

An unfolding scandal

The maintenance of hearing aids in care homes and hospitals

A report to the Care Quality Commission

Information from organisations across Great Britain helped in the preparation of this report but the recommendations apply solely to England because legal and administrative arrangements differ in devolved governments.

1. Summary and conclusions

- 1.1. My report *When silence is no longer golden*, published in September 2019, showed that voluntary organisations were highly critical of services for users with hearing loss in long-term care. Following an exchange of correspondence, I agreed to indicate to CQC how I believed its performance could be enhanced. This proved impossible without commenting on the policy framework within which CQC operates. Statutory organisations that manage, regulate and advise health and social care services are responsible for policies that impact on people with hearing loss. Unless they share common values and vision, none can achieve their full potential. The recommendations that follow have implications for them all and are more likely to gain traction with government if they have the support of CQC.
- 1.2. CQC relies on the Accessible Information Standard to regulate services relating to hearing loss. The Standard is contained in section 250 of the Health and Social Care Act 2012. It is demonstrably unsuitable for the task. It was designed to ensure people with hearing loss can access health and social care information; it does not address the needs of users to communicate with family and friends or to maintain contact with the world through the telephone, radio and television; nor does it cover recreational needs.
- 1.3. The Standard and official guidance have obscure wording which allow service providers to deny ownership of problem associated with the maintenance of hearing aids. The rights of self-funded care home residents depend on whether services are provided in a health or social care facility. Policies are blatantly discriminatory and contrary to policy statements on equality promulgated by NHS England and CQC.
- 1.4. Guidance by the National Institute for Clinical Excellence (NICE) and CQC fails to recognise that, overwhelmingly, users in long term care are unable to re-tube their hearing aids and that many front-line staff lack the necessary knowledge to do so.

2. Recommendations

1. **The Department of Health and Social Care** should consult on changing and/or clarifying the law so that all health and social care users with hearing loss have the right to a working hearing aid. (Paragraphs 4.1 to 4.4)
2. **The CQC and NICE** should amplify their guidance making it clear that users should receive practical help to clean and re-tube their hearing aids. (Paragraph 5.2)
3. **NICE** should review the membership of its Hearing Loss Guidance Committee. (Paragraph 5.2)
4. **The CQC** should, during inspections, routinely enquire about systems for cleaning and re-tubing hearing aids and include the findings in their reports. (Paragraph 5.3)
5. **The CQC** should require all care and nursing staff supporting elderly people to attend structured discussions on deaf awareness at least once a year. (Paragraph 5.3)
6. **NICE** should review the skills required by staff in homes and hospitals who care for people with sensory loss. (Paragraph 5.3)
7. **The CQC** should require homes and hospitals to record when a faulty hearing aid has not been restored to use after 72 hours. (Paragraph 5.3)
8. **The Department of Health and Social Care** should require local services to agree plans for apportioning responsibilities and costs for maintaining hearing aids in homes. (Paragraph 6.2)
9. **NHS England** should ensure that patients with hearing loss have ready access to centres where a range of assistive hearing devices can be demonstrated. (Paragraph 6.2)
10. **The CQC** should, where appropriate, encourage providers to make greater use of volunteers and voluntary organisations for maintaining hearing aids. (Paragraph 6.3)
11. **NHS England** should establish regional committees for a limited period to set-up demonstration projects on cleaning and re-tubing hearing aids. (Paragraph 6.3)

Background

- 3.1. My brother, almost totally blind, lived in care homes and hospitals during the last thirty months of his life. He was left without a working hearing aid for long periods. Due to facial cancer, saliva repeatedly blocked the aid for his one functioning ear. Managers in homes took no responsibility for the care of hearing aids; staff who helped appeared to do so in a personal capacity. Staff on hospital wards believed re-tubing required an audiologist and said there was a long waiting list. Meanwhile, conversation entailed shouting single words, staccato, into my brother's "good" ear.

- 3.2. There was no local centre where he could try-out a range of hearing devices so he bought a hand-held gadget through mail-order. But, due to poor sight, he could not operate the controls; also, it required a connection to a working hearing aid. Unsurprisingly, he slowly lost touch with the world and his mental health deteriorated markedly as he lay on his bed for weeks while his lifeless hearing aid sat on his locker. The dementia that slowly engulfed him was clearly related to his enforced social isolation. This was a disaster for him, a nightmare for his family and added significantly to the cost of his care.

- 3.3. After his death earlier this year, I circulated 78 UK organisations with an interest in hearing loss to learn their views on services for elderly people in long-term care. Half the replies were from voluntary organisations working in health and care settings. They mostly condemned health and social care providers for their indifference. I summarised the replies in my report, *When silence is no longer golden*.

4. The legal framework

- 4.1. The Equality Act 2010 requires all services to make "a reasonable adjustment" to avoid disabled people being placed at a "substantial disadvantage" to others. A person who needs a hearing aid to converse is at a serious disadvantage when it ceases to function, a disadvantage that can usually be overcome quickly and at negligible cost. I judge that the Act entitles a hearing aid user to have a defective aid restored but, as far as I know, this has not been tested in the courts.

