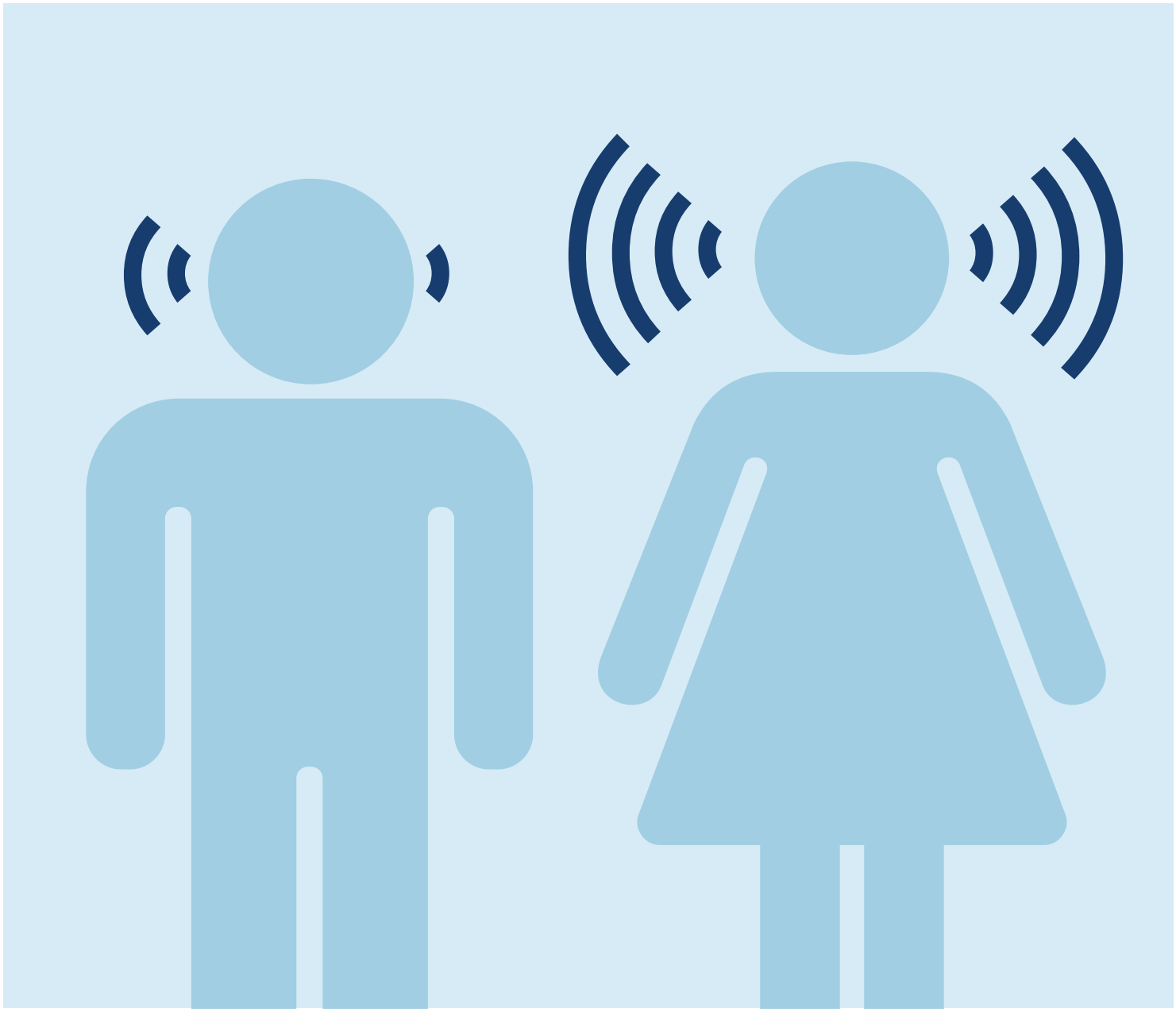


Commission on Hearing Loss:
Final Report

July 2014

www.ilcuk.org.uk

This project has been kindly supported by Boots Hearingcare.

Contents

Foreword

from Baroness Sally Greengross, Chair of the Commission and Chief Executive of ILC-UK

The International Longevity Centre-UK is delighted to have set-up the Commission on Hearing Loss. For too long, hearing loss has been ignored, overlooked and disregarded despite the millions of people experiencing hearing loss and the devastating consequences that it can have on individuals, their families and society as a whole.

By 2031, nearly 20% of the UK will have hearing loss. We must get hearing loss up the agenda and ensure that more people are able to access good hearing care services, and that society as a whole, is ready for hearing loss. We hope this Final Report from the Commission and the bold recommendations contained within it, will go some way to addressing this large and growing challenge. In this regard, I would like to emphasise five of our main calls:

- **For attention of NHS England and Department of Health:** Government should publish the long-awaited Action Plan on hearing loss. But this must be allied to a national commissioning framework and an appropriate NICE quality standard to ensure high quality services are consistently provided, developed in consultation with patient groups, individuals and professionals – representing the public, private and third sector.
- **For the attention of Public Health England:** We must focus efforts on earlier detection of hearing loss through the delivery of a nation-wide screening programme.
- **For the attention of Department of Health:** We must consider opening up hearing services so that people can self-refer. This will increase accessibility and reduce the likelihood of people falling through the net.
- **For the attention of Clinical Commissioning Groups:** There must be enough flexibility in the hearing assessment, follow-up and aftercare to ensure that it matches peoples' preferences. This may include an expansion of community-based hearing care as well as home visits.
- **For the attention of NHS England, the Department of Health and providers:** Timely follow-up and accessible aftercare must become routine in all instances across the UK to ensure appropriate outcomes are met.

We strongly recommend that you read this report in full to gain an understanding of the implications of doing nothing and how we can better support those with hearing loss in the UK. Ultimately, taking action is in all our interests. So let us do away with talk about the stigma of hearing loss, and embrace the vast role that those with hearing loss play on a daily basis in the home, the workplace, the community and more.

1. Background and role of the Commission

The terms of reference for the Commission on Hearing Loss – an independent Commission set up by the International Longevity Centre-UK - are to consider the extent of the challenges posed by age-related hearing loss in the UK and how it can be tackled. Commissioners, drawn from a wide-range of different background and sectors, were asked to consider a number of critical questions as part of a series of oral evidence sessions:

- How and to what extent can hearing loss impact on a person's quality of life?
- What are the wider implications of hearing loss with regard to social isolation, loneliness and exclusion, employment and extending working life, equal access to health and social care?
- What are the current barriers which prevent early detection and support of hearing loss?
- How can we support people to recognise their hearing loss earlier and come forward for help?
- How can we de-stigmatise hearing loss and the use of hearing aids?
- How can public and private health and social care providers improve early detection and hearing services?

How has the Commission addressed these questions?

In addressing the key questions, we draw on ideas, evidence and information from a variety of sources to shape our thinking about the challenges posed by hearing loss. This has included:

- Undertaking background desk research.
- Holding two oral evidence sessions with subject matter experts and Commissioners in the House of Lords.
- Issuing a call for written evidence through the ILC-UK's networks, inviting responses from experts including academics, representatives from private and public health organisations and charities.
- Producing a final report prepared by the ILC-UK bringing together the findings set out in the initial scoping paper, the collated evidence from the oral and written evidence sessions and the agreed future priorities for action and research.

The Commissioners

Chair: Baroness Sally Greengross

Paul Breckell, Chief Executive, Action on Hearing Loss

William Brassington, President of the British Academy of Audiology

Peter Ormerod, Boots Hearingcare

Baroness Howe of Idlicote

Rosie Cooper MP, Member of Parliament for West Lancashire

For biographies on each of the Commissioners please see Appendix A.

Acknowledgments

The Commission is extremely grateful for all of the expert witnesses who provided oral and written evidence for this Commission and we are especially grateful for all those who submitted evidence about their personal experiences of hearing loss. Without all of these individuals there would be no Commission – so we would like to take this opportunity to thank them all. Many thanks also to Sir Malcolm Bruce MP who acted as a stand-in Commissioner for our first oral evidence session. A list of the contributors can be found in Appendix B. Alongside this final report, the Commission is separately publishing the written and oral evidence that was submitted to the Commission – excluding submissions where the author/s explicitly asked for their evidence to not to be included. This project has been kindly supported by Boots Hearingcare.

2. Executive summary

The prevalence and impact of hearing loss

- Hearing loss is a major public health issue in the UK – with an estimated 10 million people experiencing hearing loss today.
- Hearing loss is set to become an even bigger issue over the coming decade given the rising number and proportion of older people. By 2031, it is expected that there will be 14.1 million people in the UK with hearing loss – accounting for nearly 20% of the total population.
- Hearing loss can have devastating implications for the individual with hearing loss as well as for their family with research showing that those with hearing loss are more likely to have communication difficulties, become socially isolated and have mental and physical health problems. And there is a growing body of research showing an association between hearing loss and dementia.
- Those with hearing loss are also significantly less likely to be in employment than the general population. New analysis undertaken for this report, estimates that this costs the UK economy almost £25bn per annum in terms of lost output.
- The devastating impacts of hearing loss for the individual and for society could be avoided if there was better support for those with hearing loss – including improved provision, take-up and use of hearing aids.
- However, research suggests that of the 6 million people who would benefit from using a hearing aid just 2 million have an aid, and of this two million who have aids, 30% do not use them.

Why are so many with hearing loss not getting the support they need?

