

Hear to Inform and Connect

Action on Hearing Loss
Final evaluation report

September 2020



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55,374 people
received information



9,744 hearing
checks undertaken



“My hearing aid has changed my whole life. I didn’t realise just how much I was missing.”

1,952 community
groups engaged



2,364
information
events
undertaken



96% of people feel better
informed about hearing loss
and/or tinnitus



92% of people better
informed about what action
to take to address their
hearing loss



“I can hear the radio, TV and most importantly conversations now.”

35% had taken
action to address
their hearing loss
after 5-7 weeks



63% had taken action to
address their hearing loss
after 9 months



Key learning points



The project was instrumental in providing the necessary information for people to address their hearing loss.



As a result of addressing hearing loss, people are less likely to feel lonely and isolated and more likely to feel better connected to family, friends and their community.



The project was also highly effective at raising awareness about hearing loss and / or tinnitus both on an individual level and within communities. This helped people to address their own hearing loss and better understand the issues faced by others experiencing hearing loss.



Taking the service out into the community increased its effectiveness at reaching people who were new to the hearing loss pathway and therefore may have encouraged people to take action at an earlier stage of hearing loss.



The hearing check is an essential component of the service as it undoubtedly increases the number of people taking action to address their hearing loss.



The 'face-to-face' delivery is highly valued by service users and means that service users are more likely to take action to address their hearing loss.



Delivering talks, presentations and information stands to a variety of audiences (general public, community groups, care homes and businesses) means that more people are likely to understand hearing loss and how to address it and also ensures that services are more likely to be adapted and become accessible for people with hearing loss.



A diverse volunteer base which reflects the ethnicity and demography of local communities is likely to lead to better engagement with service users.



Targeted methods, including links with local partners, are important to ensure that harder to reach communities are able and likely to access and benefit from Action on Hearing Loss outreach services.



A delivery model which provides central co-ordination but allows for regional flexibility and local volunteer-led delivery is most effective.

1. Project Background and Introduction

In August 2016, Action on Hearing Loss were successful with an application to the National Lottery through the Big Lottery 'Accelerating Ideas' Fund for delivery of the UK Hear to Inform and Connect (HTIAC) project. In addition, this project was also supported by charitable Trusts and Foundations, including the City Bridge Trust for the London element. The three-year project started in January 2017 and was funded until March 2020¹. It enabled Action on Hearing Loss to grow its existing information outreach services and proactively provide information to more older people (aged 50+) with hearing loss. The aim of the project was to ensure older people feel better informed about their hearing loss, better connected to their family, friends and communities, and empowered to take action to address and manage their hearing loss. The project also aimed to work with community groups and other organisations e.g. care homes to build the knowledge of community group leaders and staff on hearing loss and how better to support people with hearing loss.



The aim of the project was to ensure older people feel better informed, and empowered to take action to address and manage their hearing loss



Originally, the Lottery application was for a five-year UK-wide project, however, the Lottery requested that Action on Hearing Loss scaled back their plans in order to test out the delivery model and measure the impact of the proposed interventions. In response, the project was re-scoped and delivery was focused in three geographical locations - Northern Ireland, Scotland and London & South East England.

Information outreach was delivered through information staff and trained volunteers who provided face-to-face information in two primary ways. Firstly, through the use of staffed information stands located in a range of community settings that had a high footfall of older people (such as libraries, GP surgeries and health centres). In addition to providing general information about hearing loss and what steps people might take to address it, they also signposted to other complementary services and groups in the local community.

Secondly, each information service also delivered talks and presentations to community groups and a range of local health, social care and voluntary organisations, to support them in making their services more accessible and inclusive for older people with hearing loss. The project information services were locally developed and led, to ensure that targeted information provision was in place to best meet local needs.

Where practical, hearing checks were offered as part of the information service at both information stands and talks and presentations. In addition, the service provided information and demonstrations on assistive equipment, including amplification devices.

Staff were supported by trained local volunteers who helped run information stands and assisted at talks and equipment demonstrations. Many of the volunteers on the project had hearing loss themselves or had indirect experience of it as a result of supporting a family member or friend.

¹ The project was originally due to finish in December 2019 but was extended until March 2020.

Through the project, the focus was to expand each information service to ensure greater geographical coverage, as well as to increase the number of older people and organisations benefitting from the information provided. There was a particular focus on ensuring that 'harder to reach' groups and communities were better supported to access information about deafness, hearing loss and tinnitus.

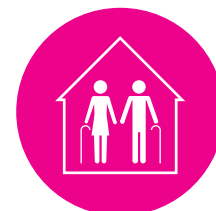
The project had three harder to reach target groups:



Older people living in rural areas



Older people from Black, Asian and Minority Ethnic (BAME) communities



Older people living in care settings.

The project was co-ordinated and managed by a UK-wide Project Manager who reported to a Project Board made up of senior representatives from across Action on Hearing Loss. The role of the Project Board was to provide a strategic overview of the project, to ensure the project was on track in terms of delivery and that learning from both within the project, and outside it, was used to inform service delivery across the organisation.

In addition, each of the project information services had its own Project Steering Group made up of a range of project beneficiaries including volunteers, service users and representatives from local organisations and health/social care professionals. The local steering groups met quarterly to review progress with the project delivery and had a role in steering the direction of the project. The steering groups fed into the Project Board, through the Project Manager and Heads of Service, to take forward any actions which needed to be addressed.

The HTIAC project was part of a wider information offer provided by Action on Hearing Loss which includes a central Information Line for service users across the UK, the provision of information leaflets and resource packs and the delivery of information out in the community.

Aims, objectives and outcomes of Hear to Inform and Connect (HTIAC)

The project had four core outcomes:

Outcome 1 An increase in the number of older people with hearing loss who feel better informed about hearing loss.

Outcome 2 An increase in the number of older people with addressed and unaddressed hearing loss who take action.

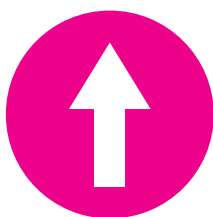
Outcome 3 Older people with hearing loss feel better connected to their families, friends and the world around them.

Outcome 4 Community groups are better informed about hearing loss.

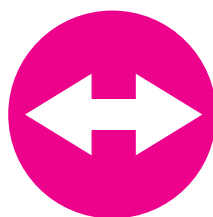
In order to achieve these outcomes across the three participating information services the project aimed to:



Deliver 2,500 hearing checks



Scale up existing reach, ensuring that approximately 50,000 older people (age 50+) with hearing loss were provided with information through the face-to-face services.



Expand current provision, enabling approximately 360 community groups and local health and social care organisations to access the information services.



Grow the team of information volunteers across the three project areas.

In addition to measuring performance against the funded outcomes, the evaluation will explore the long-term impact of Action on Hearing Loss's face-to-face information outreach services, including whether face-to-face information provision is a catalyst for change and supports people to take action.

The project evaluation revolves around two key research questions and some subsidiary questions:

1. Primary research question: "Do older people go on to take action on their hearing loss after receiving information face-to-face?"

2. Secondary research question: "Do local community groups and organisations make changes and improvements to their services as a result of receiving information face-to-face?"

What actions do people take after receiving information?

What are the catalysts for taking action?

What are the social and personal impacts of taking action?

What are the similarities and/or differences in the impact of face-to-face information provision across the different communities and project?



