) cost and would need to be incurred anyway if commissioners want access to service-level data. On the second point, the amount of time spent will depend on the total number of complaints or issues raised. This need not be related to the number of contracted providers, and is more likely to be related to the number of people using adult hearing services.¹⁵⁹

Not all commissioners were of the view that the effort involved is disproportionately high. One commissioner suggested that managing contracts is relatively straightforward under choice once the required data reporting systems are in place, and that the benefit they got from choice made the effort worthwhile. Several

¹⁵⁹ We recognise that there may be an initial increase in inquiries from patients about new providers or services when choice is first introduced (particularly if an existing provider stops providing services). However, we would expect the level of inquiries to stabilise over time, as one commissioner acknowledged.

commissioners also told us that they use the support of their commissioning support units (CSUs) to manage multiple contracts with providers.

4.6. Monitoring and enforcing contracts

As discussed in sections 3.2.4 and 3.4, the introduction of choice has typically led to new service specifications. These are often more robust or higher than those that were previously in place, and therefore raise expectations of providers. The new specifications are also underpinned by a set of quality requirements, KPIs and other outcome measures, on which providers are required to collect data on and report to commissioners. This offers commissioners an opportunity to improve their access to service-level data and therefore their understanding of the services provided to patients.

However, some stakeholders told us that it is not always clear whether contracts are being monitored or enforced or what providers' data are being used for. If commissioners are not monitoring and enforcing providers' contracts or making use of the data reported by providers, then in our view this is a missed opportunity for patients.

Commissioners might identify areas for improvement against the service specifications, either through regularly reported data, discussions with GPs or patient groups or from patient surveys. These should be raised with providers. This can help to improve services and strengthen providers' incentives to develop their services to benefit patients.

For example, based on our survey results, it seems that a significant minority of patients are not offered follow-up appointments; only 60% of patients surveyed said they had been offered a follow-up appointment in areas where choice has been introduced.¹⁶⁰ Although this outcome is slightly better than in areas where choice has not been introduced, but not significantly so (60% compared with 57%), the service specifications that many providers work to include a requirement to offer follow-up appointments. As noted earlier, follow-up appointments can influence the extent to which patients benefit from their hearing aids.

Our patient survey also identified a few people accessing NHS-funded care who said they felt under pressure to adopt hearing aids they had to pay for. Although the numbers are small, we noted in section 3.2.1 that providers often work to service specifications that are supposed to prevent this from happening at all. We expect that this could be taken up by commissioners through their contract monitoring and enforcement.

¹⁶⁰ See the patient survey report, pages 55-56.

Similarly, if other concerns are raised about particular aspects of a provider's service, this could be explored by commissioners through contract monitoring and enforcement. For example, we are aware of a commissioner who required a provider to stop using a particular type of hearing aid because it did not support the T-loop system.

In terms of the provider data reported to commissioners, we note that some patient groups would like to see that data made publicly available to help inform patients on the relative quality of providers' services.

“ *Data about patient outcomes should be publicly available, analysed and compared between services, so that patients can choose and services can improve* ”

A patient group's submission to Monitor

4.7. Commissioners' budgetary pressures

Commissioners told us that the number of patients using adult hearing services increased after patient choice was introduced. Some reported increases in excess of 30% in the first year, with some saying that numbers stabilise after the first few years. They said this caused increased spending on adult hearing services, which could create budgetary pressures.¹⁶¹ Commissioners and GPs raised concerns about provider-induced demand.

In our view, the increase in the number of patients is largely driven by the improved accessibility of the service (see section 3.2.3) and the presence of unmet demand. The evidence we have reviewed suggests that most people accessing the service do need it and benefit from it. For example, most respondents surveyed said they were finding their hearing aids beneficial in terms of improving their lifestyle (92%).^{162,163}

We also note that from a commissioner's perspective, choice in adult hearing services has meant the price per patient has decreased by about 20% to 25% in some cases (see section 3.3) and providers are expected to deliver more (see section 3.2.4). As we report in section 2.2 making services more accessible can help

¹⁶¹ A few said that, while they had seen increases in patient referrals and spending, this had been manageable.

¹⁶² In our patient survey, in areas where choice has been introduced, 70% and 22% of patients said their hearing aids were "very beneficial" or "fairly beneficial" respectively. (See patient survey report, page 52.)

