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EXECUTIVE SUMMARY

There are more than 10 million people in the UK today who live with some degree of hearing loss. The vast majority of these individuals are older people – with 71% of people aged over 70 experiencing some degree of hearing loss, and 44% experiencing hearing loss that is moderate or worse. As society ages the number of people experiencing hearing loss is set to grow.

Hearing loss has wide-ranging impacts. Improving the prevention, detection and treatment of hearing loss should, therefore, be a public health priority.

The evidence, from our own recent survey and wider research, demonstrates that hearing loss is linked to:

- Loneliness and isolation
- Reduced quality of life
- Poor physical health – including an increased risk of cardiovascular disease
- Dementia – with those with severe hearing at five times the risk of developing dementia
- Depression and other mental health issues

People with hearing loss also experience difficulties accessing health services and other every day services such as public transport, due to failure to make appropriate adjustments. They are also significantly more like to be unemployed.

However, the impacts of hearing loss are not just felt by those who are directly affected by it, but also by families and the wider community. Hearing loss affects:

- Families – with the partners of people with hearing loss more likely to experience loneliness and more likely to become depressed.
- Public services – through the increased costs of treating hearing-loss related illness. The cost of additional GP visits alone was estimated at £76million per annum.
- The economy – with the underemployment of people with hearing loss estimated to cost the nation £25bn per annum.
There is currently a very high-level of under-diagnosis of hearing loss among older people. On average, there is a 10-year delay between the onset of hearing loss and people seeking help with the condition, due to a range of factors including failure to recognise the symptoms of hearing loss, denial and stigma around hearing loss and its association with older age. There are also concerns that GPs are failing to refer some adults who could benefit from hearing services.

Similarly levels of treatment for hearing loss are shockingly low. Of the six million people in the UK who could benefit from hearing aids only two million have them and only 30% of these use them regularly.

Studies demonstrate significant benefits to hearing aid use including:

- Reduced loneliness
- Improved mental health
- Lower risk of unemployment
- Reduced risk of cognitive decline

However, the stigma of hearing loss and hearing aid use alongside practical difficulties using aids, create barriers for many older people.

Improving access to high quality after-care and to social and emotional support for people with hearing loss could help to address these barriers, but these are currently areas of weakness in hearing loss provision. We also need fresh action to tackle the stigma of hearing loss.

Unfortunately hearing loss policy has yet to catch up with current thinking about how to deliver services for an ageing society.

Around 60% of areas offer choice in NHS hearing loss services. A recent Monitor report demonstrated the benefits this has brought in encouraging the development of more flexible services on the high street and in people’s homes, offering an alternative to traditional hospital-based services. However, too little has been done to ensure that hearing loss services provide excellent after-care and to consider how to link hearing loss services to wider support, particularly from the voluntary and community sector.
The new **National Action Plan for Hearing Loss** promises to change this. The Plan commits to new commissioning guidance for hearing services and describes how these should be linked to wider provision. However it does not propose specific action to tackle the stigma of hearing loss.

We conclude that there is an **urgent need to address the incredibly low levels of diagnosis and treatment of hearing loss among older adults.**

To do this we must do two things:

- Address the barriers to diagnosis and treatment of hearing loss among older adults
- Ensure that older adults who could benefit from hearing aids have access to high quality specialist hearing services, which provide excellent after-care and link to wrap-around support

We recommend:

- Action to **tackle the stigma** of hearing loss, including:
  - Public information campaigns
  - Work with professionals in contact with older people
- Action to **improve access to treatment**, including:
  - Improving individuals’ and GPs’ awareness of the benefits of timely assessment and treatment for hearing loss.
  - Continued choice for NHS patients, including services on the high street, and in people’s own homes.
  - A pilot of self-referral for NHS services
- That the new **Commissioning Guidance** on hearing loss, promised in the recent National Action Plan should:
  - Emphasise the quality of after-care and follow-up
  - Ensure that specialist hearing services are linked-up to wider support for older peoples wellbeing.

**Royal Voluntary Service** will be taking forward a new campaign **Listen Out**, in partnership with Specsavers, to raise awareness of hearing loss and what can be done about it and to help to breakdown the stigma of hearing loss. We will work to ensure people with hearing loss are linked up to our services in the community, so that no older person is left lonely and isolated.
HEARING LOSS IN THE UK

1.1. WHAT IS HEARING LOSS?

The term “hearing loss” describes a wide range of hearing impairments:

- **Mild hearing loss** – quietest audible sounds 25-39 dB - difficulties following normal speech particularly in noisy surroundings.