2. Evaluation methods

To ensure that Action on Hearing Loss was in a good position to demonstrate the impact of HTIAC and that the organisation maximised learning from the project, a robust evaluation framework was implemented. As such from August 2017² data was collected from service users and community groups at ‘the point of contact’ i.e. the information stands and following talks and presentations.

Data was also collected from those service users who gave consent at:

**5-7
WEEKS**

via telephone,
postal or
email survey



**9
MONTHS**

via telephone,
postal or
email survey

Community groups and other organisations were also contacted 6 months after receiving a talk or presentation to explore the extent to which the talk increased their knowledge of hearing loss and how to support people with hearing loss, and to find out what action, if any, they had taken as a result.

Further details about specific outcomes and targets of HTIAC and the evaluation framework are detailed in Appendices One, Two and Three.

Qualitative data was collected alongside quantitative data in the form of focus groups and individual interviews which enabled further in-depth exploration of people’s experience of the service, what the catalysts and barriers to taking action are, and the impact that both addressing and living with unaddressed hearing loss has on people’s lives. Additional focus groups/ interviews were undertaken with project delivery staff, senior managers and volunteers in order to gain further insight into the effectiveness of the delivery model.

This report draws together both the quantitative and qualitative monitoring and evaluation data collected from August 2017 – March 2020.

Organisational wide benefits arising from the monitoring and evaluation methods

Historically, Action on Hearing Loss have measured the success of the information service in terms of service outputs e.g. number of interventions delivered, hearing checks undertaken. The HTIAC project was keen to be able to demonstrate the longer-term impact of its services, and as such, has placed a much greater emphasis on data collection and evaluation. Funding through the National Lottery Community Fund enabled the project to invest significant resources in establishing a robust evaluation framework as well as employing a part time Feedback Co-ordinator. Whilst the adoption of the data collection tools presented some challenges for the delivery teams on the ground, there is a strong consensus from the Project Board that this step-change approach to evaluation has had positive benefits not only in relation to the project but for the organisation as a whole.

² It is worth noting here that although the project started in January 2017, the evaluation tools weren’t developed until August 2017 due to project set up timings – recruitment and development of the tools. Following a pilot phase, the final evaluation tools were developed and implemented from December 2017.

3. Evaluation findings

Data from the feedback forms was analysed alongside qualitative data gathered through focus groups and interviews with Project Board members in order to provide an assessment of:



The extent to which the programme is achieving the funded outcomes



Unexpected learning from the project



The extent to which the programme is successful at engaging harder to reach communities



Whether there are variations across service areas



The effectiveness of the service delivery model.

Achievements against outputs and outcomes

The project was highly successful at meeting the funded outputs and outcomes, and in many cases exceeded the ambitious targets that had been set.

55,374

people received information – **against a target of 50,000**

9,744

hearing checks were undertaken – **against a target of 2,500**

1,952

community groups engaged

2,364

information events undertaken.

Impressively there were:



5,256

Feedback forms collected at information events with service users



2,952

Feedback forms from information events with service users

Data from the feedback forms provided a robust sample size for the evaluation (15% of service users completed a feedback form or sheet) and provided a useful overview of who accessed the information outreach service and where they were on the hearing loss pathway at the point of engaging with the service.

In addition to the feedback forms collected at information stands and following talks and presentations:

 **423**

follow-up surveys have been completed by people that consented to be contacted 5-7 weeks after they have received information.

 **123**

123 follow-up surveys have been completed by people 9 months after they have received information.



Follow-up contact has been made with **81** service managers of organisations and groups who received information talks and presentations.

The table below provides a breakdown of the evaluation data that has been collected across the programme.

Table One: Evaluation data collected

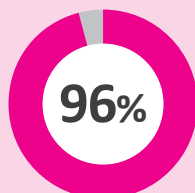
Data collected	Scotland	London and South East	Northern Ireland	Total
Feedback forms from information stands and talks and presentations with service users	1005	1286	2965	5256
Feedback forms from talks and presentations to professionals	1070	308	1574	2952
5-7 week follow-up surveys with service users	154	149	120	423
9 month follow-up surveys with service users	50	30	43	123

3.1 Performance against funded outcomes

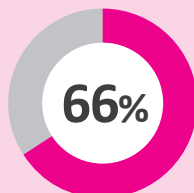
Outcome One

An increase in the number of older people who feel better informed about hearing loss

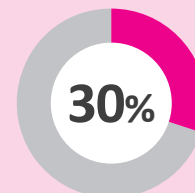
Key Findings



of people accessing the information outreach service feel that they are better informed about hearing loss and/or tinnitus.

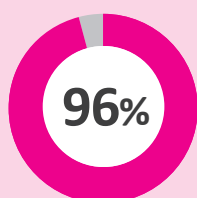


of service users were women.



of service users were Black and Minority Ethnic individuals.

Overwhelmingly monitoring and evaluation data indicates that the majority of people who accessed the information outreach service reported feeling better informed about hearing loss. There is very little variation in the statistics across the two primary delivery mechanisms, which shows that information delivered through information stands and the information provided to groups through talks / presentations were both highly effective ways of increasing people's knowledge and understanding about hearing loss.



Of those people completing a feedback form following a visit to an information stand or following a talk/presentation: 96% felt better informed about hearing loss and/or tinnitus.



The value of information received during a talk / presentation was further corroborated by feedback received during the focus group discussions. There was a consensus amongst focus group participants that the information they had received had significantly increased their knowledge about hearing loss and had also helped them to better understand what living with hearing loss was like for those affected. Many people commented that this had helped them be more empathetic and patient when communicating with someone with a hearing loss. Focus group discussions also revealed that through attending talks, people had increased their knowledge about the wider impact of hearing loss, for example, the increased risk of unaddressed hearing loss leading to early cognitive decline³ and that they had received practical information on what they could do to make communicating with someone with a hearing loss easier.

³ Wood, C. (2013) Joining Up. Action on Hearing Loss and Deafness Cognition and Language Research Centre.

“I found the stuff about the links between hearing and other things like dementia really interesting, I wasn’t aware of that before.” Service User

Furthermore, information seems to have been equally as useful to people that were already on the hearing loss pathway and served either as a reminder or provided new information.

“This talk was enlightening and it made me think about my hearing for the first time.” Service User

“Nobody told me how to look after it (hearing aid) and you don’t always like to ask. I found the presentation in such a way that I felt I could ask a stupid question. I think there is a need for this for people like me that have gone into the system but that don’t have a clue about the system. There is a lack of information out there so this Action on Hearing Loss is great.” Service User

“I’ve previously had hearing aids and didn’t realise until the talk that I wasn’t maintaining them properly which is probably why I thought they were of no use.” Service User

Raising awareness of hearing loss

Even for those people that had a hearing check that showed they had no hearing loss the intervention served as a valuable means of raising awareness about the importance of monitoring hearing. A significant number of people made reference to the fact that they would now have a regular annual check as a result of coming into contact with the Action on Hearing Loss service. This demonstrates the value of outreach services in raising awareness of hearing loss as an issue and encouraging people to take responsibility for monitoring it. In the absence of a national screening programme this is an extremely valuable intervention.