¹⁶³ This result compares well to the change in patient-reported outcomes in interventions such as hip replacement, hernia, and varicose veins. Procedure-specific Patient Reported Outcome Measures (PROMs) reveal that 4% of hip operations, 7% of knee replacements, and 17% of varicose vein operations gave the patient no perceived benefit. (Source: Provisional Monthly Patient Reported Outcome Measures (PROMs) in England – April 2013 to March 2014, November 2014 release, www.hscic.gov.uk/catalogue/PUB15722.)

ease the longer term pressures on health and social services from unaddressed hearing loss.

As explained in section 3.2.1, the evidence we reviewed does not suggest that people are being persuaded to have hearing aids unnecessarily. The patient survey did identify some patients who were looking for spare or upgraded hearing aids from the NHS. About 6% of those surveyed who had hearing aids fitted said they were looking for spare or upgraded hearing aids, but these appeared both in areas where choice had and had not been introduced.¹⁶⁴

In our view, the increase in patient numbers in areas where choice had been introduced is likely to reflect the presence of unmet demand and therefore should be considered in the context of commissioners meeting their objectives. There are some practical steps that can help commissioners manage the likely increase in the number of patients and we discuss them in more detail in section 5.

¹⁶⁴ See the patient survey report, page 35.

5. Ways to improve the effectiveness of choice in adult hearing services

Choice in adult hearing services can provide a powerful tool for commissioners to meet the needs of their patients while securing value for money. Choice can lead to services becoming easier to access for patients. This may lead to more patients being treated, which in the long term has the potential to reduce pressures on health and social services that could result from unaddressed hearing loss. Choice can also lead to providers offering better value for money: the price of treatment per patient has gone down in many areas while providers have been asked to deliver to more robust or higher service specifications.

We recognise that commissioners sometimes face risks and costs from offering choice in adult hearing services. These relate to the initial set-up costs, managing multiple contracts over time and the likely increase in the overall spending on adult hearing services.

It appears likely that the benefits of choice are likely to outweigh the costs of introducing choice, particularly in the longer term. The costs of implementing choice may not be as significant as commissioners initially think: some of the costs incurred will be transitional and may be incurred anyway under other commissioning approaches (eg assessing population needs, identifying the right providers to meet those needs, moving away from block contracts and establishing reporting processes). There may also be opportunities for commissioners to refine processes to make them more efficient and less costly (eg streamlining contract monitoring and reporting processes). Moreover, there is potential to make choice work more effectively and to deliver greater benefits for patients if particular steps are taken (eg by empowering patients to make informed choices and using reported data to benchmark providers' services).

Over the course of our project, we identified several practical steps that commissioners can take to ensure they maximise value from offering patients choice in adult hearing services, some of which are based on what commissioners are already doing. These steps, in our view, can enable commissioners to maximise the benefits of choice while minimising the risks and costs from implementing choice. These steps also go towards addressing some of the practical challenges identified by commissioners. We set these out below.

In this section, we also list some steps that we will take to help choice work better for patients. We also outline a number of actions that our system partners are taking to help choice work better for patients.

5.1. Maximising value from patient choice: suggestions for commissioners

In broad terms, well-implemented patient choice means:

- **adopting a robust process:** conducting an open, transparent, proportionate and fair qualification process that reflects commissioning objectives, promotes a level playing field, monitors and enforces provider contracts, and manages spending
- **empowering patients:** patients need to be aware of their right to choose a provider and have access to information about the options available to them.

5.1.1. Adopting a robust process

Running an open and transparent provider qualification process

1. **Be clear on the objectives for introducing choice and explore impact that choice would be likely to bring in terms of patient outcomes, service quality, demand and budgets.** Setting out objectives at the start can help commissioners get the most value from choice for patients. Objectives might be to meet unmet needs (eg by making it easier for patients to access services), to make services available out of hospital, to improve service quality in other ways, or simply to offer patients choice. Whatever the objective, it is important that it is clear and embedded within the commissioning process. One CCG suggested working with existing and potential providers to explore whether choice is likely to achieve the desired objectives.
2. **Engage early with providers and set out at the start what is expected of them in the qualification process.** We are aware of commissioners working with both potential and current providers to explain their objectives, service specifications and qualification criteria, and other aspects of the process. Examples of this engagement include holding meetings, workshops and information events. Other steps reported by commissioners to have helped with the process included nominating a central point of contact for providers and establishing word limits for applications.
3. **Design the process to encourage provider participation.** There are steps that commissioners can take to achieve this: commissioners and providers highlighted the importance of avoiding (or explaining) some of the NHS terminology that providers may not be familiar with, considering contracting for different service elements separately (eg aftercare), and not using

qualification criteria that unnecessarily limit the ability of certain providers to apply.¹⁶⁵

