Public Health England

Protecting and improving the nation's health

NHS Health Check content review form

Please read the guidance notes before completing this form. Please only complete the contact details and section 1 and return the form (as a word document) to the ESCAP secretariat at nhshealthchecks.mailbox@phe.gov.uk **by 31 March 2019**.

Section 1

	1. Please tick the categories that apply to your proposal.
	It involves amending the eligible population. It involves amending an existing component of the risk assessment.
x	**It involves introducing a new component to the risk assessment.**
	2. Please provide a short summary describing your proposed change [*max 200 words*]
Hearing loss affects 11 million people in the UK, mostly age related. An aging population means numbers will rise to 15.6 million by 2035[i]. Unaddressed hearing loss reduces quality of life and is associated with double the risk of depression[ii] and up to five times the risk of dementia[iii]. There is incontestable evidence that hearing aids improve quality of life[iv], there is also compelling evidence they slow the rate of cognitive decline[v]. Unfortunately, only around 40% of people who could benefit actually have them[vi]. Furthermore, it often takes 10 years for people to get help[vii]. In order to reduce this gap, and tackle the associated problems, we propose: • The introduction of a hearing screening check by asking two validated questions, and using a portable hand-held screener for people aged over 65. *And, if hearing loss is identified:* • To provide people with information about hearing loss and how it can be addressed. • To recommend patients either speak to their GP, or ideally provide a direct referral to an NHS audiology service.	
	3. Please state which strategic health priority in the NHS outcome framework or the public health outcome framework the proposed change supports [*max 200 words*]
"Health-related quality of life for older people" in the Public Health Outcome Framework. 71.1% of over-70s have some level of hearing lossi above[i]. Hearing loss reduces people's quality of life, and is associated with increased risk of depression and dementia. Hearing aids improve people's quality of life[iv]. have been shown to reduce people's rate of cognitive decline by 75%[v]. Using screening to boost hearing aid uptake could, therefore, have a huge impact on the health-related quality of life of older people.	

4. Please identify which of the programmes objectives the proposed change supports [*please tick*]

To promote and improve the early identification and management of the individual behavioural and physiological risk factors for vascular disease and the other conditions associated with those risk factors.

X **To support individuals to effectively manage and reduce behavioural risks and associated conditions through information, behavioural and evidence based clinical interventions.**

X **To help reduce inequalities in the distribution and burden of behavioural risks, related conditions and multiple morbidities.**

To promote and support appropriate operational research and evaluation to optimise programme delivery and impact, nationally and locally.

5. How will the proposed change support the(se) objective(s)?

To support individuals to effectively manage and reduce behavioural risks and associated conditions through information, behavioural and evidence based clinical interventions.

As mentioned earlier, hearing loss affects 11 million people in the UK[i]. There is incontestable evidence that hearing aids improve quality of life[iv] – and their use is recommended by NICE[viii]. Unfortunately, only around 40% of people who could benefit actually have them[vi] and, it often takes 10 years for people to get help[vii].

There is a well-established NHS infrastructure for providing hearing aids, which is supported by national guidance[ix]. Very high numbers of people continue to use and benefit from hearing aids once they receive them, usually around 80-90%[x] and 71% think they should have got them sooner[xi].

Getting help early is vital. Unaddressed hearing loss is associated with double the risk of depression[ii]. Mild hearing loss is associated with twice the risk of dementia, moderate hearing loss with a 3-fold increase, and severe a 5-fold increase[iii]. Furthermore, the rate of measured age-related cognitive decline is 75% less following the adoption of hearing devices[v] and estimates suggest if hearing loss were properly addressed, 9% of dementia cases could be prevented[xii]. For these reasons the Alzheimer's Society is supporting the proposals set out in this document – and you should be receiving a letter from them shortly to that effect.

People delay seeking help for their hearing loss a number of reasons. They may underestimate the serious effects that hearing loss can have, they may fear the stigma, or may be misdiagnosed or dismissed by GPs. GPs fail to refer 45% of those reporting hearing loss to NHS hearing services[vii].