Information about assistive equipment

Follow-up data highlights that information about assistive equipment which was provided through the project, either through direct demonstration or the provision of the equipment catalogue was seen as valuable aspect of the service and raised awareness of what practical equipment could help people with a hearing loss in their day-to-day lives. **Any future outreach information service should retain and potentially enhance this element of the service e.g. recruiting volunteers with a specific interest and knowledge of assistive equipment.**

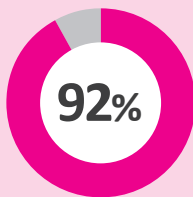
“One of the group members that has a hearing aid, he was OK one-to-one but struggled in groups but he found out about the individual hearing loop (personal listener) - he never knew there was such a thing before the talk.” Service User

By providing both forms of information provision the project was able to offer one-to-one information to individuals which was more likely to be in relation to specific concerns the person had about their own, or a relative/friends', hearing loss and through the talks more generic information about hearing loss, its impact and how to support someone with hearing loss. This dual approach to information provision is an effective way of reaching significant numbers of people whilst also providing the opportunity for more tailored information and advice on an individual basis.

Outcome Two

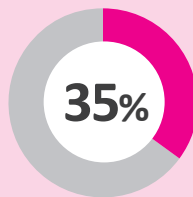
An increase in the number of older people with addressed/unaddressed hearing loss who take action

Key Findings



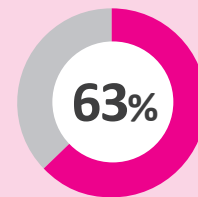
of people feel better informed about what action to take to address their hearing loss.

5-7 weeks

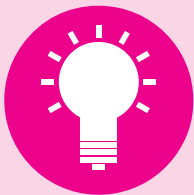


of people participating in a follow-up call had taken action to address their hearing loss.

9 Months



This increased to 63% at the 9 month point.



The information and follow-up provided by Action on Hearing Loss acts as a catalyst and encourages people to take action.

This clearly demonstrates that the information provided through the project was useful, clear and relevant and provided people with a clear route-map about what course of action they needed to take in order to address their hearing loss. It also shows that the service delivery model was highly effective in supporting people to take action.

It is worth noting that not everyone that came into contact with the service will have had a need to take action as their hearing check may have revealed that they did not have an issue with hearing loss. Follow-up calls were undertaken with a sample which included people that had some level of hearing loss identified through their hearing check and those that did not. This approach was taken

in order to gain insight into what impact the project had on those that did not have an issue with their hearing as well as those that did. As such, the statistics contained within this section of the report need to be considered within this context. In the future it would be more effective to ensure that follow-up calls were targeted at those people who needed to address their hearing loss. This would increase the percentage of people 'taking action' and would also ensure that the follow-up call acted as a 'reminder' to those people.

What prompted people to take action?

Results from the feedback form data shows that when asked what prompted people to take action, post their contact with the service, the most common response at both 5-7 weeks (17%) and 9 months (50%) was the 'information they received from Action on Hearing Loss'. The next most common responses across both feedback points was that action was driven by people's own 'frustration at not being able to hear' (5% and 11%) and that they were 'going to take action anyway' (5% and 9%). Comparison of these statistics highlights the significance of the information provided through the information as a catalyst for action. There is also evidence to show that participation in the 5-7 week follow-up call acted as a prompt for some people to take action.

"You have been a great motivator as I've been meaning to get my ears tested with the doctor for years." Service User

"I knew I needed to take action as was getting frustrated at not being able to hear properly. Getting the information from Action on Hearing Loss motivated me to book the doctor's appointment and take action." Service User

"It made me realise I need to take action now; not to leave it. It's too early to say about other impacts as I need to see audiology first."

Service User

"I was already taking action but the information from Action on Hearing Loss has spurred me on further." Service User



The provision of monitoring data collected by Action on Hearing Loss demonstrates that 9,744 hearing checks have been performed which represents 18% of the total number of people that interacted with the service.

One of the key strengths of the information outreach service was that it offered free hearing checks at the information stands or after presentations⁴ so that people could have an on the spot basic assessment. If the hearing check indicated that a person's hearing was deteriorating then they were given information to give to their GP which detailed their hearing check score. Anecdotal evidence indicates that the provision of a record outlining the outcome of the hearing check provided people with something tangible that they could take to their GP and that this made them feel more confident about making an appointment. The provision of monitoring data collected by Action on Hearing Loss demonstrates that 9,744 hearing checks have been performed which represents 18% of the total number of people that interacted with the service. This significantly exceeds the 5% target that the project originally set itself. The project did not record the percentage of people who had a hearing check that indicated a hearing loss. With hindsight, this would have been useful information as it would provide a guide to the number of people accessing the information outreach service who have hearing loss and would also ensure more targeted follow-up, as discussed above.

Feedback from service users and project staff reinforced the important link between the hearing check result and people becoming aware that they have an issue and as such, the outcome of the check strongly influences and encourages the individual to address their hearing loss, where necessary. For this **reason the hearing check is an essential component of the service as it undoubtedly increases the number of people taking action to address their hearing loss.** This is particularly important given the absence of a national screening programme as for many people (55%) the check provided through the service was the first time they had had their hearing assessed as an adult. This highlights that **a significant percentage of people accessing the service have joined the hearing loss pathway as a direct result of their interaction with the service.**

“The test was certainly a good prompt to do something about it.”

Service User

“I’ve made up my mind now that I am going to make myself that appointment because he told me the test he did was not as intensive as the one they would do at the hospital.” Service User

⁴ This was not possible at all venues as it depended on the availability of a quiet space in which to conduct the check.

There is also evidence to show that the results of the hearing check are often the first indication to someone that their hearing is deteriorating. In this sense the hearing checks provide a valuable early warning system for some and is likely to result in more people taking action to address their hearing loss over a shorter timeframe.

“I didn’t realise there was a problem until the hearing check was done.”

Service User

“I didn’t know I was deaf in one ear until they told me about it. I’m glad they did.” Service User

“As a result of your talk about 6 or 7 of us have got hearing aids me included.” Service User

What action did people take?

Analysis of the 5-7 week follow-up data shows that 35%⁵ of people went on to take some form of action in the immediate period following their interaction with the service. The action that was most commonly taken was to have had an appointment with the GP which resulted in a referral to audiology (11%). This was closely followed by having a GP appointment that did not result in a referral (9%). As no information on why people were not referred was collected it is not possible to determine why no referral was made. However, given the feedback (see section 3.2c iii) received on the inconsistent approach of referrals to audiology by GP’s, it would be an interesting area for further exploration.