Not seeking support in the first place

- Hearing loss has slow onset – partly for this reason, it takes on average 10 years before someone with hearing loss recognises that they have it and seeks support.
- There is a stigma associated with hearing loss which acts to prevent people from seeking help – with misperceptions about what hearing loss represents and about the nature of the interventions that are possible to support those with it.
- Hearing loss is seen as part of the ageing process – something that individuals may not be willing to admit helping to reinforce stigma.

The current NHS referral system

- Currently in order to have a hearing test from which an NHS hearing aid can be fitted, individuals must be first referred from their GP. Yet there is evidence which suggests that 45% of people who go to their GP to seek help for their hearing loss, do not get referred on.
- While the GP does refer over half of people with hearing loss, there is a fundamental question about whether the system should be opened up to ensure less barriers before having a hearing test.

The Hearing aid fitting process, follow-up and outcomes

- Having a hearing aid fitted is not like having a pair of glasses fitted. The audiogram – a test which is used as the basis for fitting the aid – is not perfect and can mean that individuals require further appointments to fine-tune the aid.
- There is limited public knowledge about this process and understanding of the issues and solutions associated with fitting and adjusting a hearing aid.
- Follow-up appointments and ongoing aftercare are critical to ensuring people get the most out of their hearing aids, but the knowledge and prevalence of these is varied.
- There is little knowledge about the outcomes for individuals of this entire process.

The "medicalised" nature of interventions

- The entire process of having a hearing aid fitted can be overly clinical and often takes place within hospital settings following referral by the GP.
- While hospitals undoubtedly have a role to play in supporting the needs of those with hearing loss, there is a suggestion that the entire process of intervention places too much emphasis on the medical nature of hearing loss which helps to reinforce the stigma associated with it. A person-centred approach, emphasising the needs and experiences of the individual, and providing holistic support and advice, would allow more emphasis on the social impacts of hearing loss.

Recommendations

- *There is an urgent need to detect hearing loss earlier. To support this aim there is a need for a national screening programme for adults and for hearing loss to be built into health check-ups for those likely to be at risk of hearing loss.*
- *There is a need to open up the system to reduce the likelihood of people dropping out of the system before seeing an audiologist. But there will need to be pilots of alternative models such as self-referral to see what works best.*
- *There should be enough flexibility in the way the hearing service is provided to ensure that it matches peoples' preferences. This may include an expansion of community-based hearing care services provided by the public, private and voluntary sectors, as well as home visits.*
- *Every person fitted with a hearing aid should receive a face-to-face follow-up appointment and ongoing aftercare whenever they need it. These should also be provided in accessible and convenient ways so that people are able to access help easily. Measures should be taken to properly assess and quantify the impact of proper follow-up and aftercare.*

Failure of government to design and implement a strategy on hearing loss

- Despite the significant and growing numbers of people with hearing loss and the devastating impacts that it can have on personal health and wellbeing as well as the wider economy, the Government is yet to design and implement a strategy to integrate and improve services for people with hearing loss.
- Rather than considering the wider cost of hearing loss including treatment for more serious conditions further down the line, there is a temptation for increasingly resource constrained CCGs to focus on the relatively small immediate costs of providing hearing services without considering the extensive longer-term benefits, including their associated cost savings.

Recommendations

- *Strategic direction is needed now given the possibility of some CCGs reducing their hearing services and the wider demographic challenge of population ageing, and the need for more holistic and integrated hearing services.*
- *In this regard, the Government should publish the long-awaited Action Plan on hearing loss. But this must be allied to a national commissioning framework and an appropriate NICE quality standard to ensure high quality services are consistently provided, developed in consultation with patient groups, individuals and professionals – representing the public, private and third sector.*
- *Uncorrected hearing loss is associated with other physical and mental health issues so a failure to provide support early will result in greater overall costs to the NHS and to the local CCG as a consequence of more complex health issues developing.*

A lack of wider support for those with hearing loss

- There is an apparent lack of knowledge and support across society as a whole about hearing loss.
- This lack of knowledge pervades through many aspects of our daily lives including institutional settings such as GP surgeries, hospitals and care homes as well as other areas such as the entertainment sector and transport.
- There is also a lack of knowledge and support from employers which, research shows is likely to be at the heart of lower employment rates amongst those with hearing loss.
- The Government's Access to Work scheme is very important in this regard because it provides financial support to deliver suitable adjustments such as communication support and/or equipment to help those with disabilities in the workplace, but it is being weakened.
- In all of these settings there is often little consideration taken for ensuring that the needs of those with hearing loss is fully supported – though there are important exceptions.

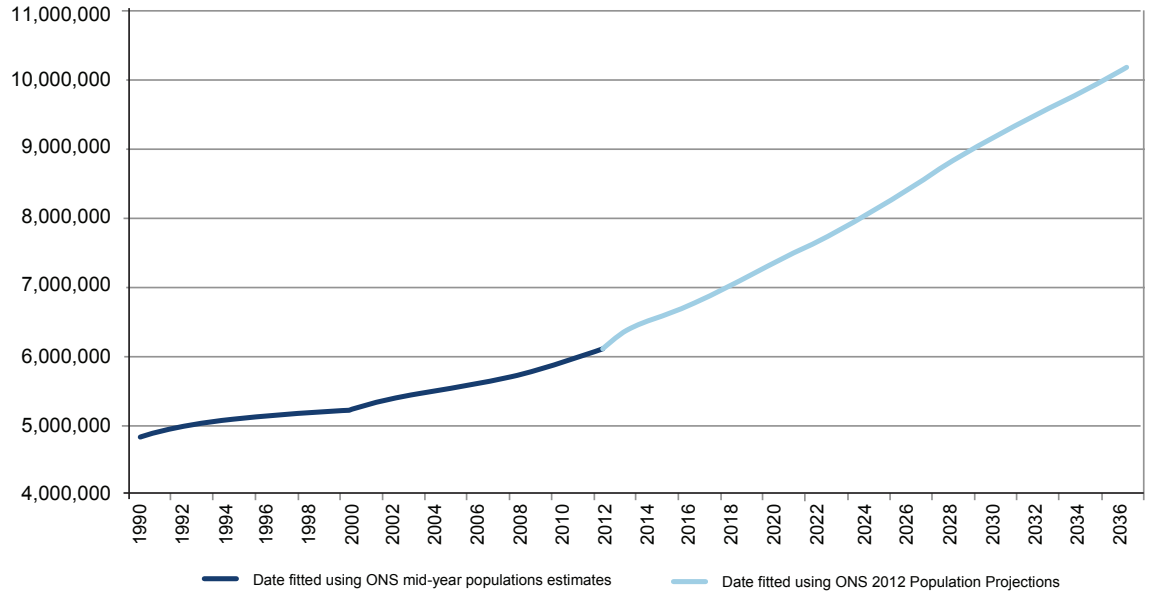
Recommendations

- *There is a clear need for a public information campaign on hearing loss as part of a wider long-term strategy to raise awareness amongst the general population.*
- *Training requirements for health and social care professionals must include specific points about the impacts of hearing loss on individuals and society as a whole, as well as recognising hearing loss, referring to hearing services, and managing hearing loss, including how to ensure good communication with the person and the proper use of equipment such as hearing aids and loops.*
- *Human Resource professionals must act as key agents to drive cultural change within organisations to ensure that people with all disabilities are included rather than isolated by day to day activities.*
- *Access to Work must be strengthened to provide more support for people with disabilities including hearing loss – ultimately it is in the Government's fiscal interest to ensure more people with hearing loss are in work.*
- *Easy, low cost changes can be made to all public and institutional settings to ensure that the needs of those hearing loss are better taken into account.*

3. Introduction: the rising social cost of hearing loss

An estimated 10 million people in the UK are affected by some degree of hearing loss. With rates of hearing loss more prevalent amongst older people, the numbers of people with hearing loss is likely to increase over the coming decades. According to current estimates, the numbers of people with hearing loss will increase from 10 million today to 14.1 million by 2031[1]. For people with hearing loss of at least 35 decibels (moderate hearing loss and above) numbers will increase from just over 6 million today to over 10 million by 2037 (see chart)[2].

Figure 1: Estimates of number of people with hearing loss of at least 35 db across the UK 1990-2037



Source:ONS, Forman and Holman (2014) and author's calculations

Despite the high and rising number of people with hearing loss, it receives relatively little public attention and there is limited widespread understanding of the detrimental impact that hearing loss can have, either for the individual and their family, or for society as a whole.

Yet evidence has shown that there can be significant personal and social costs of hearing loss. This can include increased social exclusion and loneliness as individuals with hearing loss withdraw from social activities, as well as reduced economic activity as a result of people exiting the labour market. And research from the USA has also provided strong evidence that hearing loss increases the risk of dementia – people with mild hearing loss have twice the risk of developing dementia, and this risk increases to three times for people with moderate hearing loss and five times for people with severe hearing loss – a finding confirmed in the UK in the Chief Medical Officer's report for 2012[3].

The lack of public awareness of the issue is worrying – earlier intervention including the use of hearing aids can prevent some of the worst effects of hearing loss including social isolation.

[1] Hearing Matters (2011) Action on Hearing Loss
[2] Author's calculations using ONS population projections and 1995 hearing loss prevalence rates reported in Forman and Holeman (2014).
[3] Lin, F.R., et al., Hearing Loss and Incident Dementia. Arch Neurol, 2011. 68(2): p. 214-220; Annual Report of the Chief Medical Officer, Surveillance Volume 2012 (2014) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/298297/cmo-report-2012.pdf

Yet there is evidence of significant delays in people seeking help for hearing loss, while it has also been suggested that GPs fail to refer a significant proportion of people reporting hearing loss for any intervention[4].