- **Moderate hearing loss** – quietest audible sounds 40-69 dB – difficult to follow speech without hearing aids.

- **Severe hearing loss** – quietest audible sounds 70-94 dB–most people need to lip read or sign, even with hearing aids.

- **Profound deafness** – quietest audible sounds over 95 dB – people need to lip read or sign.

While hearing loss can be experienced at any age, the vast majority of cases are in older people. Age-related damage to the cochlea – or presbycusis - is the single biggest cause of hearing loss.²
1.2. **HOW COMMON IS HEARING LOSS?**

There are more than 10 million people in the UK with hearing loss the vast majority of whom are older people.\(^3\) Over 6 million of these individuals could benefit from hearing aids (i.e. have hearing loss of at least 35dB in the better ear).\(^4\)

44% of over 70 year olds have hearing loss that is moderate or worse.\(^5\)

There is a socio-economic gradient to hearing loss, with higher levels of hearing loss amongst those in lower socio-economic groups.\(^6\)

**Hearing loss affects:**

- 41.7% of people aged over 50
- 55% of people aged over 60
- 71% of people aged over 70

1.3. **WHAT ARE THE FUTURE TRENDS?**

As society ages the number of people experiencing hearing loss is set to grow.

By 2031 14.5 million people in the UK will have hearing loss (nearly 20% of population).\(^7\) By 2037 there will be 10 million individuals whose hearing loss is moderate or worse.\(^8\)

By 2030 the World Health Organization predicts adult onset hearing loss will be the seventh highest impact health problem globally.\(^9\)
THE IMPACT OF HEARING LOSS

Hearing loss has wide-ranging impacts both on individuals affected by it, and their families and wider communities. Improving the prevention, detection and treatment of hearing loss should, therefore, be a public health priority.

2.1.
IMPACTS OF HEARING LOSS ON INDIVIDUALS

2.1.1. Loneliness and isolation

There is significant evidence demonstrating the links between hearing loss and loneliness and isolation.10

This is cause for concern given the growing evidence that loneliness harms both mental and physical health,11 and has a similar impact on mortality to smoking 15 cigarettes a day.12

Loneliness is a subjective experience – commonly understood as a negative emotional response to a perceived gap between the quality and quantity of social connections we have and those we desire.13

The evidence shows that hearing loss can damage both the quantity and quality of individuals’ social relationships:

- Hearing loss can make it difficult for individuals to communicate, particularly in group situations and in environments with background noise, leading people to withdraw from social activities.14
- While hearing loss does not necessarily reduce people’s frequency of contact with friends and family,15 over time it can damage the intimacy of close relationships as people frustrated by difficulties in communication.16
Recent research for Royal Voluntary Service among adults aged 75 and older demonstrated these damaging impacts clearly, finding that among those who reported that their hearing had got worse in the last five years:

- 36% got through social occasions by pretending they could hear things (e.g. by smiling and nodding)
- 25% felt left out
- 9% were less social
- 18% felt less confident
- 5% felt more lonely and went out less

The effects of hearing loss on social interaction can be particularly pronounced among older people, as so many have hearing loss which is undiagnosed and untreated.

Furthermore hearing loss and loneliness are linked in a vicious circle. Research shows that family members can be vital in helping older people recognise that they are experiencing hearing loss and encouraging them to take action. Older people who live alone and are already isolated are caught in a cycle of being less likely to notice and address their hearing loss, and more likely to become further isolated.
2.1.2. Reduced quality of life

Hearing loss is associated with reduced quality of life across a range of measures. For example, studies have found that only 39% of people with hearing loss perceived their quality of life to be excellent, compared to 68% of non-hearing impaired people; nearly one-third of the population with hearing loss report being in fair or poor health, compared to only 9% of the population without hearing loss; and people with hearing loss are less satisfied with their “life as a whole” than people without hearing loss.19

2.1.3. Health issues

The evidence demonstrates that hearing loss has a wide range of negative impacts on health.

2.1.3.1. Poor overall health

People with hearing loss are significantly more likely than the general population to have multiple long-term conditions. According to the recent report of the Chief Medical Officer, 29% of people who report deafness have four or more long term conditions20 and there is a correlation between the severity of hearing loss and lower levels of health related quality of life.21

There is also evidence linking hearing loss to key causes of morbidity and mortality in later life:

- A study in Finland showed that older men with hearing loss, or dual sensory loss had a greater risk of dying from any cause, and particularly cardiovascular causes, within a median 5-year follow-up.22
- Hearing loss commonly goes along with balance issues which are a key risk factor for falls – a major cause of mortality among older people.23
- Other studies have pointed to potential links between hearing loss and smoking.24
2.1.3.2. Dementia

A growing area of interest is the link between hearing loss and dementia. The relationship is complex, as there is concern that people with hearing loss may be diagnosed with dementia when in fact their issues are caused by communication difficulties.