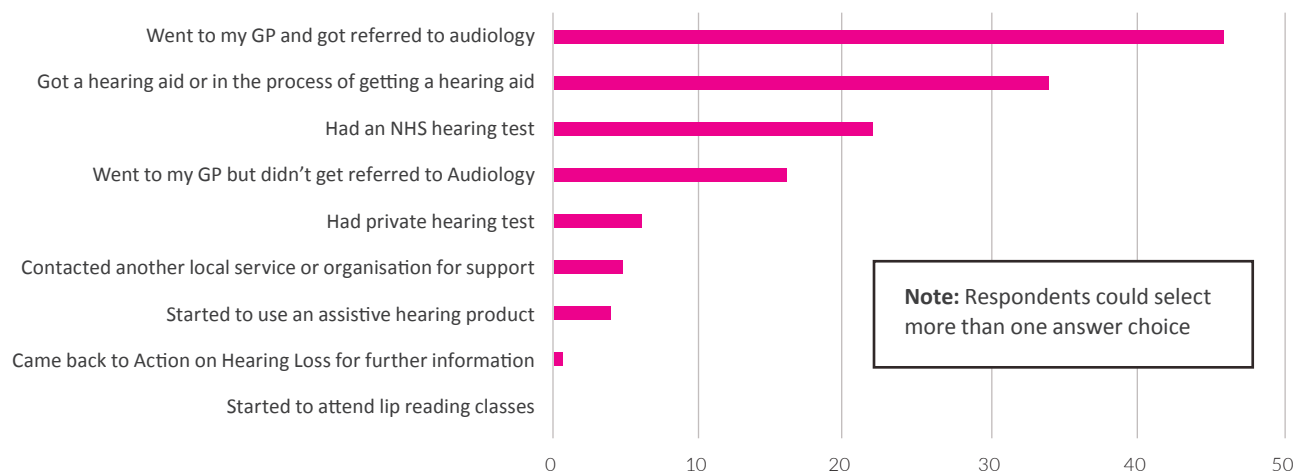
Of those people participating in a 5-7 week call, 4% had started using an assistive hearing product and another 4% were in the process of getting or had got a hearing aid. Whilst these figures are not high they need to be considered within the context of research⁶ that shows that on average it takes 10 years for someone to address their hearing loss and that this action had been taken within 5-7 weeks of someone coming into contact with the outreach information service.

Unsurprisingly at the 9 month mark there is a significant increase in the likelihood of people taking action rising from 35% at 5-7 weeks to 63%. This is likely to be linked to the fact that the passage of time has enabled people to book and attend GP/audiology appointments and to progress further along the NHS audiology pathway. The action that was most commonly recorded was ‘went to the GP and been referred to Audiology’ (37%). This was followed by ‘got a hearing aid or in the process of getting one’ (28%). 18% of people had undertaken an NHS hearing test and 13% had been to the GP but had not been referred to audiology.

⁵ It is important to note that only 40% of those who participated in a 5-7 week follow-up call had taken a hearing check at the point of contact and some may have had a hearing check which indicated that they did not have a hearing loss.

⁶ 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*; 11(42).

What action respondents had taken 9 months after receiving information from Action on Hearing Loss:



From the data collected, it is evident that the information provided by Action on Hearing Loss for many people is a catalyst to taking action, which ultimately ensures that more people address their hearing loss. This is further supported by the focus group data which repeatedly reveals that it was the information received from Action on Hearing Loss that motivated people to take action.

Why people don't take action

Qualitative feedback from service users show there are a number of common reasons why people do not take action to address their hearing loss. The most common responses given at 5-7 weeks is that people had 'Not had time to arrange a GP appointment yet' or that they 'Didn't feel they needed to take action' or 'could get by as they were'. At 9 months the survey results show that the most frequent reason given for not taking action is that people had made a conscious decision not to with 14% of people giving this as a reason. 7% of people stated they 'had not had the time' in order to progress addressing their hearing loss and 3% said they 'did not know where to go for help'.

"I tried to get a doctor's appointment a long time ago but the doctor was on holiday and since then I've just put it off and put it off. I need to do it, I'm going to do it now." Service User

Qualitative feedback from the follow-up calls and focus groups reaffirms some of the factors raised through the telephone survey but also highlight a range of other reasons why people do not take action and may provide some insight into why people consciously decide not to take action. The most common reasons are that loss of hearing is not seen as being that serious and is an inevitable consequence of ageing and as such that hearing loss is not prioritised over other 'more life threatening' health conditions.

“Didn’t bother as I was 74 yesterday so what’s the point.” Service User

“I have a heart complaint and diabetes and just haven’t prioritised this but I need to. I will book a doctor’s appointment. My TV’s getting louder and louder and my friends say I keep repeating myself.”

Service User

“I’ve had other more pressing health concerns that I’ve been seeing the GP about. Once they are sorted I will address my hearing loss in the future.” Service User

“I don’t regard the situation as urgent so I am waiting for when I need to see my GP on another matter (e.g. a medication review). I still have the letter/notes provided for me.” Service User

Many people stated that they would ‘wait’ until their next GP visit to raise the issue rather than making a specific appointment. Reinforced messaging around the impact of not addressing hearing loss and the links to poor mental health and dementia may help to strengthen the detrimental effects of delaying taking action. Messaging around the advantages of early intervention may also help as it appears that people are only likely to address their hearing once it deteriorates significantly and as such there is no sense of urgency to address the issue.

For many older people the practicalities of getting out to the GP, lack of independence and their reliance on others to take them to appointments has prevented them from taking action. The focus group discussions suggest that these issues may be exacerbated by a perception (but also real experience) of not easily being able to get a doctor’s appointment and the length of audiology waiting lists.

“I don’t get out much as I rely on my daughter in law. I don’t feel my hearing loss is that bad but if it gets worse I’ll book a doctor’s appointment.” Service User

As highlighted by the survey results, lack of time was an issue for some people who stated that they were too busy with other commitments e.g. caring commitments of grandchildren/other relatives or hobbies, to go and see the GP. This prioritisation of other activities reinforces the lack of value that many people place on their hearing and may also reflect that many people are in denial of the problem.

“I go to a couple of clubs and until recently I had caring responsibilities, so I just haven’t found the time. I have a busy life but I will get round to making an appointment with the GP in the next two weeks.” Service User

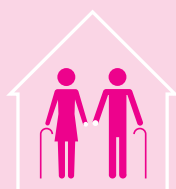
For some people there is a sense that they can ‘make do’ or don’t want to burden friends and family with the issue. For others there is a perception that they feel invisible in society and therefore no longer count, this reflects a wider issue about how we value older people in our society.

“People don’t seem to care whether I hear them or not!” Service User

“I can get by. I can speak with my grandchildren on the phone, go to a shop and buy a drink etc. I’m not bothered with hearing aids.”

Service User

Whilst it was not significant in numbers there was a common theme of people refusing hearing aids or not wearing existing aids due to the impact it had on their tinnitus. Whilst hearing aids can be used effectively to manage tinnitus for some people it exacerbates the problem.



It is evident that what underpins many of the reasons that people give for not taking action are linked to the stigma associated with hearing loss and wearing a hearing aid and that this is largely due to hearing loss being symbolic of ‘getting old’.

This was discussed in many of the focus groups and there was a consensus that this was a significant factor in why many people do not address their hearing loss and make a conscious decision to live with the condition. The other issue that was raised was linked to the perception that hearing aids are not effective and are ‘more trouble than they are worth’.

Throughout the evaluation the issue of affordability and the cost of hearing aids (private) and assistive equipment was raised. In some cases the stigma associated with wearing a hearing aid combined with misperceptions associated with the size of NHS hearing aids and people's desire to have a discrete hearing device led them to explore private options first. However, in many cases cost was a prohibitive factor in them progressing private solutions. Whilst we do not have the data to show how many people do not go on to explore getting an NHS hearing aid, our sense through anecdotal evidence is that this number could be significant.

All these factors reinforce the need for information services as a means of raising public awareness about the importance of addressing hearing loss and tackling the stigma and misconceptions surrounding it.

Below are three stories which illustrate the impact of the Information Service and also the difference addressing hearing loss has on a person's life.