Even amongst individuals who are referred and start to use hearing aids, a significant proportion do not use them consistently or stop using them altogether. This may be partly because there remains a degree of stigma associated with wearing hearing aids, as well as a lack of follow-up, aftercare and support. It is also worth noting that the outcomes of hearing aid fittings are not routinely measured.

We are in need of an overarching strategy to tackle hearing loss that does not just cut across Government departments but involves the multitude of sectors and stakeholders involved with hearing loss in the UK. By integrating and improving services, and avoiding more costs in the longer term, this will help to alleviate continuing funding pressures on central and local government budgets.

As the UK continues to age, it is crucial we face these questions today and ask how we can deliver better support for the increasing number of people with hearing loss.

[4] Hearing Matters (2011)

4. Headline stats

"Adding life to years, not years to life"

Over 10 million people in the UK have hearing loss – accounting for **one in six of the population.**

Yet only **2 million out** of **6 million people** who could **benefit from hearing aids** have access to them.

Of **2 million people** who have hearing aids, **30% do not regularly use them.**

By 2031 it is estimated that **over 14.1 million people** will have **hearing loss** – accounting for **19.8% of the population.**[5]

5 Action on Hearing Loss (2011), ONS Population Projections: Principal Projection 2012 and author's calculations.

The economic cost of hearing loss

- New analysis undertaken by the ILC-UK attempts to put a figure on the economic cost of hearing loss.
- We calculate that in 2013, due to lower employment rates for those with hearing loss than across the rest of the population, the UK economy lost **£24.8bn** in potential economic output.
- Using the ILC-UK's economic growth model, we project that, if nothing is done to address lower employment rates for those with hearing loss, in 2031 the UK economy will lose £38.6bn in potential economic output.
- The cost of hearing loss could be more if levels of underemployment for those with hearing loss is also taken into account.

See **Appendix A** for the methodology underpinning our calculations.

5. The journey for those with hearing loss

Much of the evidence obtained over the course of the Commission referred to various elements of the route or journey that individuals with hearing loss will go on before they receive some sort of support for their hearing loss.

1. Gradual awareness of hearing loss

The first part of the journey, is for the individual affected by hearing loss to realise that they are actually experiencing it and then taking some form of action. Many of those who gave evidence discussed the often significant time frame between when someone first develops hearing loss and when they seek help. Dr Roger Wicks, Director of Policy and Campaigns at charity Action on Hearing Loss said that people wait "on average 10 years" before seeking support for their hearing loss, while Dr Huw Cooper noted that the time frame can range from "8 to 20 years". This is a substantial amount of time to wait, during which the person's hearing is likely to have deteriorated further with significant consequences for their quality of life.

One of the reasons why people do not seek help for so long is because of the slow onset of hearing loss. Kevin Munro, Ewing Professor of Audiology at the University of Manchester noted that one of the biggest barriers to seeking help is that "hearing loss is slow, it is insidious, it creeps up on us and we don't recognise and notice that it is coming along". Professor Munro argued this is partly driven by low levels of public awareness about hearing loss and about the kinds of interventions that it is possible to make to improve quality of life.

On a related theme, gradual awareness may also be driven by a lack of public acceptance about age-related hearing loss as a problem. Ruth Morgan-Jones, author of a book on the impact of hearing impairment on family life as well as someone who has hearing loss suggested that when there is "more public acceptance of a problem, people are less inclined to deny they have it". There is a common perception that age-related hearing loss is just a natural part of ageing rather than something that can be addressed in a number of effective ways in its own right.

It was also suggested that a failure to seek support may stem from the stigma associated with hearing loss – with Helen Cherry, a service user and provider, noting that the "subconscious image of deaf dumb is still with us". People will not want to seek help and thereby own up to something that has this kind of connotation. As Ms. Cherry notes:

"When hearing begins to become difficult there is this rooted subconscious judgement that potentially prevents 'putting hand up' to acknowledge hearing has diminished and seek help".

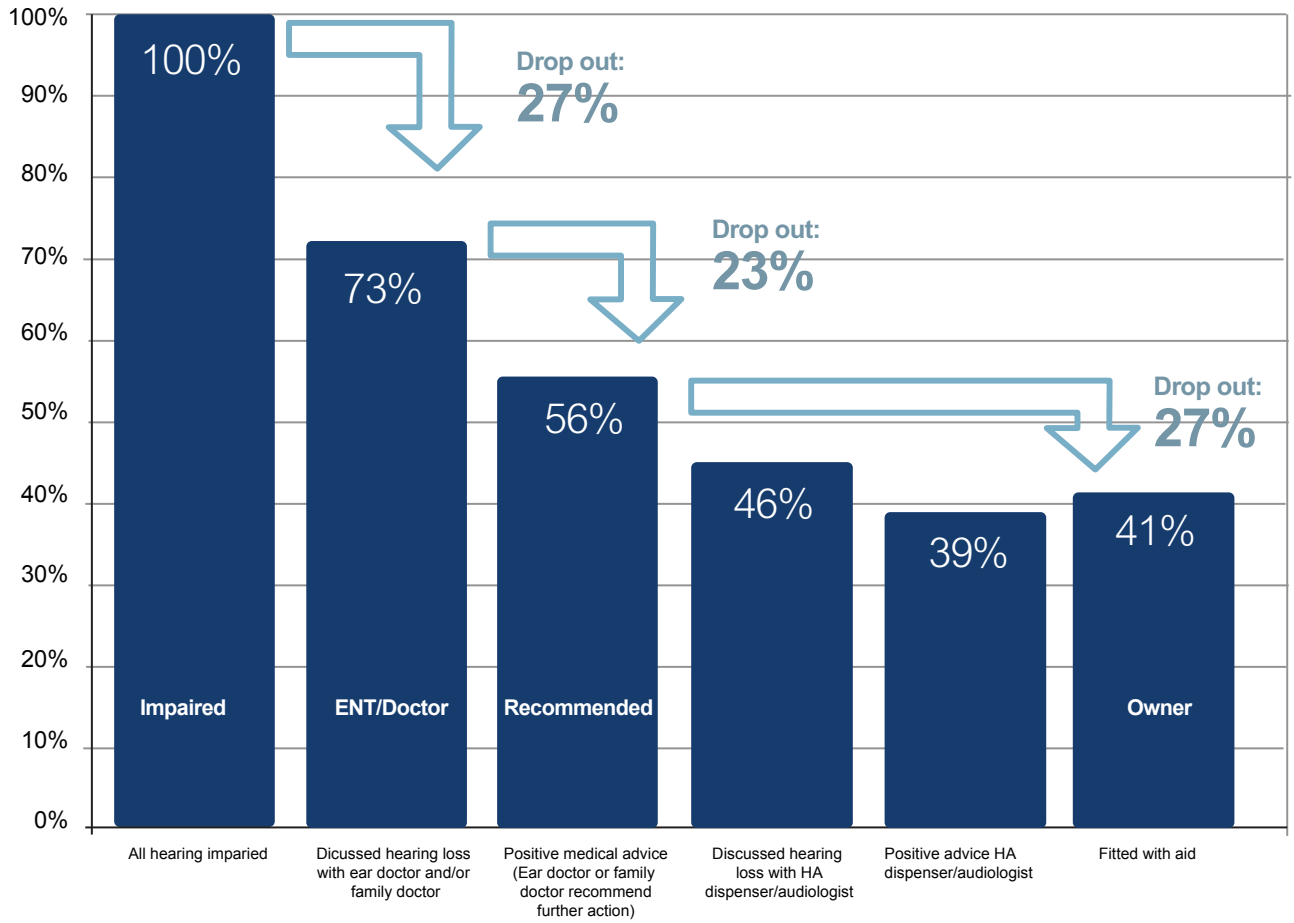
Helen alongside many others argued that awareness raising is the most critical issue in ensuring that people take the first step and seek help. Others also suggested that earlier interventions including the use of nationwide screening for people over a certain age would help to kick-start the process of people seeking help. It was also acknowledged by some, that in many cases, the initiative to seek support is taken by loved ones rather than the person with hearing loss.

2. Seeing the GP

Currently, in order to have an NHS hearing aid fitted, individuals must first go to their GP and then get referred on to an audiologist who will undertake a hearing test. A number of submissions questioned whether GPs were supporting those with hearing loss effectively enough and a few went on to suggest that the requirement to go to see the GP in order to seek help was an unnecessary part of the process.

In their written submission to the Commission, Action on Hearing Loss referred to "one study that found that 45% of people who went on to get a hearing aid were not referred on for a hearing assessment when they first raised their hearing loss with their GP". Similarly Lawrence Werth, Chairman of the British Hearing Aid Manufacturers Association, directed the Commission to some research undertaken by EuroTrack UK showing drop-out rates at various points in the process – with 23% of people dropping out after discussing hearing loss with their doctor (see chart). While the difference in the findings over the two studies is large, they both still demonstrate that a significant number of people who think they have hearing loss fall out of the system before going to see an audiologist.

Figure 2: The current route to a hearing aid



Source: EuroTrack UK

A number of the witnesses and written submissions discussed the process of going through a GP to get referred and the issues involved. Nathalie Sfankianos, who has hearing loss, summed up her experiences with her GP:

"My GP obviously has no idea of what it's like to have hearing loss and doesn't seem to be making any concessions so immediately you are put on the back foot, you feel you are making a fuss and this is where the stigma starts to build up".