However there is a growing body of research demonstrating that individuals with hearing loss are at greater risk of suffering from dementia. Indeed a recent study from the US showed that:

- those with mild hearing loss have nearly double the risk of developing dementia;
- those with moderate hearing loss have three times the risk of developing dementia; and
- those with severe hearing loss have a five times greater risk of developing dementia.

The precise pathways by which hearing loss causes dementia are not known. However one theory is that the risk is increased by the social isolation of people with hearing loss. We know that social connectedness can reduce the risk of developing dementia. So hearing loss, which causes communication problems and can leave people isolated, deprives people of the stimulation they need and in this way increases their risk of dementia. This theory is lent credibility by the fact that people who wear hearing aids do not demonstrate the same level of decline in cognitive function as those who do not.

2.1.3.3. Mental health issues

People with hearing loss are at much higher risk of experiencing mental ill-health, such as depression, anxiety etc. One study showed that people with hearing loss are 2.45 times more likely to develop depression.
Problems using health services

One potential explanation for the worse health outcomes experienced by people with hearing loss may be the increased difficulty they experience in accessing basic health services including pharmacy services and consultations with GPs and nurses.

In a survey for Action on Hearing Loss people reported a range of issues including: problems booking appointments; not hearing names being called in the waiting area; and difficulties understanding the clinician. Among those who had attended a GP appointment:

- more than one-quarter (28%) of respondents had been unclear about a diagnosis;
- around one-quarter (26%) had been unclear about health advice they were provided with; and
- approximately one-fifth (19%) had been unclear about their medication.31

Given the very high numbers of people with hearing loss experiencing other health conditions, it is vital that health services are designed with the needs of people with hearing loss in mind.32

Underemployment

Unemployment rates for people with hearing loss are significantly higher than the national average. Some 30% of people of working age with severe hearing loss are unemployed.33

Negative attitudes and the failure of employers to make reasonable adjustments (as required under equality law) can present barriers to employment for people with hearing loss. In a study for Action on Hearing Loss, people reported that they feared being seen as less competent at work if they wore hearing aids.34
2.1.5.

**Access to community life**

People with hearing loss report problems accessing day-to-day public services. For example in a members’ survey for Action on Hearing Loss, one quarter of respondents said that they found it difficult to find information during travel on public transport.

The failure to provide information in a range of formats; to offer loop systems; and to otherwise consider the needs of people with hearing loss can create barriers to getting out and about that, over time, can exacerbate problems of isolation and loneliness.

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2.2.

**WIDER IMPACTS**

The impacts of hearing loss reach beyond the individuals that experience it, affecting friends and family, communities and the nation as a whole.

2.2.1.

**Friends and family**

The evidence demonstrates that, over time, hearing loss can damage intimate relationships between couples and can lead partners and families of people with hearing loss to withdraw from social situations in which their loved one may struggle. In this way hearing loss can lead to increased loneliness and isolation among the families of people with hearing loss.

The effects of hearing loss on family members can be substantial and costly. Indeed one study found there that the partners of deaf people had a higher risk of depression. It is therefore vital that individuals with hearing loss have their needs assessed, and met, in a framework that takes account of their wider roles as partners, parents etc.

2.2.2.

**Labour market impacts**

The large scale underemployment of people with hearing loss is set to become an ever-more significant problem as the population ages. This has serious implications for the national economy. The cost of the underemployment of people with hearing loss has been estimated to be £25bn per annum and could grow to £38.6bn by 2031.
In an ageing society we will be ever-more reliant on older workers to meet our needs for labour and skills. By 2020, older people will account for approximately a third of the working age population and around three-quarters of us will have some kind of disability before the age of 68. A significant proportion of our future workforce will have hearing loss – with at least 1 in 10 adults aged 40 to 69 experiencing substantial hearing loss.

It is therefore vital that we make adjustments to our workplaces to accommodate the needs of individuals with hearing loss. This will require work to tackle the stigma of hearing loss; more widespread use of loop systems; and efforts to make specific adjustments to workplaces and working practices to accommodate individuals’ needs.

2.2.3. Costs of health and social care

The higher levels of mental and physical ill-health experienced by people with hearing loss create an additional, and potentially avoidable, burden on the public purse through the costs of health and social care services.