Hearing screening has been shown to be effective in clinical trials. Introducing handheld screeners to GP surgeries saw a substantial increase in referral rates to audiology. Data from the patient satisfaction questionnaire found that 84% respondents said that their GP referred them without delay, ensuring that the management of their hearing loss could be promptly assessed[xiii]. This contrasts strongly with the norm.

We believe that hearing screening, combined with information about the benefits and risks would provide individuals with considerable support in terms of managing and reducing their risks of poor quality of life, depression and dementia.

To help reduce inequalities in the distribution and burden of behavioural risks, related conditions and multiple morbidities.

Hearing loss is largely age related. Hearing loss can be defined as a disability under the Equality Act (2010). Hearing loss has a profound effect on people's quality of life. It is associated with increased risk of depression and dementia. Screening and educating people about hearing loss could, therefore reduce inequalities based on age and disability for those conditions.

6. What is the evidence for the clinical effectiveness of the proposed change?

Introducing handheld screeners to GP surgeries saw a substantial increase in referral rates to audiology. Data from the patient satisfaction questionnaire found that 84% respondents said that their GP referred them without delay, ensuring that the management of their hearing loss could be promptly assessed[xiii]. This contrasts strongly with the norm, where figures suggest that GPs fail to refer 45% of those reporting hearing loss to NHS hearing services[vii].

In 2007 the Health Technology Assessment (HTA) found that the optimal cut off for screening was 35 dB HL for adults aged 55-74, and the most effective screening test was to ask two verified questions along with pure tone audiometry[vii].

7. What is the evidence of cost effectiveness of the proposed change?

In 2010 Action on Hearing Loss (then RNID) and London Economics published a cost-benefit analysis of introducing a universal screening programme for adult hearing loss[xiv]. The study concluded that the benefit-cost ratio of the intervention was 8:1, meaning that for every £1 spent screening people at 65, £8 worth of benefit would be generated.

The analysis took into account a range of factors, such as:

- The purchase of the screening devices. (Estimated to be around £50 per device at bulk prices[xiv])
- The costs of training healthcare professionals in their use.
- The additional costs increased demand on audiology services, including the issue of hearing aids.

It also took into account the cost savings that would likely arise from increased hearing aid uptake, such as:

- Reducing missed appointments in NHS services. Many people with hearing loss needlessly miss appointments at GP surgeries and in other NHS settings as they do not hearing their name being called by staff.
- Helping people stay in, and thrive, in employment (as many people over 65 remain in employment)
- Reduced strain on healthcare services through reduction in depression, dementia.
- Wider personal and social benefits based on QALYS (Quality of Life Adjusted Years.

These findings are reinforced by a 2012 study[xv] which concluded "screening for bilateral hearing loss of at least 35 dB HL between the ages of 60 and 70 year, as proposed by Davis et al. is likely to be cost-effective."

8. Please provide an outline of how this would change current practice
i.e. what would frontline professionals delivering the NHS Health Check need to do that isn't already a part of the programme?

Professionals would need to check for earwax and use an easy-to-use handheld portable hearing screener to check hearing acuity e.g. Siemens HearCheck Screener.

If excessive wax was an issue, they should refer the patient to their GP. If there were no indications of excessive wax, and the hearing screener detected a hearing issue, the patient would ideally be referred directly to audiology, alternatively they could be referred back to their GP for onward referral to audiology.

Professionals could also advise patients of their entitlements to free hearing aid on the NHS, the benefits of hearing aids, and the potential dangers of leaving hearing loss unaddressed e.g. potential increased risks of depression and dementia.

9. If you are proposing a new component to the programme, please describe the effective treatment and management systems that are exist and are available.

There is incontestable evidence that hearing aids improve quality of life[iv]. Their use is recommended by NICE[viii]. Very high numbers of people continue to use and benefit from hearing aids once they receive them, usually around 80-90%[x] and 71% think they should have got them sooner[xi].

There is a well-established NHS infrastructure for providing hearing aids with services present in every CCG area across England. Over 1.3 million hearing aids were issued by the NHS in 2017[xvi]. These services are supported by national Action Plan on Hearing Loss[vi] and national commissioning guidance[ix].

10. Please state whether you feel the change will have a negative, neutral or positive impact on health inequalities and on the nine protected characteristic groups and why.

Negative Neutral **x Positive**

Hearing screening would reduce health inequalities based on age and disability.