In response to the large numbers of people failing to reach an audiologist and some of the negative experiences commented on by those with hearing loss, one clear recommendation was to improve training for GPs on the impact and management of hearing loss, so that they better understand how to recognise and undertake simple checks for hearing loss, encourage patients to seek help, and provide advice and

information to people with hearing loss and their families, including on the range of services that people with hearing loss can benefit from.

Too many hoops and barriers

While the argument for more GP training and information on hearing loss is unlikely to be controversial, there was also a more radical view taken by many of the experts and summed up by Huw Cooper:

"The argument for this initial step (referral from GP to audiologist) *is that the GP can triage patients to ensure appropriate referrals are made, but for large numbers of people with non-complex age related hearing loss this might be an unnecessary step,* as it *produces an unhelpful barrier and perpetuates the association of hearing loss with illness."*

David Greenberg, Research Associate at University College London, agreed with this and said that while GPs do a "fantastic job" at being on the front line "there is no real need for the GP to be the first stop rather than presenting straight to the audiologist". Former Care Minister Phil Hope said taking the GP out of the care pathway would help to reduce the many "barriers and hoops" that deter people from seeking help and exacerbated the stigma attached to hearing loss.

But not everyone agreed with the argument that GPs were an unnecessary part of the process. Brian Lamb, Chair of the Hearing Loss and Deafness Alliance stated that the "the Alliance would not write off GPs as one of those routes [for getting hearing checked]. 50% may not be going [to see their GP because of hearing loss] but 50% are…let's look at a number of routes".

Clearly with so many people going to their GP for information and to seek help, the GP is a useful touch point for those with hearing loss – even if not enough people are being referred. In future it may be that the ideal scenario would be to open up multiple routes, including the GP in order to ensure people can gain open access to the hearing services that they need.

3. Going to see the audiologist

If the GP thinks someone may have hearing loss, they will be referred to an audiologist to test the individual's hearing and fit a hearing aid. As a consequence of the introduction of Any Qualified Provider (AQP), individuals in some areas can choose where they go to get their hearing tested and hearing aids fitted – it does not have to be in a hospital setting though in practise it often is.

Similar to the experience of going to the GP, a number of the submissions raised concerns about the medical or clinical nature of going to the audiologist as well as the lack of adaptations made to ensure that the process was accessible for individuals with hearing loss. Nathalie Sfakianos, for example, noted that her local audiology department persisted in calling out names – which seems bizarre given the nature of the issues that individuals visiting that department were experiencing. Writing from personal experience one submission noted that having the aid fitted by the audiologist is "quite technical with the patient allocated a short appointment time". The demand for more patient time was echoed by Teresa Sienkiewicz – another who wrote to us with personal experience of hearing loss.

To help improve the process of visiting the audiologist, David Greenberg recommended ongoing education for people at the front line including audiologists to better take into account the changing preferences of those with hearing loss. Others suggested that the NHS needed a greater number of audiologists to meet the demand and have more flexibility to provide a more person-centred service.

4. The audiogram and fitting the aid

As part of the hearing assessment, individuals will have an audiogram. While the audiogram is undoubtedly a useful way of assessing hearing loss it has its limitations. Corne Kros, Professor of Neuroscience at the University of Sussex said that the "traditional audiogram…requires quiet and needs calibration and doesn't capture all hearing loss". As a result, he noted that someone with hearing loss can record a "perfectly normal audiogram but…still struggle [to hear] in a room full of people". A number of other experts shared this sentiment with Lawrence Werth noting that audiograms were never intended to be used to fit hearing aids – a process which he called "flawed" but added that we "haven't yet got the prospect of a relevant solution". Teresa Sienkiewicz explains from the perspective of someone who has personal experience of the process:

"It really does take time to adjust to wearing an aid and it may be necessary to have a number of appointments to obtain the optimum solution for an individual's type and level of hearing loss. I recently acquired a new aid and really struggled with it despite wearing an aid for over 40 years… new wearers may not appreciate that sometimes it is a process of trial and error".

In one submission, it was noted that in the absence of prior knowledge about the process, and training about how to listen with a hearing aid, patients may simply take out the hearing aid and may not put it back in again. **Many of those giving evidence argued that better education and information for those using aids plus better follow up arrangements after the initial fitting are needed to ensure that individuals make the best use of their aids. Hearing therapy, counselling, lipreading classes, befriending, advice and group support sessions with other hearing aid users can also be very beneficial.**

5. The benefits and limitations of hearing aids

Research has shown that there are wide-ranging benefits to using hearing aids. In his oral evidence session, Lawrence Werth highlighted many of these benefits using results from a survey undertaken by EuroTrack:

- 83% of hearing aid owners who are working think their hearing aid(s) are useful for their job.
- The proportion of people suffering from symptoms of depression are far higher in the group with hearing loss but without a hearing aid than the group with hearing loss but with a hearing aid.
- Symptoms of dementia are also higher in the group with hearing loss but without a hearing aid than those with hearing loss but with an aid.

Alongside these benefits, a number of expert witnesses also noted the aesthetic improvements that have been made to hearing aids. Dr Huw Cooper for example spoke about how the typical NHS choice of hearing aids – which are free at the point of use – are far from the clunky piece of technology that people expect. Dr Cooper noted that "even in the NHS after many years of the availability of cosmetically attractive, high quality digital hearing aids, many patients come for hearing assessment with totally inaccurate expectations of what modern hearing aids are like and what the NHS has to offer."

Despite the provision of a choice of good free hearing aids via the NHS, a running theme throughout the evidence sessions was a desire for greater personalisation of aids and improved links with other forms of technology. Baroness Barker said for example, that "we will have got somewhere the day that we can walk into an apple store or go and buy a hi-fi that enables us to set the settings for our hearing aids to our personal profile" while allowing us to "amplify speech

and cut down background noise". It was noted that this is already starting to happen with technology allowing hearing aid users to hook up and control their devices through smartphones and starting to use hearing aids as communication hubs.

Alongside the digital NHS offerings, there are a wide variety of different aids available via the private sector. The counter challenge was that hearing aids are still not viewed in the same light as glasses. Rather than glasses, which are now perceived as something of a fashion accessory, it was noted that for hearing aids, the emphasis remains on invisibility. As Dr Huw Cooper noted, this approach may help to "*…reinforce the stigma of hearing loss by emphasising the need for small or invisible amplification. In contrast…the vision industry has successfully turned spectacles into fashionable attractive items people are happy to wear and see it as part of their overall appearance".* However, there remains limited research on the actual preferences of consumers in this regard.

With regard to the limitations of hearing aids, many of the comments within the evidence sessions and written submissions referred to the fact that it can take a while to fine-tune the hearing aids – amplified sound is not the same as normal hearing and background noise is often reported to be an issue. A key concern was therefore how individuals with hearing loss were supported after the initial fitting. Personalisation is not therefore just about the type of hearing aid, it was argued, but also about individualised care and support afterwards. In a written submission from private provider umbrella body The British Society of Hearing Aid Audiologists (BSHAA) it was argued that:

"…there must be a consistent and positive representation of hearing aids as beneficial devices fitted by professionals with a protocol which offers continuing support to optimise outcomes so that satisfied hearing aid users become advocates for others".

The BSHAA refers to the Swiss model of hearing provision which allows fitting and trial of different types of devices and provides ongoing counselling after fitting. Just 3% of Swiss hearing aid owners are nonusers by comparison to 30% in the UK. Hearing therapy, lipreading classes, assistive equipment, befriending, advice and group support can also be very helpful in providing a personalised service to ensure the person gets the most benefit out of their hearing aids.

Towards de-medicalisation?

Underpinning some of the arguments about the limitations of hearing care, is the notion of it being "medicalised" which, it was suggested adds to the stigma of hearing loss. Professor Kevin Munro summed up this position when he said:

"People go to their GP because they have a disease because they are ill, they go to hospital because they're concerned about illness; a hearing impairment is a change that occurs across our lifetime just as our eyes do so I am not at all convinced that people need to go to their GP as this reinforces the fact that I feel like I'm getting old, shuffling towards the finishing line and that's a potential barrier in the way that glasses or going to the dentist is not a barrier, it's a choice we make in our everyday life".

In response to this issue, a number of expert witnesses questioned whether GPs and hospitals were the best places to deliver hearing services or whether there were better delivery mechanisms. Again the analogy of eyesight was used – with it being noted that many people are happy to go to their local opticians to get their eyesight checked and glasses fitted unlike hearing services where hospitals remain the main go to place where hearing assessments take place and aids are fitted. Many therefore argued for a more flexible, community-based approaches that emphasise personalisation. Helen Cherry, explained:

"Personalisation is the person looking out at what they want their service to look like to meet their needs and encourage [them] *to explore outside of traditional services. Explore what best fits their own circumstances. Personalisation strengthens true sense of ownership* [and helps people to take] *greater responsibility for* [their] *own health and wellbeing."*

The delivery of an ongoing high quality service was highlighted by William Brassington - President of the British Academy of Audiology- as an important priority and the Commission agreed that there should be consistently high standards regardless of the location from which the service is being delivered and when identifying new locations for delivering services, care should be taken to ensure appropriate standards are met.

In summary, for an individual who has hearing loss, getting support can be a complex process. First, it can take time for someone to recognise that they have hearing loss in the first place and seek support. Second, even if they do seek support they may not be referred on to an audiologist or to other services that provide support or equipment, or they may drop out for other reasons. Third, even if they do get assessed for hearing loss and a hearing aid is fitted, the hearing aid may not suit the preferences of the individual straight away and require further appointments for fine-tuning. Fourth, some individuals – particularly for those that are unfamiliar with the processes involved - may decide that a hearing aid is not for them despite the recognised benefits that they can provide. So while there are undoubtedly examples of good practice within GP surgeries, in hospitals and in the community – there is also room for improvement if we want to address the extent of hearing loss in the UK and address the rising challenge that an ageing population will present.