The links between hearing loss and depression (which costs the NHS £520m a year); falls (which costs the NHS at least £1.9bn a year); and dementia (which is estimated to cost £16,700-£37,500 per person affected) all point to a substantial increased cost to the NHS of dealing with the knock-on effects of hearing loss.

Studies have demonstrated that people with hearing loss are more likely to be admitted to hospital. And one study estimated the cost of additional GP visits among those with hearing loss at £76 million per annum.

However there is potential to reduce this burden. One study calculated that better management of hearing loss among people with dementia could lead to savings of £28m in the cost of delayed entry to residential care alone.

Clearly, therefore, there is a substantial financial imperative to improve the diagnosis and treatment of hearing loss.
3.1. PREVENTION

This paper does not consider prevention in detail, as the vast majority of older people experience hearing loss linked to ageing, which is currently not seen as preventable.

However, it is clear that certain forms of hearing loss – particularly those related to damage due to prolonged exposure to loud noise – are susceptible to early intervention, including work to improve the safety of those working in noisy environments, and this needs to be driven forward.

Furthermore, it is clear that with more investment in research into hearing loss – which is currently a “poor relation” compared to other long-term conditions – further opportunities for prevention may be identified. Given the very serious impacts of hearing loss on quality of life and mental and physical health, this should be a priority.
Late diagnosis of adult-onset hearing loss is a significant cause for concern. It is thought that, on average, there is a 10-year delay between the onset of hearing loss and people seeking help with the condition. 48

Ensuring earlier diagnosis of hearing loss is important as it allows individuals to adjust to their hearing loss and get used to using aids, before they have become used to a quiet world and before they have withdrawn socially, with all the other negative impacts this can bring.

Royal Voluntary Service research found that 37% of those whose hearing had got worse had not told friends or family about it and 31% had not sought any professional help with their hearing. 49

There are a number of factors behind the delay in seeking help with hearing loss: a key factor is the gradual nature of its onset which means that people do not always spot that it is happening. 50 However there are also a range of psychological factors including: denial; thinking that hearing loss is a natural part of ageing; and the idea of being a person with hearing loss not fitting with people's perception of self. 51

Another key issue is lack of understanding of the potential for diagnosis and treatment. The recent Royal Voluntary Service research showed that the most common reason given for not having sought help with hearing loss was a sense that it was “not bad enough”. Other reasons included concerns about being taken seriously, thinking nothing could be done about hearing loss, and having learnt to live with it. 52

3.2.1.

**Stigma**

The psychological barriers to diagnosis discussed above point to a worrying stigma around hearing loss. Much of this stigma is linked to the fact that hearing loss is perceived (not-inaccurately) as an issue affecting older people. In this way hearing loss stigma can be seen as part of a broader societal ageism.

Ageist attitudes have a negative impact on our response to hearing loss in a number of ways – the idea that later life is a time of loss leads people to “accept” loss of hearing as inevitable rather than considering that it might be susceptible to treatment; and a general perception that being older is “a bad thing” leads people to deny their hearing loss, in order to avoid being perceived as “old”.

3.2.

DIAGNOSIS
It is therefore vital that these ageist attitudes are tackled. However to address the stigma of hearing loss itself we need to talk more about it – so that people understand that, while hearing loss may be associated with growing older, living with hearing loss is not an inevitable part of ageing; and that, with proper treatment, the negative effects of hearing loss can be significantly reduced, so that people can continue to live, work, and socialise normally.

Several organisations, including the recent ILC-UK Commission on Hearing Loss, have argued that we need a large-scale public campaign to raise awareness of the early signs of hearing loss and to encourage individuals to take action.\(^5^3\)

3.2.2.

**Routes to diagnosis**

At present there is no national screening programme for hearing loss in adults. However voluntary organisations have repeatedly called for one to be established. A cost-benefit analysis of a one-off screening programme for people aged 65, estimated that it would cost £255 million over ten years and would bring benefits across the same period amounting to over £2 billion.\(^5^4\)

In the absence of a screening programme, the main route to diagnosis of hearing loss is through consultation with a GP, leading to a referral to a specialist hearing service.

Among participants in the *Royal Voluntary Service* research, 42% of those who perceived their hearing to have got worse in the last five years had sought help from their GP – making this the most common destination for those wanting help - and 84% of those who did not yet perceive themselves to have experienced hearing loss said they would turn to their GP if this changed.\(^5^5\)

Unfortunately, evidence suggests that GPs fail to refer as many of 45% of those reporting a hearing problem for any further intervention, such as a hearing test or hearing aids.\(^5^6\)
There are, however, other ways of checking your hearing – including Action on Hearing Loss’s online and telephone-based Hearing Check service, and the growing number of high street hearing clinics (which were visited by 16% of those experiencing hearing loss in our survey\(^57\)), which often offer no-obligation hearing checks. However, unfortunately without a GP-referral further services cannot be provided on the NHS.