- 4.2. The CQC relies on section 250 of the Health and Social Care Act 2012 to regulate services relating to hearing loss. This legislation requires health and adult social care providers to follow the Accessible Information Standard which is narrower in scope than the Equality Act. With certain exceptions, it requires service providers to ensure

- 4.3. users have access health and social care information. It is silent on communication issues like the need to connect with family and friends, to maintain contact with the world through the telephone, radio and television or engage in recreational activities.
- 4.4. My understanding is that the Standard does not bestow a blanket right to have a hearing aid cleaned and re-tubed. Hospital in-patients and care home residents funded by a local authority or the NHS have the right if they need help to communicate with NHS staff but not otherwise. Self-funded care home residents have the right only when they attend an NHS facility and cannot otherwise communicate with staff. Strict adherence to the law would penalise self-funded residents unable to travel to an NHS facility in person to have an aid re-tubed. Few staff or patients understand these arcane distinctions. Despite the Standard being part of an Act of Parliament, NHS England tells me it is not law. (Email 2nd September 2019).
- 4.5. It is indefensible that entitlement to re-tubing depends, not on patients' needs but on the kind of accommodation in which they live and the source of their income. The Standard conflicts with NHS England's *Equality and Health Inequalities Statement* and CQC's Equality Objectives for 2019 – 2021.

5. The role of CQC

- 5.1. CQC guidance can only be as good as the underlying legislation it regulates. Imprecise legal enactments intensify the imbalance of power between service providers and users. It would strengthen the hand of users and their advocates if they could argue unequivocally that the law requires care homes and hospitals to restore faulty hearing aids to use in a timely manner. But a robust regulatory system remains essential. Nothing will be gained if the courts are swamped by disputes concerning the date that a particular aid became defective or about the durability of different makes of plastic tubing. But, like other consumers, health and social care users deserve the dignity of rights that they can enforce.
- 5.2. CQC guidance on the Accessible Information Standard says users “should get support to communicate” and that this could include help with the use of hearing aids. (Meeting the Accessible Information Standard, CQC. 2018). *Help* is a loose term. NICE guidance (NG 98) assumes help is sufficient if users are informed about “troubleshooting”. But. Research shows that, overwhelmingly, users in homes and hospitals lack the manual dexterity and eyesight required to clean and re-tube a hearing aid so the NICE guidance is an inappropriate benchmark. “Maintenance” is a better description of the process than “Troubleshooting” As indicated in *When silence is no longer golden*, membership of the NICE Hearing Loss Guidance Committee is heavily

weighted towards health specialisms and does not adequately represent the range of skills and experiences of personnel who respond to the day-to-day needs of adults with hearing loss.

- 5.3. As a matter of routine, CQC should enquire about systems for cleaning and re-tubing hearing aids during inspections and report on their adequacy. *When silence is no longer golden* recommends that CQC should introduce regulations about deaf awareness training for staff. Bearing in mind that 75% of elderly residents in homes have some hearing loss, pending further guidance from NICE, I now make a more specific recommendation. I also make recommendations about record keeping, consistent with Regulation 17 of the 2008 Health and Social Care Act.

6. Expanding services

- 6.1. Immense improvements can be made to services for people with hearing loss at little cost to the public purse. Most staff in homes and hospitals can become proficient in cleaning and re-tubing hearing aids by “sitting next to Nellie”. If formal training is required, it can usually be provided by volunteers. Releasing staff from day-to-day duties to participate in training has an indirect cost but this can be reduced or even avoided by training volunteers.
- 6.2. Currently, in some homes, managers take the lead in ensuring that hearing aids are maintained. In others, voluntary organisations, audiology departments or local authorities are the key players. Sometimes, no one accepts responsibility or services falter because an audiology department fails to supply batteries and tubing. There is no single “right” way to organise services but without clarity, they will remain in no man’s land. There is also a need for more centres to display and demonstrate hearing devices.
- 6.3. Volunteering is likely to offer an important way of developing services in the foreseeable future. CQC can help stimulate voluntary enterprise by encouraging providers that are struggling to forge partnerships with voluntary organisations. Regional committees of experts might assist in setting-up demonstration projects on cleaning and re-tubing aids and spread information about good practice. Some audiology services currently make extensive use of volunteers to maintain hearing aids but volunteers present challenges, particularly to organisations with overly hierarchical staffing arrangements. The appendix below describes some of the issues.

7. Appendix on sustaining volunteering

- 7.1. Volunteers are not a second-best add-on. Volunteer recruitment can be a way of interesting local people in the work of hospitals and homes, of breaking down barriers and bringing outside influences to bear on institutions that are in danger of becoming isolated and inward-looking. There is scope to involve local community organisations in the life of homes and hospitals. The relatives of residents in long term care can become part of the solution. Volunteering has the advantage of disseminating knowledge about the care of hearing aids to benefit people in need who live in their own homes.
- 7.2. Volunteers quickly detect tensions between staff, especially if this adversely affects patients. They identify inefficiencies and gaps in provision and are motivated by a desire to help users – not organisations or staff - so their loyalty should never be taken for granted. They focus on outcomes and are exacting critics of the way services operate. If they do not change the service in which they work they are not reaching their potential. For managers, this is the flip-side of breaking-down barriers between institutions and the communities they serve and will not always be a comfortable experience.
- 7.3. Volunteers may be a breath of fresh air or a nuisance, depending on your perspective. Not every manager can be expected to recognise the advantage of deploying them or welcome their presence. A workforce that is demoralised or unsure that it is valued by its managers or users will resist their involvement and is probably better served without them. Staff morale is currently fragile in some services, leading to staff discontent and cynicism which is incompatible with the successful deployment of volunteers. But, as shown by organisations quoted in *When silence is no longer golden*, managers and professionals who open their doors to volunteers may be rewarded by an enthusiastic workforce dedicated to improving outcomes for users. This will sometimes offer the only realistic opportunity for an unglamorous service to extend its reach.

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