6. An alternative model of delivering hearing services

If we were trying to design an alternative model of delivering hearing services, what might it look like? This section tries to outline an alternative approach – picking up on many of the views discussed by the individuals who gave evidence to the Commission. What follows, in no way claims to be the definitive approach but is representative of what might constitute best practice in an ideal world in order to stimulate further debate.

Earlier detection of hearing loss – national screening and health check-ups

If it takes an average of ten years for people to take action about their hearing loss, then detecting hearing loss earlier and acting quickly is of vital importance. A number of experts called for a nationwide screening programme for adults with hearing loss to help address this issue. In their submission, Action on Hearing Loss pointed Commissioners towards research that they have undertaken on the cost effectiveness of such a national screening programme. Based on a cost benefit analysis of a one-off screening programme for everyone aged 65, they estimate that hearing screening would cost £255 million over ten years, but the benefits across this period would amount to over £2 billion[6].

According to the underlying analysis, there are significant savings to be made through reductions in the personal and social costs of hearing loss, reductions in employment related impacts of treating hearing loss and through reductions in healthcare costs[7]. In our alternative model of delivering hearing services, the introduction of a national screening programme would hopefully identify hearing loss at a much earlier stage for many people. But there are a number of other ways that early detection of hearing loss might be improved as well. For example, in our alterative world hearing loss assessments are made as part of regular check-ups for individuals at certain ages or for people in high risk areas – for example, those living in a care and residential homes, and those visiting the GP, hospital or pharmacy for other reasons. In particular, there is a need for hearing screening for those with dementia – especially given a growing body of research to suggest an association between hearing loss and dementia.

Multiple referral routes

A radical approach suggested by some, was to "take GPs out of the care pathway" and allow "people just to go to an audiologist and get themselves assessed easily without going through hoops". While self-referral may be an important part of ensuring more people are assessed for hearing loss, there is still a significant case for GPs playing a major role as Brian Lamb outlined in his evidence noted above. So in our alternative model, individuals can be referred in a number of ways including if the GP thinks they might have hearing loss, if hearing tests taken by independent providers flag possible hearing problems, if national screening identifies a problem, or if hearing tests taken online or via specific mobile applications or other devices suggest a problem. This way there are a multitude of routes to getting to an audiologist – preserving the traditional way through the GP who remains a trusted provider of advice as well as taking advantage of national screening and new technologies.

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[6] http://www.actiononhearingloss.org.uk/supporting-you/policy-research-and-influencing/research/our-research-reports/research-reports-2010.aspx
[7] RNID (2010) Cost benefit analysis of hearing screening for older people: http://www.actiononhearingloss.org.uk/supporting-you/policy-research-and-influencing/research/our-research-reports/research-reports-2010.aspx

Flexible hearing assessment

Building on the desire to have hearing assessments that meet the needs and preferences of individuals, our alternative model makes allowances for more flexibility in hearing assessments. This means that alongside the traditional role of hospital-based audiology and hearing tests, there is an increase in the number of local public, private and voluntary providers springing up to meet demand and greater use of drop-in centres. There will also be more assessments made in the home for those who are unable to make it to the hospital or to the local provider to have their hearing assessed. Where there is good evidence that it is effective, telehealth – where communications technologies are used to deliver health services at a distance – could be used to help deliver hearing assessment. As one expert noted, given that the core focus of the Commission is age-related hearing loss, home assessment should play more of a role. In short, in the alternative scenario hearing assessment is delivered in a variety of ways but crucially without compromising the quality of the assessments.

Regular, personalised follow-up

Effective follow-up and aftercare was one of the most important areas highlighted in the evidence received by the Commission. It can be the difference between the effective use of hearing aids which provide real quality of life benefits to the user or ineffective use including failure to wear hearing aids altogether. In our alternative model, those with hearing loss have a timely follow-up and easy access to ongoing aftercare, hearing therapy, counselling services, other equipment, lipreading classes, as well as links to support and befriending groups attended by other individuals who have experiences of hearing loss. Such support networks are delivered within the community as well as online and through the hospital.

Through this alternative model, there is arguably a greater chance that individuals with hearing loss will have it detected earlier, will be given hearing aids to effectively address hearing loss and will have regular support to ensure that the aids are effective and any other associated issues are discussed and addressed. The diagram below sets out two stylised approaches to hearing care – the first based on the current model and the second based on the alternative model set out above.

Current model: age-related hearing loss

Alternative model

7. Turning the alternative model into a reality: focusing on outcomes is key

A key question put to the Commission was who is going to pay for the substantial changes that were recommended by experts from which the alternative model set out above is based upon. In particular, many flagged up that there is likely to be a substantial challenge in managing demand if everyone who had hearing loss suddenly seeks help from an audiologist.

Evidence submitted by Keith Dunmore, a Consultant Clinical Scientist and Audiology Service Manager, noted that Clinical Commissioning Groups (CCGs) – who control local health provision and are accountable for approximately 60% of the NHS budget – are concerned about the cost of hearing aid provision and in some cases "wish to limit access to NHS hearing aids". He added that some Commissioners are worried that they would not be able to afford to fund hearing services "if there was any increase in the referral rate". Mr Dunmore highlighted the case of North Staffordshire – as did many of the expert witnesses – where as of July 2014 the local CCG is consulting on whether to restrict the fitting of NHS aids to those who have profound or severe hearing loss despite the significant benefits that aids can have for those with mild or moderate hearing loss. **In sum, with funding pressures on all areas of the NHS, there is a significant risk that without concerted efforts to ensure awareness is raised and services are improved, the provision of non-acute services such as those related to hearing, will be reduced by CCGs.**

In response to this challenge, many experts argued that it was important for CCGs to take a long term outcomes-based approach to the commissioning of services – to think about what the commissioning decisions mean for patient wellbeing and not just the costs of the individual processes involved. It was also argued that failure to take a long-term approach could lead to inefficiencies and ultimately more costs borne by the NHS. In a submission from the private provider umbrella body the National Community Hearing Association (NCHA), it was argued that there is a need to "shift away from volume and waiting times" and "towards quality". They assert that it is "unrealistic to ask an older person to absorb information and adapt hearing aid use through one fitting and one follow-up" and note that "there will continue to be a large number of drop outs and inefficient use of NHS resources unless commissioners are supported to address:

- Access
- Pathway redesign
- Better support and aftercare
- Measuring outcomes for patients and not providers."

In the evidence given by David Hewlett, Chief Executive of the NCHA, it was argued that CCGs need clear guidance about hearing loss or "nothing will happen". Mr Hewlett referred to the publication of a Government Action Plan on hearing loss – something that has been promised for some time with various drafts circulated, but as yet is still not in the public domain. The Action Plan, he argued, should be part of a "national framework in which commissioners locally work with patient groups and providers to work out what needs to be done to assess local health needs, so we have the benefits of a national framework with national standards but local flexibility".

Others argued that the cost benefit of interventions to address hearing loss was firmly on the side of doing more rather than less. For example, Professor Munro stated that modelling work clearly shows that national screening had substantial benefits outweighing any associated costs – something that was also noted in the submission from Action on Hearing Loss. And Paul Breckell, Chief Executive of Action on Hearing Loss and a Commissioner, asserted that the cost benefit argument for hearing aids had been solidly proven.

The alternative model not only emphasises more options for referral and therefore more demand for hearing services but also more choice in the provision of that service – with people having their hearing services provided in their local communities including at home. To help facilitate this, Any Qualified Provider (AQP) enables individuals to choose between different providers of hearing care. There is a need to evaluate the quality of services and outcomes from AQP providers. Furthermore, AQP implementation has not been rolled out everywhere – indeed according to the NCHA's evidence "only 50% of CCGs have given their older population the right to access" through AQP so far. This does not necessarily mean that these CCGs are not providing services in a community setting - indeed some NHS hearing services are being delivered in the community – but it does mean that individuals are likely to have less choice in who provides their hearing services.

The need for better measurement of data and outcomes was a common theme running throughout the evidence sessions. In particular, it was noted that there was a particularly pressing need for data on the numbers of people with hearing loss, the proportion seeking help, the proportion provided with hearing aids, as well as patient outcomes such as improvement in hearing, increases in quality of life, ability to take part in activities, and satisfaction with the service. In addition, it is important to assess the impact of different types of interventions on these outcomes - such as the impact of effective follow-up and aftercare on the likelihood of someone with hearing loss sticking with their hearing aid over the long-term and making the most of it. Only through comparable measures will we be able to identify local needs, where services need to improve, and make the kinds of targeted interventions necessary to improve the wellbeing of those with hearing loss.

8. Towards a society that is ready for hearing loss

The Commission also asked experts to consider how to ensure that society as a whole, could become more adaptable to hearing loss given the increasing number of people with hearing loss in the UK. There are many aspects to this, but to help focus the discussion, specific questions were asked about the ability of health and adult social care settings to support those with hearing loss, and the role of government and employers in encouraging people with hearing loss to join or remain part of the labour force. In addition there were some pertinent points made about transport and entertainment.

Health and social care

In a submission from Hearing Link, it was argued that "within the health and social care sectors, the ability to communicate well must be seen as a basic right and an essential prerequisite for effective care". The Commission would argue that this is absolutely the right starting point. Unfortunately, however, simple obstacles get in the way of achieving this objective for individuals with hearing loss.

