NES 39.

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Strategic Planning & Modernisation

Date 02.04.08
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Dear Sir /Madam,

In response to the consultation exercise being conducted by the Scottish Government on the Draft National Standards for Adult Hearing Rehabilitation Services, please find below comments from NHS Lothian.

1. Setting of Quality Standards

The production of these Quality Standards is welcomed as they will provide a useful tool in ensuring that Audiology service provision across Scotland meets the needs of patients whilst also being efficient and effective in their delivery.

In this regard it will be important that the application of the Standards and their monitoring is used for benchmarking purposes to allow the Audiology Departments across Scotland to work together on achieving equity of service provision to the same acceptable levels of quality.

2. Specific Comments on the Draft Quality Standards for Adult Hearing Rehabilitation Services

Standard 1: Accessing the Service

1a Electronic Referrals - The opportunity should be taken to set as a standard the requirement to make referrals electronically, utilising the necessary referral template – and using the CHI patient indicator.

1a.ii Delivery of services close to patients for their ultimate benefit – It requires to be recognised that specialist equipment cannot be replicated throughout numerous sites for effective testing (this applies also to 1c.iii and 3a.iv).

1a.iv Reassessment Patients - In terms of re-assessment patients, there needs to be greater clarity as to how a continuum of care is to be provided for these patients.

A possible starting point would be to have referral criteria for re-assessment, that will enable GPs to determine that the person requires to be referred on to the Audiology service – or that it is suitable that they wait until their 3 year Review appointment is due. Currently there is the ability for patients to self refer – sometimes for in-appropriate reasons.

Reference to Median Waiting Time at foot of pages 12, 13, 33 & 34 - This reference should be taken out as it is misleading to use median waits from other specialties that require to meet the clinical needs of cancer patients and other urgent life threatening conditions. Waiting Time Standards should be set by the Scottish Government Delivery Unit – and it is only the definition set by them that should be referred to.

1c.ii Access to Repair Services - In terms of standard setting – it would have been useful if evidence from around the country had been evidenced to quantify the merits between walk in repair services versus booked repair services – in order to determine which one was the best model for the hearing aid user. Given this, local policy should be accepted where it is proven to be accessible and timely.

Standard 2: Information Provision and Communication

2a Significant Others - Given that these standards are to be accessible to all, they may read better if the phrase "family and friends" could replace this sterile sounding definition of said family and friends.

2a.vii Accreditation of Deaf Awareness Training - The requirement to have this training approved by a relevant third party appears to carry a risk, as it does not include as part of this standard a safeguard that only organisations, which are regularly accredited themselves, should perform such a role.

It may be better that the appropriateness of the training is measured as a mandatory indicator in the patient surveys, through patients assessing that staff utilised the necessary skills to allow for effective communication.

Standard 5: Implementing an Individual Management Plan

In terms of patient choice – whilst there are standards around providing patients with the required information to make an informed choice around what happens next - Standard 5b appears to set a default that a hearing aid will be given to the patient.

Experience in England of developing Choice Models of Patient Care have demonstrated that for some patients they may actually make the choice of not wishing to be provided with a hearing aid – even if it has been identified that they would benefit from one. Patients may also wish to only have one aid provided – particularly if a BTE aid – for cosmetic reasons, wishing to avoid being seen to have two aids.

By having a standard that allows patients to make informed choice about what they wish to do next – there will be the opportunity to help address the anecdotal evidence around patients putting hearing aids into drawers and not using them.

5biii Bilateral Fitting - The standards would benefit from the availability of further evidence indicating the benefits of bilateral fitting, particularly from authors who were not members of the standard setting group.

Before final publication of the standards the cost of not only meeting this requirement for 95% of new patients but also for 98% of existing wearers should be quantified to the Scottish Government to make them aware of the additional level of investment that will be required.

Standard 6: Outcome

In terms of clarity for 6a.iv – it would be beneficial to identify which patient cohorts should be covered by surveys, e.g. new patients, existing patients being followed up or a mixture of both.

Recognising the continuum of care it would be beneficial if the standard was set as there being a mixture of both new and existing patients being surveyed on an annual basis.

Standard 7: Professional Competence

Reference requires to be made against this standard of the requirement to link CPD into the Local Delivery Plan HEAT Target for NHS Boards to ensure that all employees covered by Agenda for Change have an agreed KSF personal development plan from March 2009.

Page 28 – Foreword: This section with reference to commissioners etc, appears to be very generic in order to be applicable to UK wide provided services – rather than being tailored more specifically to the particular way that health services are now provided within NHS Scotland.

Quality Rating Tool

Page 31 – Convenient Access – in terms of defining reasonable access, it may be more appropriate to quantify this in terms of a similar service that would require specialist equipment and accommodation in order to make a proper assessment. For Audiology the requirement for the appropriate testing facilities (circa £90,000 per new testing booth in existing accommodation), means that the availability of these will be different to physiotherapy, which is a service that can at times be provided in local GP practices.

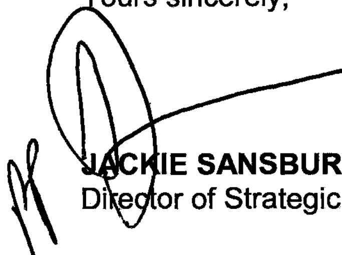
Page 37 – Service Development – In order to ensure that there is equity in providing access and meeting the particular needs of local populations it would be beneficial to set out what are the key demographic factors to be captured.

Page 58 – Bilateral Hearing Aids – The 50% measure does not tie up to the description of the standard as set out on page 21. The 98% measure needs to be better quantified as per the definition on page 21.

I trust that you will find the comments above helpful in the process of finalising the Draft National Standards for Adult Hearing Rehabilitation.

If you require any further clarification on these comments please contact Grahame Cumming at NHS Lothian, using the contact details provided at the top of this letter.

Yours sincerely,



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