The recent ILC-UK Commission on Hearing Loss report proposed piloting a system of self-referral into the full range of NHS audiology services, which would seem a sensible way of testing out whether this might widen access to diagnosis and to treatment where appropriate, by offering people the greater flexibility and accessibility that community providers are often able to provide.\(^{58}\)

### 3.3. TREATMENT

Current levels of access to treatment for hearing loss are very low. There are around six million people in the UK who could benefit from hearing aids; but only two million have them, and only 30% of these use them regularly.\(^{59}\) This means there are more than four million people who have an unmet need for treatment, and many more who could be better served.

#### 3.3.1. The benefits of using hearing aids

The evidence is very clear that using hearing aids not only brings immediate benefits – in helping people to hear better - but also mitigates the wide negative impacts of hearing loss.

A study in the US demonstrated that, compared to older, hearing-impaired people who use hearing aids, those who do not use hearing aids are more likely to report:

- sadness and depression;
- worry and anxiety;
- paranoia;
- less social activity;
- emotional turmoil; and
- insecurity.
And older people whose hearing loss is treated report benefits including:

- better relationships with their families;
- better feelings about themselves;
- improved mental health; and
- greater independence and security.

It also showed that older people with hearing loss who use hearing aids are more likely than non-users to be involved in their neighbourhoods, and in group social activities etc.\(^60\)

A more recent meta-analysis confirmed these findings, demonstrating that hearing aid use improved the psychological, social and emotional wellbeing of adults with acquired hearing loss.\(^61\)

Hearing aids can also support people to stay in work. Those with severe hearing loss who do not use hearing aids have unemployment rates nearly double those who do.\(^62\) And 83% of hearing aid owners who are working think their hearing aids are useful for their job.\(^63\)

There is even some evidence that hearing aid use may improve, or at least slow down the deterioration in, cognitive function. However, the impact of hearing aids of dementia needs further investigation, to understand the extent to which this is a direct effect, or whether hearing aid use only reduces decline if it also leads to reduced social isolation.\(^64\)

3.3.2. **Barriers to hearing aid use**

There are a number of reasons why individuals may be reluctant to accept hearing aids, or may not use them regularly after they have been supplied.

The stigma of hearing loss, and its association with being older (discussed above), is a key barrier to use.\(^65\) In our recent survey 43% of those whose hearing had got worse, said they would not consider a hearing aid citing concerns about how they look, about being treated differently, and about appearing old. It is therefore vital that the stigma of hearing loss is addressed, in order that people can feel comfortable using aids day-to-day.

Practical concerns around comfort, usability and maintenance of aids, can also lead people to stop using aids that have been prescribed. However in many cases proper follow-up and after-care can help overcome these barriers.
3.4. **AFTER-CARE**

The numbers of people who currently have hearing aids, but do not use them are shockingly high. However many of the reasons given for ceasing to wear hearing aids - including problems with fit, sound levels, whistling etc - could be addressed through more effective follow-up and after-care by hearing services. Unfortunately the recent report by Monitor highlighted after-care as a key weakness of the current system.

Making hearing services more accessible – for example through increasing the number of services offering follow-up on the High Street, and through home visits, on the NHS – may be one way of improving after-care as older people may struggle to make repeated visits to hospital services. Better monitoring of hearing service contracts will also be important to improve provision in this area.

However there are also opportunities to further enhance after-care by linking it up to other support so that is not limited to enabling proper use of aids, but includes wider rehabilitation, for example through link ups with social care and voluntary sector provision.

3.5. **WIDER REHABILITATION**

Action on Hearing Loss explain that “Following a timely diagnosis people with hearing loss need a range of services and support including health, rehabilitative and social services - to help manage and adapt to their hearing loss and enable them to lead fulfilling lives.”

Unfortunately, at present, hearing service provision is often limited to treating the immediate presenting issue, and fails to address older people’s needs in the round. It therefore does not provide the support people need to deal with their hearing loss in the context of their wider experience, and does not address the other issues hearing loss may have caused – such as loneliness and isolation.

A survey by the RNID in 2008 found that four-in-every-five people with hearing loss received no information on further services when they were fitted with their hearing aids.
As a minimum, people need information about further support for their hearing loss including: assistive technologies – such as visible fire alarm systems, doorbells and telephone “ringers”; support available from voluntary organisations such as Action on Hearing Loss’s Hear to Help services; and rehabilitative services such as lip-reading classes.