Nathalie Sfakianos - someone with hearing loss - told the Commission that simple things such as calling out individuals' names remains commonplace in medical settings which can cause "great anxiety". As a result she said "right from the beginning of the process you are anxious and disturbed because you are never sure what's going to happen and I've missed A&E appointments because of it and both my GPs work the same way". Measures such as ensuring induction loops for hearing aids are provided and working, using text relay, providing a variety of contact methods, and using visual display screens – which one person described as a "real boon" in doctors surgeries – are a simple yet effective ways to address this problem and so it is concerning that there remain settings where screens of this type and other adaptations are not common practise.

Evidence submitted by the Social Care Workforce Research Unit (the SCWRU) suggested that "there should be more widespread acknowledgment of that social work and social care practice with Deaf people is too often inclined to focus on British Sign Language users." They add that it is "important to recognise that those with acquired hearing loss tend to have higher levels of pscho-social needs and emotional difficulties adjusting to hearing loss". They add that there is a "lack of information on the number of social care service users who experience hearing loss, particularly if it coexists with another condition or disability".

Alison Seabeck MP also implied that there was a problem of recognising and adapting to hearing loss within a social care setting. She said: "I go into care homes and you hear people shouting at their residents and they sort of say oh they're hard of hearing and when you ask what's being done about it, sadly not enough is being done".

In order to provide better support for those with hearing loss and avoid the kinds of issues highlighted above, many argued for more training of health and social care providers. The SCWRU called for induction and ongoing training programmes that include the use of hearing loss equipment and "teach workers to support people with hearing loss". In addition, they called for training to cover the "wider impact of hearing loss on older people and ensure that notions of getting older were challenged" as well as training to cover how to support people

using their hearing aids". Similarly, the charity Sense argued for better training to recognise and identify indicators of sensory loss – be that hearing, eyesight or both. Sensory loss must be more engrained, they argued, into assessments of an individual's care and support needs.

The Commission would agree that training for health and social care providers must include awareness raising about the impacts of hearing loss and how to recognise, check and manage hearing loss, given its prevalence amongst the older population and the detrimental affect it can have on individual's wellbeing. The Commission would also argue that many of the adaptations required to make health and social care settings more accessible for those with hearing loss are relatively simple and low cost to implement.

For example, it seems reasonable to ensure that all waiting rooms have visual display screens that include peoples' names, as does ensuring that health and social care front line staff have a basic understanding of the communication challenges associated with those with hearing loss and how to overcome them. And finally, the Commission believes that there is a role for healthcare providers to help ensure that those at risk of hearing loss are tested for it – including those who are suffering from dementia given the relationship between dementia and hearing loss.

Employment

According to past research, employment rates of those with hearing loss are substantially lower than the average UK employment rate. The latest estimates suggest that employment rates amongst the hearing impaired working age population (age 16-64) is approximately 64% relative to 77% for people who do not have a long-term health issue or disability[8].

A number of experts submitted evidence about the barriers to employment facing those with hearing loss. Hearing Link argued that barriers often arise as a result of a "lack of information and awareness in employers and in employees, in job-seekers and in statutory employment providers". The submission suggests that there needs to be better signposting to support such as the Government's Access to Work Scheme (which provides funding and support for disabled people), and there needs to be consistency across the country in the provision of support for those with hearing loss.

Some of these points were echoed in the submission from Action on Hearing Loss which noted that the attitude of employers is perceived by people with hearing loss to be one of the biggest barriers to work. The authors argued that employers should be more proactive in supporting those with hearing loss, ensuring people have access to communication support and equipment that can help them, as well as developing an inclusive culture to "safeguard against feelings of isolation".

The Human Resource function has a critical role to play in driving forward the inclusive agenda within organisations in order to ensure that the right measures and equipment are put in place to support those with hearing loss. If HR departments are not successful in this regard, organisations will lose out by failing to retain or recruit competent and talented staff. The Commission would argue that in the context of an ageing population and an associated slowing in the size of the traditional working age population, the need for staff retention will become increasingly important. As a consequence, ensuring that workplaces are supportive of the diverse needs of employees of all ages will be vital to success.

Action on Hearing Loss also discuss the Access to Work programme and note concern about

[8] Based on unpublished analysis of Q2 2013 Labour Force Survey data by Action on Hearing Loss.

the reduction in flexibility and support available to deaf people through the scheme, including restrictions on communication support. In addition, the submission notes a number of other problems including "inaccessible contact processes, a lack of awareness amongst staff regarding hearing loss issues and limited awareness of the support and equipment that is available to people in the workplace".

The Commission would argue that weakening the Access to Work programme is short-sighted. Ultimately, enabling those with hearing loss to get back to work or stay in work longer will boost public finances. As noted earlier in this report, hearing loss related unemployment costs the UK economy an estimated £24.8bn per annum in lost output – strengthening policy measures to support higher employment rates for those with hearing loss is ultimately in the taxpayer's interest.

Similar to the assertions around health and social care provision, it was noted that simple things can be done to ensure that those with hearing loss are not excluded. Some easy solutions suggested by experts included less emphasis on the use of telephones – much communication can be achieved by text, email or social media, or encouraging the use of text relay to communicate by telephone. Another easy solution was to encourage more face to face conversation.

Adapting to hearing loss in other settings

Many of the issues outlined above regarding the issues associated with supporting those with hearing loss in the health and social care sectors as well as in the workplace are also evident in other settings. Nathalie Sfakianos spoke about family life, travel and the entertainment industry – all of which, she implied, need to become more supportive to those with hearing loss. She noted that progress was happening in some areas, and gave the example of the National Theatre's programme of giving out discounted tickets to people with hearing loss or the displays for tubes and buses – but argued there that there are still many barriers to break down.

Urgent need for a public awareness campaign

Underpinning many of the barriers and issues facing those with hearing loss is a lack of understanding amongst the general public. In this regard, there was almost unanimous support from those who gave us evidence, for a public information and awareness campaign. In general, it was recognised that this needed to be a national campaign delivered with a positive message about hearing loss and the individuals experiencing it. It was suggested by many that positive role models and celebrities should be used in this regard to help to reframe the debate. But alongside a big public awareness campaign, others also recommended more targeted information about hearing loss – such as leaflets in the workplace, in the doctor's surgery or in care homes – all substantial touch points for those with hearing loss.

The Commission would endorse the call for a major public awareness campaign around hearing loss and believes that a national campaign emphasising the positive contribution that those with hearing loss make on a daily basis is a vital starting point in the challenge to raise awareness about hearing loss. Targeted information and leaflets are also likely to be a useful, low cost measure to address knowledge gaps. We would however assert that any one-off campaign should be part of a concerted, long-term effort to raise the profile of hearing loss in the UK. Therefore raising the profile of hearing loss over the longer term should be incorporated in any Government-led strategy on hearing loss.

Raising public awareness and other measures to improve prevention of hearing loss

The issue of prevention was also mentioned by a number of our expert witnesses and through the submissions we received. According to evidence from Action on Hearing Loss, occupational noise exposure is a major cause of noise-induced hearing loss, but social noise exposure has also increasingly become a significant driver of hearing loss in the UK. The evidence notes the dangers of loud music with an estimated 4 million young people in the UK at risk of hearing damage from amplified music. Public health messages must therefore flag the risks of hearing loss associated with different social and occupational activities and this could be woven into any nationally targeted awareness campaign.

In addition to raising awareness through public health messages, a number of other prevention methods are noted in the submission including:

- Encouraging use of ear protection in music venues.
- Carefully targeting messaging in "at risk" settings, such as universities and colleges.
- Use of innovative technologies to prevent hearing damage – such as noise-cancelling headphones which enable music to be heard by reducing background noise rather than increasing the volume.

9.Recommendations

Towards alternative pathways to delivering hearing services

The Commission believes that it is worth exploring alternative pathways for the delivery of hearing services with the crucial caveat that there are sufficient safeguards in place to ensure that alternative routes do not lead to lower standards of care and/or worse overall outcomes for those with hearing loss. Such safeguards would be provided in part by national quality standards which set out what such services should ensure they achieve.

Early identification

The current challenge

- It takes 10 years on average for someone to realise that they are suffering from hearing loss and to then seek help. This is not good enough – during those 10 years someone's hearing will continue to deteriorate adversely affecting their quality of life and reducing their ability to adjust in future.

Recommendation

- ***A nationwide screening programme*** – We endorse the view of many of the expert witnesses for a nationwide screening programme, which it was argued, would be cost effective because it would help to prevent the additional health and employment costs which stem from uncorrected hearing loss.
- ***Pilots*** - in order to establish the evidence base for such a screening programme, we would encourage NHS England to work with the sector and CCG's to carry out screening pilots. The pilots should be carefully evaluated so that, alongside measuring outcomes for those with hearing loss, it is possible to calculate the impact on demand for hearing services and the ability of GPs, hospitals and community-providers to adapt.
- ***Health checks -*** Hearing loss checks should be integrated into health check-ups for those deemed at risk of hearing loss – either due to age or other identifiable factors such as testing those with dementia. In addition, hearing along with sight loss should be routinely tested in care homes and other care or residential establishments. In order to meet this challenge it is essential that health and social care providers are adequately trained about hearing loss and its wider impact.
- ***Checking for hearing loss for those with dementia –*** Given the growing body of evidence to suggest a relationship between hearing loss and dementia – with some suggesting that hearing loss may help to accelerate dementia – there is a pressing need for hearing screening and proper management of hearing loss for all those who are suspected of having dementia.