4. **Make clear at the outset when new opportunities to qualify will arise.** We are aware of several commissioners who have recently decided to invite (or are currently considering inviting) applications from new providers of adult hearing services. This can increase current providers' incentives to deliver quality services.
5. **Make the mobilisation process clear to providers.** This might include specifying and keeping to timelines for awarding contracts, and supporting providers to load information onto the relevant referral system. Some commissioners may find it helpful to consider options to mitigate any impact of providers deciding not to mobilise (eg setting a date by which providers have to mobilise otherwise their qualification expires).

Promoting a level playing field

6. **Align service specifications and prices for all providers of adult hearing services in a given area.** Where commissioners have inherited contracts that include adult hearing services, decisions need to be made on how those contracts will be migrated to the new service specifications and prices, and over what timeframe. These arrangements should be made clear to existing providers ahead of the qualification stage. They should set out proposed treatment of VAT from the outset so that providers can take it into account when building their business cases.

Monitoring services and enforcing providers' contracts

7. Require all providers to supply service outcome data and to **establish processes to ensure regular and accurate provision of data.** For example, we are aware of one area where data is collated and processed by a CSU and reported to the CCG on a monthly basis.
8. **Use provider data to monitor services and obtain patients' feedback** on the quality of services. Patient feedback could be obtained by engaging with local GPs and patient groups, by seeking copies of providers' surveys of patients and/or GPs, or by doing independent patient surveys to confirm whether particular aspects of services are working well (eg follow-up appointments and aftercare). For example, one commissioner surveyed about 60 patients to obtain assurances about the service quality of different providers in the area. Commissioners might also consider using the Action on Hearing Loss evaluation framework; we are aware of a CSU that has found

¹⁶⁵ Two providers told us that they had been unable to apply in some areas due to the commissioner requiring providers to have premises already established in the local area.

the framework useful.¹⁶⁶ Outcomes arising should be discussed with providers.

9. Engage with prospective and current providers to seek feedback on existing arrangements and any issues that providers might face (eg around referral patterns).

Managing spending on services

10. **Anticipate likely increases in the numbers of patients needing treatment at the start.** We are aware of at least one commissioner using the Atlas of Variation¹⁶⁷ to estimate likely levels of unmet need. Alternatively, commissioners might use feedback from other CCGs with similar population coverage and demographics and/or similar service provision.
11. **Consider preparing guidance for GPs when referring patients to ensure services are used by those who most need them.** Guidance might be embedded within referral protocols used by GPs. For example, one commissioner said that GPs were an important gatekeeper to make sure that patients do not get several hearing aids from different providers.
12. **Require providers to report on patients' use of hearing aids to ensure that patients benefit from NHS-funded care.** One of the service outcome measures that providers are required to report against sets a target for the number of patients who continue to use their hearing aids at the review stage (ie after three years). This might be used by commissioners to monitor whether patients are benefiting from their NHS hearing aids.

5.1.2. Empower patients to make informed choices

1. **Secure GPs' support at the outset by explaining the commissioning process and informing them who has qualified.** This should include an explanation of how providers were selected, the quality requirements that were met, the service specifications they work to, and the terms under which providers operate. Some commissioners said that workshops with GPs were useful for this purpose. Some also emphasised the importance of continuing to engage with GPs over time. This includes updating GPs when changes are made to adult hearing services or the provider list, and responding to

¹⁶⁶ Action on Hearing Loss. (2013) Evaluation framework for adult hearing services in England, www.actiononhearingloss.org.uk/evaluationframework

¹⁶⁷ The NHS Atlas of Variation series quantify geographical variations in the use of healthcare services that cannot be explained by differences in patient demographics or patient preferences over how they want to be treated. They aim to support commissioners and clinicians to maximise health outcomes and minimise inequalities by addressing unwarranted variation. See <http://www.rightcare.nhs.uk/index.php/nhs-atlas/>

questions or concerns GPs raise so that they remain confident about the providers and services available to patients.

