PC 31

Ymchwiliad i ofal sylfaenol

Inquiry into primary care

Ymateb gan: National Community Hearing Association

Response from: National Community Hearing Association

HEALTH, SOCIAL CARE AND SPORT COMMITTEE: CONSULTATION ON PRIMARY CARE

1. The National Community Hearing Association (NCHA) represents community hearing care providers in Wales. NCHA members are committed to good hearing for all and have an excellent record of outcome, safety and patient satisfaction.

2. Making hearing care a primary care service in Wales would reduce pressure on GP practices, ENT departments and hospitals, and help address existing inequalities in access to hearing care. Our response highlights the scale of hearing needs, why action is required and what can be done to improve primary care in Wales.

HEARING NEEDS AND THE IMPACT OF HEARING LOSS

3. Hearing loss affects half a million people in Wales. Age-related hearing loss is the single biggest cause of hearing loss and the main reason people visit hearing services (also known as audiology). As the population grows older more people will develop a hearing loss and the demand for NHS hearing care will increase exponentially.

4. Unmet hearing needs are a major and growing public health challenge[1]. Hearing loss is the 5th leading cause of years lived with disability in Wales[2] and one of the most common long-term conditions in older people. Unsupported hearing loss increases the risk of depression[3], loneliness[4], isolation[5], early retirement[6] and cognitive decline[7]. Quality hearing services limit these impacts of hearing loss and help people to stay healthy and independent for longer. Investing in hearing care can therefore reduce the pressures on health and social care[8].

HEARING CARE

5. The vast majority of people with hearing loss will have age-related or noise-induced hearing loss, for which there is no medical cure. These patients require support from non-medical adult hearing services. It is estimated that 50,000 referrals are made each year to the adult hearing service. In addition to this an estimated 117,000 people will seek help for impacted earwax. These are not medical problems, yet the vast majority of these individuals will see a GP, an ENT doctor or both. This highlights how the existing model of hearing care in Wales is over medicalised. Evidence-based reforms will benefit patients, the NHS and taxpayers.

TAKING ACTION IN PRIMARY CARE

How GP cluster networks in Wales can assist in reducing demand on GPs and the extent to which clusters can provide a more accessible route to care (including mental health support in primary care).

6. GP cluster networks can help reduce demand on GPs by adopting evidence/risk-based referral and treatment criteria for adults with hearing loss. For example, the USA and other countries have reviewed the evidence and risks, and come to the conclusion that adults (aged 18 and over) should be able to access non-medical hearing care directly – i.e. there is no need to see a GP first[9]. This would save at least 50,000 GP visits per year, and potentially as many as 160,000 if earwax was also managed by adult hearing services.

7. There is no evidence-based reason to make adults see their GP in order to access non-medical hearing services. In fact non-NHS patients can and do already see hearing care professionals without a GP referral. The NHS in contrast requires each patient to visit their GP, and often an ENT doctor, before they can access a hearing aid service. This is analogous to making every adult that only needs spectacles see their GP for a referral, and then have many people unlikely to have medical eye problem see an ophthalmologist – i.e. it is a system that would be unsustainable in eye care, and one that is increasingly unsustainable in hearing care. This is why NHS commissioners in England have started to address inequalities in access, with 50% of commissioners focussing on providing a community-based rather than hospital-based hearing service and others removing the requirement to see a GP before accessing NHS hearing care

The emerging multi-disciplinary team (how health and care professionals fit into the new cluster model and how their contribution can be measured).

8. Hearing care professionals, registered with the Health and Care Professions Council (HCPC), can be part of multi-disciplinary teams. They can perform diagnostic assessments in primary care, support people with hearing loss and manage earwax. This will help address both unmet hearing needs and the growing needs from an ageing population, in a sustainable way. It will also address existing capacity and workforce constraints.

9. The reduced number of visits to GPs and ENT for non-medical hearing problems – e.g. age-related and noise-induced hearing loss and earwax management – could be used to measure the impact of service changes. Reducing false positive referrals to ENT could also be used as a measure of the positive contributions HCPC registrants can make to local services.

The current and future workforce challenges.

10. GPs, ENT departments and NHS hearing services are under significant pressure

and all face workforce challenges. GPs and ENT might require significant investment to address workforce and capacity challenges. Hearing care however is an exception, in that HCPC registered hearing care professionals living and working in Wales want to offer NHS services in the community – as they can and do in England – but the NHS in Wales does not yet commission services from them. It is only once Wales uses the entire qualified and registered hearing health workforce that it will be able to reduce pressure on GPs, reduce unnecessary referrals to ENT and hospital and deliver more cost-effective services overall.

The funding allocated directly to clusters to enable GP practices to try out new ways of working; how monies are being used to reduce the pressure on GP practices, improve services and access available to patients.

11. We support the principle of allocating funding directly to clusters of GP practices to try new ways of working with partner agencies and local providers. For example in parts of England GP surgeries offer hearing care and/or use local community-based providers so that patients do not have to visit acute hospitals or limited charity-based services for non-medical care.