Person A is a 70-89 year old British Female who visited an Action on Hearing Loss information stand. In her 9 month telephone interview she stated:

"Having now been through the GP and hospital referral process I now feel more aware of the support available. Initially I took the letter you gave me to the Doctors and saw the nurse who gave me drops to put in my left ear for the wax build up in there. I went back the following week for a check-up and the wax still hadn't gone so I had to use the drops for longer before further check ups and an eventual referral to hospital audiology. I eventually went to the hospital on 3rd January and had a very thorough hearing test with the audiologist who states at this time I do not need a hearing aid but has booked me in again for one year's time to have a follow-up check. The ear drops I was initially given to help with my wax have worked. My ears feel clear and my hearing noticeably better. My overall sense of wellbeing has increased and I feel reassured that I've had the all clear. It was Action on Hearing Loss services that prompted me to act. I'm very satisfied with your services and don't feel they could be improved in anyway. We're so fortunate and lucky to have you."

Person B is a 70-89 year old British Female who visited an Action on Hearing Loss information stand. In her 9 month telephone interview she stated:

"I have literally just returned from audiology this morning with a hearing aid for my right ear and what a difference it is making. The TV felt so loud on my return and I can hear conversations. It's helping my tinnitus also instantly. I also attended a 1 and a half hour tinnitus session which was very helpful; offered good coping techniques. It was on the recommendation of your lady. It was admitting it to myself that I needed to seek help. I always felt that there were people with more pressing medical matters that deserved the doctors time more. I'm on local committees and in the choir. I was starting to feel I was missing jokes etc. I was feeling isolated and unable to complete my roles. I was seriously considering standing down from my position within the committee but no more. My hearing aid has changed my whole life. I didn't realise just how much I was missing. I was starting to feel isolated. I didn't realise just how many problems I was creating by not acting on my hearing loss. I could have saved myself so much heart ache. It's an amazing service. The more that are informed the better. Even the slightest hearing loss should be checked."

Person C is a 70-89 year old Black British Female who visited an Action on Hearing Loss information stand. In her 5 to 7 week telephone interview she stated:

“Your lady Sinead was saying she was doing random hearing checks and a friend prompted me to get one at your stand. Your lady Sinead checked my ears and said I appeared to have an inner ear problem. She gave me a scoresheet and I took this to my doctor who confirmed I do have an inner ear problem and I am currently waiting on an ENT referral. I have also had a hearing aid since the start of the year which kept falling out and on Sinead’s advice walked up to my local hospital (St George’s audiology department) where they changed the piping on it and gave me some new batteries which has fixed the problem. As a result of this my overall sense of wellbeing has increased and I am able to communicate with people easier. I feel happier for addressing my hearing loss and more confident when communicating with people. I actually first saw your lady Sinead a year ago at a Wandsworth talk where it was her that motivated me to take action and go get myself a hearing aid in the first place. When I saw her again a year later at St Michael’s Church I wanted to say thank you and tell her how much her talk at Wandsworth day centre a year ago had helped me. Keep getting funding for people like me in the community who need help addressing their hearing loss. I can hear the radio, TV and most importantly conversations now.”

Outcome Three

Older people with hearing loss feel better connected to their families, friends and the world around them

Key Findings



People most commonly report feeling happier and better able to communicate with people as a result of acting on the information received through the project and addressing their hearing loss.



Research⁷ has shown that unaddressed hearing loss can have a severe detrimental impact on people’s mental wellbeing and that it can lead to people becoming isolated and withdrawing with interaction from family, friends and social situations. Amongst focus group participants there were common views held about the effects of hearing loss. People reported that hearing loss led to people feeling ‘isolated and disconnected’ which had a negative effect on their mental health.

“The woman I know was really isolated. If you’re deaf you don’t know what’s going on so you just start to shut down.” Service User

⁷ Davis, A. (2011) National Survey of Hearing and Communication.

Analysis of the evaluation data and feedback demonstrates that for those people that have taken action to address their hearing loss there are significant positive outcomes. The impact at 5-7 weeks was less evident with many people reporting that it was too early to determine the impact of addressing their hearing loss largely due to the fact that they were still awaiting appointments with GPs or audiology, which meant that their hearing issues remained unresolved. For people for whom the check had shown they did not have a hearing issue the most common impact at 5-7 weeks was a raised awareness about the importance of addressing hearing loss.

At 9 months the impact is much more evident with 19% of people reporting that they felt 'happier because they had addressed their hearing loss' and 18% stating that they were able to 'communicate more easily with people'. It is important to view these statistics alongside the qualitative feedback received from service users which provide powerful testimonials to the difference that addressing their hearing loss has made to their lives both practically and emotionally.

“My ears feel clear and my hearing noticeably better. My overall sense of wellbeing has increased and I feel reassured that I’ve had the all clear. It was Action on Hearing Loss services that prompted me to act.”

Service User

“My hearing aid has changed my whole life. I didn’t realise just how much I was missing” Service User

“My hearing aid has changed my whole life. I didn’t realise just how much I was missing. I was starting to feel isolated. I didn’t realise just how many problems I was creating by not acting on my hearing loss. I could have saved myself so much heart ache.” Service User

“It’s fantastic my new hearing aid has made such a difference. I can hear so much better, I don’t need to feel embarrassed going out.”

Service User

“I’ve since got a hearing aid in my left ear. I’ve had it for a few months and it’s making a huge difference to my life.” Service User

“The ringing has gone from my ears. I don’t miss things in groups anymore and I communicate better on the phone.” Service User

“It’s impacted on my life by making me take my hearing loss more seriously. It made me realise hearing is just as important as sight and you wouldn’t ignore that.” Service User

“I’m not so nervous about workplace situations.” Service User

“It’s helped a lot with groups. Before if I was in a group of 6 people I couldn’t tell who was talking or what they were saying; now I hear well. Also if I was in the drivers seat of the car I couldn’t hear someone talking behind me but no more. I was definitely isolating myself before my hearing aids.” Service User

“It’s just helped me on a more practical basis than mentally/emotionally. I didn’t realise anything was wrong with my hearing really until I actually got the hearing aids and it’s made such an awful difference to my life/hearing.” Service User

“It’s all worked out so well. It’s of such a big benefit. I have sight loss also and so it has made my hearing all the more precious and a priority to my quality of life.” Service User

“I’ve noticed that I’ve turned my TV right down and I can hear the birds chirping again. The hearing aids just too good as I can hear too much background noise.” Service User

“It really has made all the difference, I can communicate with people again.” Service User

“Thanks a million. After the home visit you even left me a TV listener to help me hear the TV and radio and keep me connected with the world.” Service User

“I go to church every Sunday and before I often couldn’t hear the speaker depending on their voice type. I would miss bits; now it doesn’t matter I hear whoever is talking.” Service User

Many of these positive benefits of addressing hearing loss were also reflected in the focus group discussions. In particular people felt that addressing hearing loss led to people feeling less social isolated and enabled people to retain a sense of independence.

“They become better connected and it gives them a whole new lease of life.” Relation of a Service User

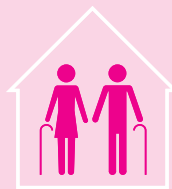
“It used to be that I had to go in with him and the Dr would say something and he’d say ‘what was that’ but now he’s happy to go in by himself.... I’d say his whole quality of life has probably improved. It’s been amazing.” Relation of a Service User

What is overwhelmingly evident from these testimonials is that as a result of addressing their hearing loss people’s quality of life significantly improves by enabling them to participate in the activities that make them feel reconnected to the world and feel less lonely and isolated.

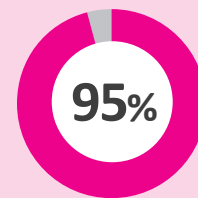
Outcome Four

Community groups are better informed about hearing loss

Key Findings



Community groups take positive action to benefit older people with hearing loss as a result of talks and presentations.