2. Seek to **engage with and provide information to GP practice staff** as well as individual GPs. The GP interviews suggest that practice staff can be well placed to ensure the information gets absorbed by GPs and passed onto patients.¹⁶⁸
3. **Make information available to patients and GPs about providers and services.** The GP interviews¹⁶⁹ suggest that any information should be succinct, setting out all the local providers with a side-by-side comparison of key aspects (ie waiting times, quality of hearing aids and aftercare). We note that providers' reported outcome data may be a useful starting point. Some GPs also said that receiving patient feedback on local services would be helpful, and that information might take the form of a leaflet for GP practices to share with patients and/or a dedicated online resource.^{170,171} We are aware of a CCG that is looking to distribute leaflets and/or posters about local services for GP practice's waiting rooms. It is also considering distributing samples of providers' hearing aids to GP practices. Commissioners might also consider promoting third party information about providers' services (eg Action on Hearing Loss' online tool Locate and Rate, results of patient surveys undertaken by local Healthwatch teams).
4. **Make arrangements to allow patients to change their provider when dissatisfied with their service.** To the extent that the payment mechanism makes it difficult for commissioners to reclaim payments when patients switch providers, commissioners might make relevant adjustments to the tariff structure which will make it easier to reclaim. Commissioners might also clarify and put in place arrangements so that patients are referred back to their GP at the review stage. This will ensure that patients are reminded that they have a choice and will have support if they want to change provider.
5. **Consider whether there are ways to improve the extent to which services for those with hearing loss are connected.** For example, there may be scope to strengthen existing obligations on providers of adult hearing service to signpost other complementary services. Similarly, providers of other support services might be encouraged to make themselves known to commissioners and providers of adult hearing services.

¹⁶⁸ See, in particular, the GP interviews (the GP interviews report, page 78).

¹⁶⁹ See the GP interviews report, pages 63-64 and 82.

¹⁷⁰ See the GP interviews report, pages 63-64.

¹⁷¹ A patient group said that it was important for patients to be given information that they can take away and consider at home (eg a leaflet), possibly consulting with family and friends before making a decision. Their view was that patients should not be rushed into deciding where to go to for treatment.

5.2. Next steps for Monitor

There are several actions that we will take to make choice work better for patients:

- Hold a number of commissioner workshops to share the insights arising from our research and facilitate the sharing of information between commissioners. We will also publish materials for commissioners that set out key principles of well implemented choice in adult hearing services, including tips for commissioners who are thinking about using patient choice and other resources to aid decision-making.
- Engage with commissioners to consider adding an obligation to the service specifications for providers to inform patients, in their promotional and marketing materials, that they may have a choice of other providers.
- Work with local Healthwatch teams, Action on Hearing Loss and other patient groups to remind patients, in areas where choice has been introduced, of their service entitlements and that they can choose who provides their care
- Explore ways that providers' service outcome data might be shared practically and cost effectively with patients. We propose to undertake a pilot where we will work with a CCG to determine how best to communicate providers' reported data to GPs and patients. We will share any findings of this pilot with other commissioners.
- Review adult hearing services in 12–18 months time to understand the impact of our work and consider whether further action is needed.

5.3. Steps our partners are taking

Some of our partners are also planning to take steps to make choice in adult hearing services work better for patients:

- NHS England and DH are about to publish an Action Plan for Hearing Loss which will cover a full range of hearing issues. Part of this report will be devoted to the development of a commissioning framework for hearing services to provide commissioners with the best possible resource to shape services. We will work with NHS England and DH to help ensure that the insights from our research are made available to commissioners as part of this framework.
- The Commission for Hearing Loss is currently developing their work programme for the year and has already indicated that they believe choice to be at the heart of effective patient care in this area. Monitor has met with members of the Commission for Hearing Loss to discuss their plans and priorities.

- The Hearing Loss and Deafness Alliance is also intending to build on both this report and the NHS England and DH Action Plan on Hearing Loss to create further resources for commissioners, including evidence and guidance on commissioning hearing services.



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work for patients

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.gov.uk/monitor

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