Disability: Hearing loss can be classed as a disability under the Equality Act (2010). Unaddressed hearing loss may increase the risk of depression and dementia, hence ensuring that more people get help for their hearing would reduce health inequalities related to disability.

Age: Hearing loss is mostly age related. Unaddressed hearing loss may increase the risk of depression and dementia, hence ensuring that more people get help for their hearing would reduce health inequalities related to age.

11. Please name a local authority that has already adopted this proposed change to their delivery of the NHS Health Check programme.

N/a

12. Please list any relevant references

See endnotes

Section 2 For completion by the ESCAP secretariat

13. Proposal to be shared with ESCAP

Yes

14. ESCAP feedback

ESCAP members agreed that hearing loss poses a considerable challenge to the public's health and recognised the importance of taking action to address it. Members felt that it would be important to give thorough consideration to introducing a routine assessment for hearing loss as part of an NHS Health Check. While it was recognised that this assessment met some of the requirements of the content review process it was noted that the UK National Screening Committee currently advise against screening for hearing loss. Therefore, members felt that this proposal should be put on hold and reconsidered once the UKNSC publishes its updated review and recommendations on screening for hearing loss.

[i] Action on Hearing Loss (2015) Hearing Matters

[ii] Saito, H., Nishiwaki, Y., Michikawa, T., Kikuchi, Y., Mizutari, K., Takebayashi, T., & Ogawa, K. (2010). Hearing handicap predicts the development of depressive symptoms after 3 years in older community-dwelling Japanese. *Journal of the American Geriatrics Society*, *58*(1), 93-97.

[iii] Lin, F. R., Metter, E. J., O'brien, R. J., Resnick, S. M., Zonderman, A. B., & Ferrucci, L. (2011). Hearing loss and incident dementia. *Archives of neurology*, *68*(2), 214-220.

[iv] Ferguson, M. A., Kitterick, P. T., Chong, L. Y., Edmondson-Jones, M., Barker, F., & Hoare, D. J. (2017). Hearing aids for mild to moderate hearing loss in adults. *Cochrane Database of Systematic Reviews*, (9).

[v] Maharani, A., Dawes, P., Nazroo, J., Tampubolon, G., Pendleton, N., SENSE-Cog WP1 group, & Constantinidou, F. (2018). Longitudinal relationship between hearing aid use and cognitive function in older Americans. *Journal of the American Geriatrics Society*, *66*(6), 1130-1136.

[vi] NHS England and Department of Health (2015) Action Plan on Hearing Loss

[vii] Davis, A., Smith, P., Ferguson, M., Stephens, D., & Gianopoulos, I. (2007). Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. *HEALTH TECHNOLOGY ASSESSMENT-SOUTHAMPTON 1*(42).

[viii] NICE (2018) Hearing loss in adults: assessment and management, NICE guideline [NG98]

[ix] NHS England (2016) Commissioning Services for People with Hearing Loss: A framework for clinical commissioning groups

[x] Perez, E., & Edmonds, B. A. (2012). A systematic review of studies measuring and reporting hearing aid usage in older adults since 1999: a descriptive summary of measurement tools. *PloS one*, *7*(3), e31831.

[xi] EHIMA (2018) Eurotrak UK 2018

[xii] Livingston, G., Sommerlad, A., Orgeta, V., Costafreda, S. G., Huntley, J., Ames, D., ... & Cooper, C. (2017). Dementia prevention, intervention, and care. *The Lancet*, *390*(10113), 2673-2734.

[xiii] Davis, A., Smith, P. A., Booth, M., & Martin, M. (2012). Diagnosing patients with age-related hearing loss and tinnitus: Supporting GP clinical engagement through innovation and pathway redesign in audiology services. *International Journal of Otolaryngology*, *2012*.

[xiv] RNID/London Economics (2010) Cost benefit analysis of hearing screening for older people

[xv] Morris, A. E., Lutman, M. E., Cook, A. J., & Turner, D. (2012). An economic evaluation of screening 60-to 70-year-old adults for hearing loss. *Journal of Public Health*, *35*(1), 139-146.

[xvi] Written answer to Parliamentary Question https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-12-01/117036/