Unfortunately, in recent years these services have been under threat of closures due to cuts. In 2005 lip reading classes were classified as a leisure activity by the Learning and Skills Council putting their funding at particular risk.70

However, proper rehabilitative support should go beyond these specialist services, linking into wider provision to address the impacts of hearing loss. Some older people will need help with emotional issues; others may need help with rebuilding social relationships following a period of isolation. Unfortunately the evidence shows that at present few older people are given psychological support they need to grieve their hearing following a diagnosis of hearing loss,71 and the links between hearing services and wider care and support are known to be poor.72

There is huge potential for the voluntary sector to be part of the solution in addressing these needs as it already provides many of the services people with hearing loss most need in the community.

The benefits of voluntary sector led wrap-around support have been demonstrated by research. For example a 2002 evaluation of a voluntary sector programme of psychosocial rehabilitation for people with hearing loss demonstrated sustained improvements across a range of measures of wellbeing and health.73 Such wrap-around support could potentially create virtuous circles of impact – as individuals who have been reconnected to social networks following hearing aid fitting are likely to have much greater incentives to keep up their hearing aid use.
4.1. APPROACHES TO OLDER PEOPLE IN AN AGEING SOCIETY

The UK population has been ageing over recent decades, and this will only accelerate in the years to come – with people aged 65 and over set to make up nearly a quarter of the population by 2033. The growth in numbers of older people has, in the past decade or so, driven recognition of the need to shift our approach to ageing from one in which older people are treated as a burden on our communal resources, to one in which they are recognised as societal assets, and supported to utilise their considerable personal, social and financial resources for the benefit of the wider community.

Initiatives such as the 2005 national ageing strategy *Opportunity Age* have attempted to shift the narrative away from talking about later life in terms of the losses associated with age, to emphasising the positive and focussing on how to encourage people to stay healthy and active in later life.
Two particular drivers of recent policy have been the recognition that, in an ageing society, we need more older people to work for longer; and the understanding that if we do not act to keep people as healthy and independent as possible for as long as possible, the costs of health and care services will overwhelm us.

In relation to employment this has meant increases to the state pension age;\textsuperscript{76} a ban on retirement ages and attempts to tackle age discrimination in the workplace;\textsuperscript{77} and increasing consideration of what needs to be done to accommodate older workers.\textsuperscript{78}

In relation to health, this has forced a renewed effort to shift the NHS and care systems away from treating illness towards promoting health and wellbeing, to reduce the cost of services. Few of us will reach later age without a number of long term conditions, with which we will live for many years. For many of us, hearing loss will be one of these. The challenge for policy makers and practitioners is therefore to help people manage these conditions better, so they do not lead to dependency and/or expensive health emergencies.

Increasingly it is understood that to do this effectively we will have to move away from a medical model which treats each condition separately, towards a system that works within a day-to-day reality in which each condition layers on top of the other, and in the midst of which we need to maintain our other roles as partners, parents, grandparents, care givers, volunteers, workers and community members.

More-and-more policy makers are recognising that doing this will mean drawing on the expertise and resources of all sectors, including the voluntary sector, to help support people, and more importantly to help people support themselves.
Publications like the recent Age UK / NHS England Ageing Well guide are a small-scale example of this approach in action. However the same understanding also underpins large scale programmes – including the Better Care Fund and the NHS Five Year Forward View, New Models of Care “Vanguards” programme, and changes in the Care and Support system through the Care Act 2014. These programmes all espouse the same core principles of early intervention, individual choice and control and the integration of services, and acknowledge the role the voluntary sector can play as part of the health and care system to deliver better outcomes for individuals.

In theory these concepts are intended to be at the heart of all health and care policy going forward, and therefore should inform our future approach to hearing loss.

4.2. **HEARING LOSS POLICY**

In many ways, the approach to hearing loss to date seems rather out of step with these broader shifts in ageing, health and care policy.

While hearing services were chosen to pioneer “choice” under the Any Qualified Provider (AQP) scheme, beyond this little has been done to take hearing services beyond the narrow medical model, or to locate the diagnosis and treatment of hearing loss in the wider context of individuals’ needs, including heir economic, social and emotional needs.

However in recent months there have been a number of significant developments – including a report by Monitor on the impact of choice in hearing loss, and a new National Action Plan for Hearing Loss.