95% of Service Managers reported taking some form of action following a talk from Action on Hearing Loss.

Across the three service areas there have been 1,952 talks delivered to community groups and other service providers e.g. care homes, which far exceeds the project target of 360. All talks covered a core range of issues such as the impact of hearing loss, how to better communicate with people with hearing loss and what adaptations could be made to improve accessibility. Where necessary talks were modified to reflect the nature of a specific group. A sample of community groups/organisations were contacted to provide feedback on the value of the information they had received and to find out what action, if any, they had taken as a result of the talk in order to improve the accessibility of their service/activities for people with hearing loss. Of the 81 surveyed all of them said that they felt better informed about hearing loss as a result of the presentation from Action on Hearing Loss. In addition, all organisations interviewed also said that they felt better able to support people with hearing loss following the presentation they received. Common feedback from service managers was that they felt reassured that they knew where they could get support from in the future and would be able to signpost others to that support.

“As a day care worker involved with programmes within the centre and as a result of being in the group while Barry was presenting his power point I gained valuable information on the service Action on Hearing Loss provides and this will help me inform other services users.” Community Organisation

“I feel much more able to support and include people with hearing loss, as there were lots of strategies discussed.” Community Organisation

“Hearing loss is a big problem in our club. Eleven members decided to have their hearing checked at a subsequent meeting. The discussion about hearing aids was very useful. Members now know how to check their batteries.” Community Organisation

Significantly 95% of service managers surveyed, reported taking some form of action following the information talk or presentation. This demonstrates that service managers were not only better informed about hearing loss but the information received resulted in changes being made to improve service delivery for people with hearing loss.

“Since the visit from Action on Hearing Loss, we have begun a 10 week Lip Reading & Hearing Loss course here that is fully attended by 10 people, most whom also attended the talk session.”

Community Organisation

The most common actions taken by service managers were to ask people about their communication needs, to alter seating plans, reduce background noise and to provide staff with communication tips. What these actions have in common is that they are all simple, no or low cost solutions that whilst easy to implement significantly improve the quality of the service user's experience. This reaffirms the value of the talks as a means of raising awareness with service providers in order to ensure that hearing loss is considered in all aspects of their service delivery.

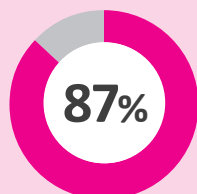
“I thought the training was excellent and I thought parts of it would be useful for a talk directly to tenants as well as to Trust staff, I think lots of older people struggle on with poor hearing and some information and support would be of great benefit.” Community Organisation

“I feel this training was very good as I deal with different age groups and realise now that hearing loss is a bigger issue than I originally thought, also that hearing loss can affect anyone and we may not even know someone has hearing loss.” Community Organisation

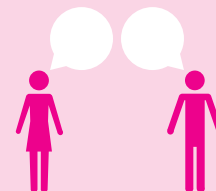
“It was so useful, I now understand different degrees of hearing loss, the importance of group sizes, of someone being able to see your lips, volume etc. We are getting a hearing loop induction next week as a result. It was a brilliant insight.” Community Organisation

“I had a few people say they can't hear the speakers when they turn away from the screen so we are discussing getting a microphone on the committee. We have also identified the two main ladies who are hard of hearing and make sure to put them on the front row in front of the speaker so they can lipread to help them.” Community Organisation

Significantly, 81% of survey respondents stated that they had cascaded the information they had received through the talk to other people. This demonstrates the value of the talks in terms of knowledge transfer and highlights that the indirect reach of the project is likely to be significantly higher than the 55,374 people that directly interacted with it.



of survey respondents stated that they had cascaded the information they had received through the talk to other people.



3.2 Additional findings

Feedback collected throughout the project from service users, volunteers and staff has highlighted a number of key findings, in addition to those discussed above, that impacted upon either the delivery of the project or the project outcomes. These additional findings are discussed below and fall into the following areas:



a) The importance of repeat intervention – the ‘drip, drip’ effect



b) Who accessed the service and why?



c) Perceptions of how hearing loss is addressed by the NHS

3.2a The importance of repeat intervention – the ‘drip, drip’ effect.

Analysis of the evaluation data highlights the effectiveness of repeat interventions in encouraging people to access the service and take action in relation to hearing loss. By regularly returning to venues or undertaking repeat visits to groups people were given the opportunity to overcome their anxieties about asking for advice or having their hearing checked.

Most notably however, it is evident that the 5-7 week follow-up call acts as an important reminder to people to do something about their hearing loss.

“This call has reminded me I need to go to (named a private hearing provider) and do something about it actually.” Service User

Similarly, at 9 months some people still report that they have not addressed their hearing loss. One interviewee said when asked if they had done anything about their hearing loss since the 5-7 week call;

“No. Not since speaking with you. I must make another hospital appointment. This has encouraged me.” Service User

Although the follow-up calls were only intended to be used to collect evaluation data, in the future Action on Hearing Loss may wish to consider **how some form of follow-up contact with service users can be built into the design of the information outreach service.**

3.2b Who accessed the service and why?

50+

Analysis of the feedback forms completed at information stands shows that approximately 82% of people accessing the information outreach service were aged 50+ (the target age group for the project).

Analysis of the feedback forms completed at information stands shows that approximately 82% of people accessing the information outreach service were aged 50+ (the target age group for the project). Whilst the project targeted delivery at groups and venues frequented by 50+'s many of the information stands were undertaken in public buildings e.g. libraries that were open to the general public. Inevitably, the stands and talks attracted interest from people who fell outside of the target demographic, however, the project adopted a policy to offer information and support to anyone who required it. In many cases those who fell below the 50 threshold were accessing information on behalf of a parent or older relative. Whilst the majority (71%) of events were aimed at the wider public, 15% attracted a mixed audience of public and professionals and 14% were targeted at professional e.g. information stands held at workplaces or session targeted at care home staff who often did not fall into the 50+ age bracket.

Of those people that completed the feedback forms, 83% were accessing information for themselves and the remainder were collecting information for either a family member, friend or someone they cared for.

Further breakdown of these figures shows that the service was accessed by significantly more women (66%) than men (29%) (5% did not disclose their gender). Whilst this to some degree reflects the national demographic imbalance towards women in this age group, it also highlights that women are more likely to access health information than their male counterparts. This may suggest however that

there is a need to better understand what would encourage men to access health information the outcome of which may result in the development of targeted interventions specifically aimed at men.

The fact that the service is being accessed by more women than men was also discussed during the focus groups, one of which was held at the 'Men's Shed' group in Newry (Northern Ireland). This focus group was attended mostly by men who generally felt that they would be less likely than their wives to access health services. This view was also supported in other focus group discussions and it appears that older men who are in a relationship are more likely to rely on their partners to access health information on their behalf.

“It was really good to get the screening done my husband would never have gone to the doctors with that.” Service User

“I know coming from a farming background my father and brothers would never go and address anything...that just from a rural perspective.” Service User

“I don't think this a problem specific to this service I think men go to the doctors when their wives tell them too.” Service User

This re-enforces the need for information targeted at family members/carers of people with hearing loss but also suggests that initiatives like the 'men's shed' are an effective avenue to encouraging men to access the information outreach service.