Referral

The Challenge

- While the GP has an undoubtedly crucial role to play as the first point-of call for many people who are seeking information or think they might have hearing loss, the GP referral route may also act as a barrier which prevents more people from receiving full hearing services. One study suggested that 45% of people who go to the GP for a hearing aid are not referred on for treatment.

Recommendation

- ***Opening access –*** there is a case to be made about opening up the referral route. Little is known however, about the feasibility of alternative referral models and the ability of the hearing service providers to cope.
- As a consequence, the Commission recommends careful pilots of alternative referral models in certain areas which allows for a multitude of routes to the delivery of hearing services. One alternative model could include self-referral for individuals who think they may have hearing loss on the basis of taking online hearing tests or because of a hearing assessment undertaken by a local provider. The GP could still refer under this model, but GP referrals would be just one route of many. As with the example of national screening, the pilots for these different referral models would need to be carefully measured to ascertain how they might affect those with hearing loss as well as the demand and supply of services.
- In summary, we are urging for greater innovation beyond the traditional referral model from the public, private and voluntary sector and further research on the efficacy and evidence base of any new pathways of access.

Effective follow up, after care, support and equipment

Challenge

- Of the two million people in the UK who have already accessed hearing aids, only 1.4 million regularly use them. From the evidence obtained as part of this Commission, it is clear that timely follow up and easy access to ongoing aftercare is as important a part of the process as having the first meeting with the GP or having the hearing aid fitted by the audiologist. If people are not happy with their aids and do not know where to go for help and support, they will not get the best out of them – a major factor in explaining why so many people with hearing loss do not use their aids.

Recommendation

- ***Improved emotional and practical support*** - Given that individuals may need to go through a process likened to "fine-tuning" to ensure that their hearing aids are fit for purpose – follow-up appointments and appropriate aftercare are critical to ensuring people make the most of their hearing aids. Indeed, we would argue that timely follow-up and accessible aftercare must become routine in all instances across the UK.
- In addition there should be improved provision of and easier access to ongoing aftercare, hearing therapy, counselling, lipreading classes and support groups, including those which contain other individuals who are facing similar challenges. This support should be delivered and actively publicised by hearing services, hospitals, GP surgeries, pharmacies, in the community and online.
- Much of the aftercare and support can be delivered at low cost. Part of the challenge is for different institutional settings to better signpost some of the formal and informal support networks that already exist – though more of such networks are likely to be needed. It is also about managing expectations – just because the hearing aid might be uncomfortable today does not mean that it cannot be adjusted to better fit the needs of the individual tomorrow. Those with new to hearing aids in particular need to be aware of this and made to feel welcome to return to the audiologist for adjustment if necessary.

- While evidence from other countries suggests that follow-up and aftercare do result in better outcomes for those with hearing loss, there is an urgent need for better measurement of the effects of follow-up and aftercare in the UK in order to underpin the case for timely follow up and easily accessible ongoing aftercare.

Time to deliver a strategic plan on hearing loss

Challenge

- There are significant funding pressures on NHS services which could lead to a reduction in non-acute services such as hearing services unless the case is made that improved integration and quality of services for people with hearing loss will improve communication and quality of life, as well as reducing costs in the long term.

Recommendations

- ***A long-term strategic plan based on cost benefit analysis*** - With an ageing population expected to drive a 4 million increase in the numbers of people with hearing loss by 2031, the Commission believes that continuing to ignore the problem will not work and will result in storing up problems for the future. But in order to build a comprehensive plan, the sector in collaboration with policymakers will need to build and communicate a strong economic case that meeting demand, integrating care and meeting communication needs will save the system money in the long term.
- ***Strategic direction is needed now -*** Government should publish the long-awaited Action Plan on hearing loss. But this must be allied to a national commissioning framework and an appropriate NICE quality standard to ensure high quality services are consistently provided, developed in consultation with patient groups, individuals and professionals – representing the public, private and third sector.
- ***Ensuring support of CCGs*** - Winning over CCGs is critical to ensuring that hearing services are not reduced. Whilst efficiencies can be found through new innovative ways of working and maximising the use of technologies, a reduction in hearing services would constitute short-termist thinking, resulting in worse outcomes further down the line. Unaddressed hearing loss is associated with other physical and mental health issues so a failure to provide support early on would result in greater overall costs to the NHS and to the local CCG as a consequence of reduced health outcomes and more complex health issues emerging.

In addition the Commission recommends that:

- To drive this approach we recommend that NHS England includes hearing loss when it issues calls to action – which typically discuss the socioeconomic and demographic changes impacting the way in which health services must be delivered. Given the current and future prevalence of hearing loss and its links to population ageing we think it deserves specific attention.

Towards a society that is ready for hearing loss

Alongside asking experts to discuss how we might improve different aspects of hearing services, and how we might develop different models of delivery, we also asked for views about how other aspects of society should adapt in response to the challenge of hearing loss. In particular the Commission focused on health and social care as well as employment and the labour market:

Recommendations

Health and social care

- ***Improved education and training for health and social care providers*** – better training for those providing health and social care about hearing loss is urgently needed. Health and social care professionals are key touch-points particularly for older people who are most likely to have hearing loss. Continuing Professional Development programmes must include reference to hearing loss while better cascading of information about hearing loss is needed for all front line staff across these sectors.

- ***Low cost, simple adaptations*** - many of the adaptations required to make health and social care settings more accessible for those with hearing loss are relatively simple and low cost to implement. For example, it seems reasonable to ensure that all waiting rooms have working loop systems and screens that include peoples' names, as does ensuring that health and social care front line staff have a basic understanding of the communication challenges associated with those with hearing loss and how to overcome them.

Employment

- Employers must make reasonable adjustments to ensure people with hearing loss can communicate and are not isolated within the work place, for example providing a range of communication methods and equipment.

- ***Human Resource departments -*** must act as agents of change to ensure that organisational cultures are inclusive to people with all kinds of disabilities including those with hearing loss. Appropriate measures must be taken to provide the right support and equipment for those that need it. If HR departments are not successful in this regard, organisations could lose out by failing to retain or recruit competent and talented staff.

- ***Reforming Access to Work*** - Access to Work helps to support those with disabilities to get back into work but evidence suggests that the provisions for people with hearing loss and other disabilities has been weakened. Weakening the Access to Work programme is short-sighted. Ultimately, enabling those with hearing loss to get back to work or stay in work longer will boost public finances. As noted earlier in this report, hearing loss related unemployment costs the UK economy an estimated £24.8bn per annum in lost output – strengthening policy measures to support higher employment rates for those with hearing loss is ultimately in the taxpayer's interest.

In addition to the above measures to support a society ready for hearing loss, the Commission also calls for:

- ***A public campaign to raise awareness*** – The Commission would endorse the call for major public awareness campaign around hearing loss and believes that a national campaign emphasising the positive contribution that those with hearing loss make on a daily basis is a vital starting point in the challenge to raise awareness about hearing loss.

- ***Targeted information*** including better use of social media, leaflets and posters in surgeries and care homes are also likely to be a useful and low cost way of addressing knowledge gaps. The Commission would, however, assert that any campaign should be part of a concerted, long-term effort to raise the profile of hearing loss in the UK. Therefore raising the profile of hearing loss over the longer term should be incorporated in any Government-led strategy on hearing loss.

- ***Prevention agenda –*** While the numbers of people living with hearing loss is likely to increase due to population ageing, there are measures that could be taken to reduce the extent of this increase. The main one is for individuals to avoid extended exposure to loud sounds that will cause hearing loss. Individuals need to be aware of how certain activities might damage their hearing over the long term and what they could do to prevent this. Public health messages must therefore flag the risks of hearing loss associated with different social and occupational activities and this could be woven into any nationally targeted campaign.

Appendix A: Biographies of Commissioners

Chair: Baroness Sally Greengross, cross-bench peer and Chief Executive of the International Longevity Centre UK

Baroness Sally Greengross has been a crossbench (independent) member of the House of Lords since 2000 and chairs five All-Party Parliamentary Groups: Dementia, Corporate Social Responsibility, Intergenerational Futures, Continence Care and Ageing and Older People (Co-Chair). She is the Vice Chair of the All-Party Parliamentary Group on Choice at the End of Life, and is Treasurer of the All-Party Parliamentary Group on Equalities. Sally is Chief Executive of the International Longevity Centre – UK; Co-President of the ILC Global Alliance; and was a Commissioner for the Equality and Human Rights Commission from 2006-12.

Baroness Greengross was Director General of Age Concern England from 1987 until 2000. Until 2000, she was joint Chair of the Age Concern Institute of Gerontology at Kings College London, and Secretary General of Eurolink Age.

Baroness Greengross is Chair of the Advisory Groups for the English Longitudinal Study on Ageing (ELSA) and the New Dynamics of Ageing (NDA). She is President of the Pensions Policy Institute and Honorary Vice President of the Royal Society for the Promotion of Health. Baroness Greengross is Patron of the National Association of Care Caterers (NACC) and Patron of Care & Repair England. She holds honorary doctorates from eight UK universities.

Paul Breckell, Chief Executive, Action on Hearing Loss

Paul is the Chief Executive of Action on Hearing Loss. He has been in this position since August 2012 and has worked for the charity since July 2007. Action on Hearing Loss is the new name for RNID; the charity working for a world where hearing loss doesn't limit or label people, where tinnitus is silenced and where people value and look after their hearing.