4.2.1. **Choice in Hearing Services**

Since 2012 the provision of adult hearing services on the NHS has been managed under AQP in around 60% of areas, which means that in these areas patients should be offered a choice of providers of audiology services on the NHS.
A recent report by Monitor, looking at the impacts of choice in hearing services, found that this system had led to improvements in the services available to patients – with an increased range and flexibility of services making it easier for patients to access support. It recognised the added value of community providers entering the market, providing easily-accessible services to patients through high street provision, home visiting services etc. It also found that in some areas where new providers had entered the market and promoted their services there had been increased take up of services.83

However, worryingly, it found evidence that few patients were made aware of their choice by GPs: primarily due to GPs’ lack of knowledge about the options; and false assumptions about whether people wanted choice.

The report also noted problems with after-care and recommended new targets to drive improvements in this area; and highlighted the need for better joining-up between hearing services and wider support.

4.2.2. Hearing loss policy behind the curve

It is clear that hearing loss policy to date has not driven system reform of the kind underway in the wider health and care system.

The ongoing issues of poor rates of diagnosis, and treatment; and the failure to locate audiology services within a wider framework of care and support services for people with hearing loss suggest that commissioners have yet to recognise hearing loss as a significant driver of overall health and wellbeing. An inference which is backed-up by Action on Hearing Loss’s recent survey of Directors of Adult Social Services which found that only one third of areas had assessed the needs of people with hearing loss as part of their Joint Strategic Needs Assessment.84

However, the Government’s recently published Action Plan on Hearing Loss shows promising signs of a move to more joined-up thinking.
4.2.3. The National Action Plan on Hearing Loss

In March 2015 NHS England and the Department of Health published their long awaited National Action Plan on Hearing Loss. The plan promises a more person-centred and integrated response to hearing loss, and includes commitments across five priority areas which are:

- Prevention
- Early diagnosis
- Integrated, patient centred management
- Ensuring those diagnosed do not need unscheduled care or become isolated
- Ability to partake in every-day activities including work

Helpfully, the Action Plan recognises that “older people normally need a four stage cycle of access; assessment; correction/advice (depending on their wishes); and on-going support (linked to other support e.g. sight, mobility, social care) - all of which can be provided in a primary care setting.”

Among the specific commitments to action included in the plan is the development of new Commissioning Guidance for hearing loss to support the more person-centred services, based on the “house of care” model being used across the wider health and care system; and work to improve the links between hearing loss and other services across health, social care and the voluntary sector to identify, and treat hearing loss more effectively in the context of people’s wider care and support needs.

This commitment creates opportunities for voluntary organisations interested in improving outcomes for older people affected by hearing loss to work with policy makers and commissioners at national and local levels to develop new and improved services for older people with hearing loss.

However, as the Action Plan does not promise any further resources for Hearing Loss services, there is a risk, particularly in times of austerity, that these commitments may not be translated into action.

Notably the Action Plan also rejects the case for a screening programme, and does not propose any specific work to address the stigma of hearing loss – despite the very clear evidence of the significance of stigma in the high rates of under-diagnosis and treatment.
CONCLUSIONS AND RECOMMENDATIONS

This report has identified that hearing loss is a significant and growing issue for older people with wide-ranging consequences both for the individuals affected and for wider society.

The evidence is clear that hearing loss is susceptible to effective treatment, primarily through the provision of hearing aids, but that this treatment is most effective when provided in the context of wider support for individuals affected.

For many years policy on hearing loss has not caught up with the shifts in policy in relation to an ageing society and the change underway in health and care policy. However the National Action Plan on Hearing Loss points a helpful way forward to start to address that. It is vital that its implementation is driven forward purposefully by central and local government in partnership with private providers and organisations across the voluntary sector, including Royal Voluntary Service.

Voluntary sector organisations already have considerable experience of providing older people with in-the-round support and real expertise in tackling some of the key impacts of hearing loss, such as loneliness and social isolation and of working in partnership with health and care providers.

It is clear that there is an urgent need to address the incredibly low levels of diagnosis and treatment of hearing loss among older adults. To do this we must do two things:

- Address the barriers to diagnosis and treatment of hearing loss among older adults
- Ensure that older adults who could benefit from hearing aids are able to do so, by ensuring people have access to high quality specialist hearing services, which provide excellent after-care and are able to link people into wider packages of wrap-around support for wellbeing, including, in particular, voluntary and community sector support.