Of the service users who completed the feedback forms 30% were from Black and Minority Ethnic (BAME) communities. This represents a significant increase from the interim report figure (9%) and demonstrates the impact of the proactive targeting work undertaken during the latter half of the project. Further details of the engagement of BAME communities can be found in section 3.3b.

(i) What made people access the information stands?

Feedback from service users shows that a significant number of people came into contact with the Action on Hearing Loss information stand incidentally as a result of visiting another service such as the library or the hospital. As such, many people's interaction with the service was 'opportunistic' and unplanned which resulted in them accessing information or having a hearing check that they would otherwise not have proactively sought out. This highlights the value of the service being located out in the community and held in public spaces. There is also evidence to show that people were more

likely to approach the stand because it was run by a charitable organisation and staffed by lay-people rather than medical professionals or a private company. Many people referenced the friendly and approachable nature of the staff and volunteers and the relaxed and informal approach of the service which contributed to them feeling comfortable to access the information they required and take a hearing check if it was available.

“Just passed by and thought I'd have my hearing screened as suspected deafness in past.” Service User

“It was by chance. I went to Airyhall Library and fortunately the Information Service was available.” Service User

“I had been worried about my hearing for a while and when the hearing loss information roadshow came to the library I took the opportunity to take a quick hearing test when it was offered.”

Service User

“I am aware my hearing is deteriorating and I happened to come across your stand that day.” Service User

“There were two mains reasons 1) it was free and 2) because it was a form of support available in a very rural community. I had seen it advertised in the local parish bulletin.” Service User

“I'd been having some hearing loss in my right ear. I've never had a hearing test before and so when I saw you there I thought I'd go and have a chat.” Service User

“I've been having problems with hearing loss and tinnitus which I didn't want to bother the doctor with so when I saw you there it was opportune.” Service User

“I was going to the hospital and you just happened to be there.”
Service User

(ii) Influence of family and friends

A significant number of people interviewed made reference to the fact that they had been 'encouraged' to get their hearing checked by a family member or friend and that this had been what had made them approach the Action on Hearing Loss stand. Feedback from talk attendees also highlights how the 'herd mentality' appears to reduce the stigma or anxiety around having a hearing check. The influence of family and friends is also a recurrent theme in the feedback on what motivated people to take steps to address their hearing loss. Both of these examples illustrate **how the influence of other people appears to be a key factor in why some people decide to take the initial step to getting support and go on to take further action.** It would be worth exploring how this could be further exploited in any future projects.

“Well I just went with the flow. You were there and everybody was queuing so I thought I'd go for a check up. I'd not long been to the doctor to check my hearing but everything was fine. No past problems.” Service User

“My daughter and son have been nagging me.”

Service User

“My wife attends the women’s group where you’ve been a few times and when she went and you were there again she called me up and told me to get down there.” Service User

3.2c Perceptions of how hearing loss is addressed by the NHS

Although perceptions around how hearing loss is addressed by the NHS was not a focus for the project evaluation, feedback with service users highlighted some key issues about how the system and the medical professions attitudes towards hearing loss impact upon peoples’ ability or confidence to take action. This is focused around three main issues; accessing NHS services, how GPs respond to hearing loss and the lack of follow-up support for people who have been fitted with a hearing aid.

(i) Accessing NHS services

Difficulties relating to getting an appointment with the GP were raised in both focus group discussions and user feedback. This means that older people are less likely to request an appointment just to talk about their hearing loss and will often wait until they have other health issues to raise or wait for forthcoming routine appointments for other existing conditions as an opportunity to discuss their hearing loss. This causes delays in people getting the appropriate treatment they require and reflects the low value that many older people place on their hearing.

“It’s so difficult to get an appointment at the doctors; that’s what put me off.” Service User

There is also evidence to support that people are not referred to audiology as soon as they should be and that repeat visits to the GP may be needed before a referral is made or that GP’s will push people down the route of private testing. Given the issue described above of people experiencing difficulty in getting a GP appointment this presents another significant barrier to people addressing their hearing loss.

“I have requested my doctor again to refer me and I think he will this time. Very frustrating having to beg!” Service User

“It's so difficult to get an appointment at the doctors; that's what put me off.” Service User

“I've been to the doctors several times about my ears but they always say there's no problem when they look in them. I'm struggling to hear on the bus.” Service User

“I've been to my doctor and he took a look at my ears. He said to go to have a private hearing test. It wasn't very helpful so I'm going back to my GP again next week to ask him again.” Service User

Alarminglly there were a number of comments from service users about GP's and other surgery staff not being clear about the process for referring people to audiology.

“I mentioned it to my GP but he didn't know at that time how to refer me onto audiology. I have another appointment booked for Monday when he is going to sort it for me.” Service User

“Went to surgery and was advised to go to SpecSavers or Boots to get hearing test!! Second time of attending surgery was advised to go upstairs where there was supposedly an audio clinic - this clinic only deals with hearing aids. Visited "upstairs" and was advised it was Audiology at Stirling Hospital I had to go to. Luckily I went online and found a phone number for Audiology in Stirling and left a message but then somewhere that it is the doctor who has to refer (printed this off and returned to surgery), have finally made an appointment today for Friday morning. Altogether have seen 5 members of staff from surgery who did not know the doctor is the person to refer you to Audiology!!! Gave them the print out from NHS Forth Valley about Audiology!!!”

Service User

Once users are in the system the biggest issue they often face is the length of time they have to wait for an audiology appointment. In some cases this was reported to be as long as seven months. More than one person also mentioned that it is possible to disappear from the waiting list.

“Sometimes you think you are on the waiting list and then you phone to check and find out that you’re not so then have to go back to the GP and get a referral again.” Volunteer

“It was a 7 month wait but finally I have a hearing aid.” Service User

Obviously this may place older people who may be experiencing other health conditions at further disadvantage as they may not feel able to proactively track their referral.

“I have learnt to work the system and to be proactive if you wait for them to get in contact with you could be waiting for ever.” Service User

“I went to the Doctor and got a referral to audiology. I've even chased it up since but because it's so rural out in Enniskillen the consultant only visits the local hospital once a month and so the waiting list is huge. I've been on it 6 to 7 months now. Another lady in the stroke group got her hearing aid only last week so it must be my turn soon this next month.” Service User

“I went to the practice nurse and got a referral onto audiology. I've also chased it up at the doctors but still nothing. My husband whose hearing is even worse than mine is in the same position too.”

Service User

“I have been on the waiting list to see audiology for over 6 months now. In fact just the other day they sent me a letter asking me to confirm if I still needed to be seen which I returned answering yes.” Service User

It is evident that in some cases the NHS response to hearing loss leads people to either believe that their hearing loss cannot be addressed by the NHS; “I didn't realise you could get a hearing aid on the NHS” (Service User) or that the private sector offers a more effective route for addressing hearing loss. However, this also means that due to the costs of hearing aids available through the private sector that some people believe that they just cannot afford to address their hearing loss.

“I still need advice from the Doctor. I went to see (private hearing provider) after seeing you but they wanted £3000 for hearing aids. I thought about it but couldn't afford it so left it.” Service User

(ii) Attitude of GP's

Feedback from service users highlights the inconsistency of approach and poor attitude and awareness of hearing loss amongst some GP's. There is evidence to support that some GP's do not take hearing loss seriously and share the wider opinion of many people that it is just an inevitable part of ageing. In some cases, this has resulted in people being made to feel that they are wasting NHS time.