Prior to this Paul was the Finance and Corporate Services Director of the Church Mission Society for seven years and the Head of Finance at the HIV/AIDS healthcare charity Mildmay for three years. He is a chartered public finance accountant (CIPFA), having trained whilst working with the Audit Commission. Paul is a past Chair of the CIPFA Voluntary Sector Panel and was a member of CIPFA Council, its Board of Trustees from 2008 to 2013.

From 2003 to 2007 Paul was the Chair of Charity Finance Group (formerly Charity Finance Directors' Group) and he was made an honorary life member in 2008. He continues to write and speak on a number of topics in relation to leadership, governance and finance in the 'beyond profit' sector, is a Trustee of the Roffey Park Institute, a member of Amnesty International (UK) Finance and Audit Committee and the Audit Committee of the Nuffield Foundation, and is actively involved in his church and local community as a volunteer youth and children's worker.

William Brassington, President of the British Academy of Audiology

William Brassington works clinically as a Consultant Audiologist and the Head of Audiology at Nottingham University Hospital NHS Trust in the UK. He trained as an Audiologist in 1989 in Birmingham and London and later went on to complete his MSc Audiology in Manchester. He maintains a keen interest in advanced rehabilitation, implantable devices, vestibular assessment and rehabilitation. He has taken an active role within his professional body over the last 6 years where he has worked as board director for Professional Development, Finance and Treasurer and Vice President. In November 2013 William took over as the new President of the British Academy of Audiology, the largest professional body for Audiology professionals in the UK.

Peter Ormerod, Boots Hearingcare

Peter has been a registered Hearing Aid Audiologist since 1985 and has practical experience of all aspects of Hearing Aid Dispensing having been involved in High Street service delivery, NHS Hospitals and domiciliary Services. He is currently a Panel Member of the Health Care Professions Council (HCPC) and is a founding director of the National Community Hearing Association. He was a former Council member of the Hearing Aid Council (having been Chair of its Education and Training Committee and part of its Disciplinary Committee). Peter is also a former Council Member of the British Society of Hearing Aid Audiologists.

Peter's has extensive experience of both Private and Public hearing services and is committed to a patient focused approach to Hearingcare provision in the UK.

Peter has recently retired as Chairman of Boots Hearingcare.

Rosie Cooper MP, Member of Parliament for West Lancashire

Rosie Cooper MP was elected on the 5th May 2005 as the Labour Member of Parliament for West Lancashire. In 2007, she was Parliamentary Private Secretary (PPS) to then Health Minister Ben Bradshaw MP. In June 2009, she followed Mr Bradshaw as his PPS when he became Secretary of State for Culture, Media and Sport. Previously, Rosie was PPS to Lord Rooker, Minister for Rural Affairs at DEFRA, from 2006 to 2007.

During her first term in Parliament from 2005 to 2010, Rosie served on the Justice, Northern Ireland and North West select committees. In July 2010 Rosie was appointed to be a member of the Health Select Committee.

Rosie has been actively involved in politics since the age of 16 becoming a Liverpool City Councillor in 1973 for Broadgreen. During her 28 years as a City Councillor Rosie also became the Lord Mayor of Liverpool
in 1992-93.

As the eldest child of deaf parents the young Rosie Cooper was often her parents' voice. It was during these years Rosie became aware of the barriers facing people with disability and that she had to fight hard to make her parents voices heard. Rosie's political career has very much been shaped by her experiences as a child of deaf parents.

Baroness Elspeth Howe

Elspeth Howe was appointed a Crossbench member of the House of Lords in 2001. She was Chairman of the BOC Foundation for the Environment from 1990 to 2003 and was President of UNICEF UK from 1993 to 2002, and Vice-Chairman of the Council of the Open University from 2001 to 2003. From 1992 to 1994 she Chaired the Archbishops' Cathedrals Commission resulting in the publication of Heritage and Renewal in October 1994. From 1975 - 1979 she served as the first Deputy Chairman of the Equal Opportunities Commission. She is an Emeritus Governor and Honorary Fellow of the London School of Economics. She has Chaired the Broadcasting Standards Commission (1993-99), and Business in the Community's Opportunity 2000 initiative (1994-98). She was also Chairman of the Inner London Juvenile Court (1970-90), and served as a member of the Parole Board (1972-75).

Appendix B: Names of experts who submitted evidence to the Commission

Witnesses for oral evidence sessions

Alison Seabeck MP
Professor Corne Kros
David Greenberg
Baroness Barker
Dr Roger Wicks
Dr Huw Cooper
David Hewlett
Barry Downes
Phil Hope
Professor Kevin Munro
Nathalie Sfakianos
Jonathan Parsons
Lawrence Werth
Brian Lamb

Individuals and organisations who provided written submissions

Action on Hearing Loss
British Society of Hearing Aid Audiologists
David Blane
The Ear Foundation, Nottingham
Hearing Link
Helen Cherry
Keith Dunmore
National Association of Deafened People
National Community Hearing Association
Ruth Morgan-Jones
Sense
Social Care Workforce Research Unit, King's College London
Teresa Sienkiewicz
Vivienne Pozo

Please note that we will be publishing this evidence and the transcripts of the oral evidence sessions alongside this report.

Appendix C: Methodology for the cost of hearing loss to the UK economy

To calculate the costs of hearing loss to the UK economy we have followed the method used in a 2006 report for Hear-it with a couple of changes[9]. The 2006 report calculates the economic cost by first looking at the difference between the employment rate of those with hearing loss by comparison to the average UK employment rate. The assumption is made that the lower-than-average employment rate of those with hearing loss is purely down to hearing impairments rather than any other factor. Then, in order to calculate the economic cost of lower than average employment rates for those with hearing loss, the author applies average UK earnings to the estimated number of individuals who are unemployed because of hearing loss. This creates an overall figure for the cost of hearing loss to the economy.

In this report, we have a few changes to the calculations. Rather than using average earnings to estimate the cost of hearing loss to the economy, we have used economic output per worker. We have used this measure for the simple reason that it gives a better indication of the total cost of hearing loss to the wider economy – rather than the cost of hearing loss to the individuals who are experiencing it. We have also restricted our efforts to the working age population (ages 16-64) as this makes the calculation easier allowing us to avoid having to make difficult judgements about whether or not those who are not in work after retirement age have exited the labour market due to hearing loss or something else. And finally, rather than assessing the difference between the employment rate of those with hearing loss and the UK average employment rate, this report looks at the difference between the employment rate of those with hearing loss and the employment rate of those without a long-term health issue or disability. We think this will result in a more accurate measure of the amount of unemployment due to hearing loss.

To calculate the future economic cost of hearing loss in 2031, we have used the ILC-UK's economic growth model which uses the ONS' principal population projections, and makes assumptions about age-related employment rates and labour productivity to calculate output over the next twenty years. We assume future age-related employment rates equal their long run averages and that the annual rate of economic growth is consistent with its long-term historical average rate.

Total cost in 2013: £24.8bn

Total cost in 2031: £38.6bn

[9] Shield (2006) *Evaluation of the social and economic costs of hearing impairment*, A report for Hear-it: http://www.hear-it.org/sites/default/files/multimedia/documents/Hear_It_Report_October_2006.pdf

Assumptions underpinning calculations for cost of hearing loss

2013 calculations

Total number of people of working age with hearing loss	Sources and explanatory notes for calculations
3,721,000	Action on Hearing Loss (2011), Hearing Matters
Proportion of those with hearing loss in employment	
64%	Unpublished analysis of Q3 2013 Labour Force Survey (Action on Hearing Loss)
Employment rate for those without long-term health issue or disability	
77%	Unpublished analysis of Q3 2013 Labour Force Survey (Action on Hearing Loss)
Numbers of people unemployed as a result of hearing loss	
2,381,440	Estimate of number of people employed with hearing loss
2,865,170	Estimate of number of people employed with hearing loss if equal to employment rate of those without disability
483,730	Estimated unemployment due to hearing loss
GDP per employed person in the UK (2013 figures)	
1,531,428,000,000	Total UK GDP (chain volume measures: ONS identifier ABMI)
29,896,000	Total UK in employment (ONS identifier MGRZ)
51,225	GDP per person employed
GDP uplift if all those unemployed due to hearing loss found work	
24,779,156,624	Estimate of lost economic output (£)
1.62%	Estimate as proportion of GDP

2031 calculations

Total number of people of working age with hearing loss	Sources and explanatory notes for calculations
3,856,944	Hearing Matters Report and ONS Population Projectors
Proportion of those with hearing loss in employment	
64%	Unpublished analysis of Q3 2013 Labour Force Survey (Action on Hearing Loss)
Employment rate for those without long-term health issue or disability	
77%	Unpublished analysis of Q3 2013 Labour Force Survey (Action on Hearing Loss)
Numbers of people unemployed as a result of hearing loss	
2,468,444	Estimate of number of people employed with hearing loss
2,969,847	Estimate of number of people employed with hearing loss if equal to employment rate of those without disability
501,430	Unemployment due to hearing loss
GDP per employed person in the UK (2013 figures)	
	All figures use ILC-UK economic growth model (assumptions are based on current trends)
2,395,249,691,512	Total UK GDP
31,137,655	Total UK in employment
76,925	GDP per person employed
GDP uplift if all those unemployed due to hearing loss found work	
38,570,168,013	Estimate of lost economic output (£)
1.61%	Estimate as proportion of GDP

ILC–UK
11 Tufton Street
London
SW1P 3QB
Tel : +44 (0) 20 7340 0440

www.ilcuk.org.uk

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