Overleaf we set out some steps which we believe should be taken forward in partnership between central and local government, private sector providers and the voluntary sector to achieve these ends.
5.1. ADDRESSING THE BARRIERS TO DIAGNOSIS AND TREATMENT

Action is needed to tackle the stigma of hearing loss. This requires:

- Public information campaigns to “normalise” hearing loss in the public consciousness
- Work with a wide range of professionals in regular contact with older people – and particularly health and care professionals – to improve their understanding of the signs of hearing loss, and to increase their awareness of how to help individuals (a) recognise their hearing loss and (b) seek effective diagnosis and treatment

Action is needed to improve access to treatment. We must:

- Ensure that individuals and GPs are more aware of the benefits of timely assessment and treatment for hearing loss
- Ensure that the NHS continues to offer patients access to a choice of specialist hearing services, including those offering easy access on the high street, and in people’s own homes
- Consider how to widen access to audiology services including piloting self-referral for NHS services as recommended by the Commission on Hearing Loss and by increasing awareness of the variety of options available for assessment and treatment.

5.2. ENSURING ACCESS TO WIDER SUPPORT

New Commissioning Guidance on hearing loss, promised in the recent National Action Plan must:

- Place greater emphasis on the quality of after-care and follow-up from hearing aid fitting – ideally using continued use of hearing aids as a key indicator of service quality
- Ensure that specialist hearing services are linked-up to wider support for older people’s wellbeing, so that people receive truly person-centred, integrated services to help them to age well

Statutory bodies – including in particular Health and Wellbeing Boards and commissioners across health and social care – need to work in partnership with private providers and the voluntary sector to develop innovative models of wrap-around support to meet these needs.
WHAT WE WILL DO TO ADDRESS HEARING LOSS

At Royal Voluntary Service we understand well the devastating impact of loneliness and isolation on older people’s lives and we are proud of the work our volunteers do every day to help older people stay healthy, happy and connected.

We believe it is unacceptable that so many older people face untreated hearing loss, leaving them feeling unable to join in with their families and communities, and slowly becoming more withdrawn and lonely. We believe that it is time to break the silence for older people with hearing loss.

To that end Royal Voluntary Service has teamed up with Specsavers to start to take practical steps to address hearing loss among older people. We want to raise people’s awareness of just how common hearing loss is in later life, and to break down the stigma of hearing loss, letting people know that they can access treatment and support.

Our Listen Out campaign aims to get people talking about hearing loss and to improve awareness of the routes to diagnosis and treatment, both among members of the public and commissioners and providers of health and care services.

Alongside this, we will continue to work with policy makers and commissioners throughout the country to identify opportunities to deliver joined-up services for people affected by hearing loss – linking up Royal Voluntary Service’s wide range of volunteer-led services with specialist hearing services – and making sure that no older person need be left lonely and isolated by hearing loss.
CASE STUDY

Mr A is in his 80’s and lives alone. He has for many years suffered from hearing loss. The situation has progressively become worse. Mr A avoids social situations due to hearing loss. He chooses not to engage in social activities because his is embarrassed by the hearing loss. Mr A cannot understand what others are saying, especially in situations with significant background noise. Mr A would rather avoid those situations than have to ask others to repeat themselves. Mr A said that he feels lonely and depressed because of his hearing and unable to engage in social situations.

Mr A has no family living in the area; his only daughter lives over 200 miles away. Mr A’s wife died 6 years ago. His daughter contacted Royal Voluntary Service to enquire about the befriending service.

A volunteer befriender from Royal Voluntary Service generally visits Mr A at home at least once a week. The volunteer reported that he was unable to hear the doorbell, didn’t use the telephone and lived with the television volume at the maximum. Mr A communicated with his volunteer by barking instructions and saying “you’ll have to speak up I can’t hear”! The volunteer soon became aware that Mr A had been prescribed hearing aids many years ago but had given up on them because he said he didn’t like wearing them and would often forget to put them in!

The volunteer who also has a hearing disability explained to Mr A that she had ignored her own hearing issues for many years before taking any action. One sign of hearing loss is when people can hear someone talking but cannot understand what is being said. Hearing loss is one of the most common disabilities as we get older. The loss of hearing due to age is called Presbycusis. This type of hearing loss generally occurs gradually and many people feel they hear just fine when in fact, they have a significant loss of hearing sensitivity that affects their social interactions and quality of life.

The volunteer explained that hearing aids had improved over the years and that it might be a good idea to have his hearing retested. With the support of the volunteer Mr A had his hearing retested and now wears his ‘new’ hearing aids with pride. Mr A has since joined a local social club and likes to go to the cinema. Mr A is able to talk to his daughter on the telephone and hear the doorbell when people call round to his home.

The Royal Voluntary Service befriending service has encouraged Mr A to deal with a presiding hearing issue and supported him to engage in social opportunities thereby reducing his isolation.
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