12. GPs and clusters would also be able to work with community-based hearing care providers to reduce referrals to ENT. For example we estimate that 45% of referrals waiting for adult hearing services in Wales come via ENT departments, when – based on the burden of disease data – we would expect this to be less than 10%. If GPs work with a wider range of stakeholders they will be able to reduce visits to hospital and GP practices, at the same time as improving access to hearing services.

*Local and national leadership supporting the development of the cluster infrastructure; how the actions being taken complement those in the Welsh Government's primary care plan and 2010 vision, **Setting the Direction**.*

13. We have been long-standing and public supporters of the Welsh Government's primary care plan and 2010 vision *'Setting the Direction: Primary & Community Services Strategy Delivery Programme'*, including
    - the majority of health care needs can be met in the community (p.5)
    - services should be of high quality and convenient for local people (p.4-5)
    - the "*aim to deliver community-based services across Wales that are reliable and accessible irrespective of where people live*" (p.6), and
    - that success would depend on a "*system that provides the right treatment and care to the right patient at the right time in the right place by the right person in the right way*" (p.13).

14. Unfortunately progress over the last seven years has been slow, especially in hearing care. As noted above, people in Wales still have to see a GP, and often an ENT doctor, before being able to access non-medical hearing aid services with no evidence whatsoever of this improving outcomes, the pathway, the patent experience, cost-effectiveness or demand management. All the data point in the opposite direction as well as putting excessive pressure on GPs and

hospitals, and requiring the people of Wales to confront unnecessary barriers in accessing care.

15. Patients also have to travel considerable distances for a service that can be delivered locally. For example, the main reason a person will visit adult hearing services in acute hospital settings is to have their hearing aid repaired (aftercare), and it is clear this was not the vision set out in the Welsh Government's primary care plan and 2010 vision, *Setting the Direction.*

16. Charities and policymakers have long recognised that visiting hospital when you are not ill is not in the best interests of patients or the NHS. Delivering non-medical hearing services out of hospital and closer to home has therefore been a longstanding goal. It is also widely recognised that patients would benefit, for example the UK Heads of NHS Hearing Services recognise that care closer to home is a major benefit for patients in terms of improved access and that this would also support more patient benefit from hearing aids through better wear[10].

17. Despite the many documented advantages for patients and the wider NHS, the NHS still fails to provide people with hearing loss with "*the right treatment and care to the right patient at the right time in the right place by the right person in the right way*". The reason for this, in our view, is the failure of the NHS to engage with a more diverse range of stakeholders – e.g. when local and national leadership has tried to transform services they have faced opposition from hearing care professionals that wish to continue working in acute sector settings. This resistance to change has also resulted in an avoidable capacity shortfall, which continues to present a risk to the quality of care –e.g. although follow-up care is critical to good outcomes, in some cases waits of up to 17 months for follow-up have been reported[11]. As the population grows older and hearing needs increase, the impact of capacity shortfalls will become more problematic and, to avoid systems failure, action and leadership from the Welsh Government and NHS Wales is urgently required to ensure services are designed around the needs of patients, not institutions.

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[1] NHS England (2015), Action Plan on Hearing Loss, p.12

[2] Vos, T et al (2015), Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet

[3] Acar, B. et al. 2011. Effects of hearing aids on cognitive functions and depressive signs in elderly people. *Archives of Gerontology and Geriatrics*, 52(3), pp. 250-252.

[4] Cacioppo JT, Hawkley LC, Norman GJ, Berntson GG. Social isolation. *Ann N Y Acad Sci*. 2011;1231:17-22

[5] Hidalgo, J. L. et al. 2009. Functional status of elderly people with hearing loss. *Archives of Gerontology and Geriatrics,* 49(1), pp. 88-92

[6] Helvik, A. 2012. Hearing loss and risk of early retirement. The Hunt study. *European Journal of Public Health,* 23(4), pp. 617-622

[7] Lin, F. R. et al. 2011. Hearing Loss and Incident Dementia. *Archives of Neurology*, 68(2), pp. 214-22; Lin, F. R. et al. 2011 Hearing loss and cognition in the Baltimore Longitudinal Study of Aging. *Neuropsychology*. 2011; 25(6):763-770.

[8] Monitor (2015), NHS adult hearing services in England: exploring how choice is working for patients, p.6

[9] National Academies of Sciences, Engineering, and Medicine. 2016. *Hearing health care for adults: Priorities for improving access and affordability*. Washington, DC: The National Academies Press. doi: 10.17226/23446, pp.4-5

[10] Reeves, D.J. et al., 2000, *Community provision of hearing aids and related audiology services*, *Health technology assessment*, vol. 4, no. 4The survey had a 77% response rate in Wales. The original paper can be found here: http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0008/64817/FullReport-hta4040.pdf

[11] Smith, 2014 http://www.walesonline.co.uk/news/local-news/patients-cwm-taf-health-board-7318502