“I have a slight hearing loss and several friends who have yet to admit to hearing difficulties. My doctor thinks that I should wait until someone remarks that I have a hearing problem.” Service User

“My doctor made me feel like a timewaster.” Service User

Some focus group participants also felt that generally GP's do not adapt their service to ensure that their service is fully accessible to people with hearing loss.

“Doctors don't understand hearing loss – I go to my Doctor and he's sitting talking away to the screen and we can't hear them.” Volunteer

Whilst these issues may not be replicated in every GP surgery, it highlights the **need for on-going awareness raising work to be undertaken with GPs about hearing loss in older people and the impact it has on their broader health and wellbeing.** There is also a case to be made for the rollout of the work Action on Hearing Loss have undertaken to increase the accessibility of GP services for people with hearing loss.

(iii) Lack of follow-up support for people that have been fitted with a hearing aid

Whilst the project has been instrumental in getting people on the hearing pathway for the first time, inevitably the project has also supported many people who are, or were, existing hearing aid users. There are numerous examples of people that had stopped wearing their aids due to issues relating to comfort/fit or simple routine maintenance such as blocked tubing or replacing batteries. The lack of awareness and access to follow-up support for people that have been fitted with a hearing aid was mentioned by service users repeatedly and appeared anecdotally at all stages of the evaluation data.

“I previously had a hearing aid but mislaid it and never really got to grips with it. Since seeing you I have called audiology and they've sent me a new one out within 6 weeks.” Volunteer

Action on Hearing Loss should continue to share the findings of this evaluation with the NHS and also consider partnership approaches to ensure that people are fully aware of the service available to them through the NHS and organisations such as Action on Hearing Loss to address their hearing loss.

It is well evidenced⁸ that timely follow up appointments and ongoing aftercare is crucial in ensuring continued use of hearing aids, those who do not receive this support often stop wearing their hearing aids altogether. However, previous research by Action on Hearing Loss⁹ has found that many NHS providers are unable to offer a full package of support due to budgetary pressures and increase in demand. For example, only offering a hearing aid repair service in a hospital setting may create barriers to those who are less able to attend these settings.

8 Perez E and Edmonds BA. (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. doi: 10.1371/journal.pone.0031831; European Hearing Instrument Manufacturers Association. (2015). Eurotrak Survey 2015; Abrams H, Chisolm TH,

McArdle R. (2002). A cost utility analysis of adult group audiologic rehabilitation: are the benefits worth the costs? Journal of Rehabilitation Research and Development 39(5): 549-558

9 Under Pressure Report, Action on Hearing Loss (2015)

3.3 Engaging harder to reach communities

A key focus of the project was to ensure that its services were accessible to harder to reach communities. In order to achieve this, three target communities were identified:



Communities
in rural and
remote areas



Diverse Black, Asian and other
minority ethnic communities



Care Homes and
other residential
care settings.

Whilst specific targets were not set for engagement with these communities, each of the information teams were responsible for proactively delivering targeted interventions to ensure that their services were accessed by these three groups.

The inclusion of all three target communities was ambitious, particularly given that they were originally intended to be delivered as part of a 5-year project. Although proactive engagement with these harder to reach groups presented challenges, it encouraged project staff to put accessibility at the heart of their service which significantly extended service reach. It also resulted in the production of a range of new translated and accessible format information resources which encouraged the information teams to take a more creative and tailored approach to their service delivery.

Where successes have occurred in engaging with the target communities, these were primarily achieved through establishing effective relationships with other organisations working with the target groups.

3.3a Communities in rural and remote areas

Historically, outreach services delivered by Action on Hearing Loss have focused on towns and cities with more significant populations and the infrastructure to support service delivery e.g. Glasgow, Belfast, and London, as a way of ensuring that the service can be accessed by as many people as possible. Whilst this has been a successful strategy to date it has meant that resources have been targeted mostly in urban areas, although delivery in rural areas takes place whenever resources allow. What is evident is that the project has been able to considerably extend the reach of the information outreach service far beyond the major towns and as a result now has a much more significant presence across a much wider geographical area.

Through working with other rural services such as mobile library services and community 'meals on wheels' teams, the programme has been able to reach some of the most remote rural communities and in turn has enabled people to benefit from a service that they would otherwise have been unable to access.

Feedback from the rural focus group in Northern Ireland highlighted the value of the outreach nature of the service and how ease of access had encouraged people to attend.

“I think if it had been held in the middle of Newry or somewhere built up we wouldn’t have gone. But here’s it’s really accessible with plenty of parking.” Service User

Discussions with project staff revealed that there were some additional challenges in taking the service out to rural communities. For example, this often involves travelling significant distances, particularly in Scotland, which is both time consuming and expensive. Also, lower footfall in a rural location is to be expected, which may be difficult for projects with service user targets. In the future, the additional costs of delivering services to rural communities should be considered and factored into project resources.

3.3b Reaching Black and Minority Ethnic Communities

In the second half of the project, significant progress was made in reaching Black, Asian and Minority Ethnic (BAME) individuals. - Of the service users who filled in feedback forms throughout the project (5,256), 30% of them were people from BAME backgrounds. It should also be noted that particularly in London and the South East the percentage of people accessing information was estimated to be higher than 30%, more in the region of 45%. It was not always possible for BAME service users to complete feedback forms due to barriers such as language barriers and the forms not being translated into other languages.

Of those BAME service users, just over a quarter (27%) agreed to a follow-up call at 5-7 weeks, although this percentage was higher in Scotland and London and the South East of England.

Table Two – Engagement of BAME service users with evaluation

	Scotland	London & South East	Northern Ireland	Total
Total number of service users who filled in a feedback form	1,005	1,286	2,965	5,256
% of BAME service users	20%	31%	33%	30%
% of those BAME service users agreeing to follow-up	65%	46%	12%	27%

In order to improve the project reach at mid-stage the following key suggestions were made (based on the on-going learnings):

1. Mapping where Action on Hearing Loss has existing relationships or contacts with BAME organisations and communities and to use this as the focus for engagement.
2. Setting specific targets for BAME engagement for each of the information teams as a way of focusing delivery.
3. Focusing on recruiting volunteers from BAME communities as a way of increasing access to specific communities. Suggested avenues for BAME volunteer recruitment include; Universities (targeting specific societies, international student offices/deaf students, health and social care students); Equality and diversity groups and existing volunteer networks that have BAME volunteers e.g. AGE UK, International Women's Centre.
4. Building a better understanding of the cultural nuances that may deter different ethnic groups from accessing information and support with hearing loss.
5. Working in partnership with other agencies trying to reach specific BAME communities to put on joint events.
6. Utilising the translated resources made available through the project.¹⁰

The fact that by the end of the project 30% of people completing feedback forms were individuals from BAME backgrounds shows that Action on Hearing Loss implemented strategies following the interim stage to pro-actively reach out to BAME communities. Most notably in London and the South East there was a pro-active drive to recruit volunteers and project staff, where vacancies arose, from BAME communities. Additionally in all areas, teams identified communities and venues where people from BAME backgrounds were more likely to be and also targeted BAME organisations for the delivery of talks. These strategies were successful in achieving greater reach to BAME communities and ensuring the project was inclusive. In Northern Ireland the presence of someone from the BAME country-wide network on the project steering group also helped to increase BAME engagement through providing the project with key contacts and access routes into hard to reach communities.

Specific feedback received from BAME individuals

During the evaluation two focus groups with different BAME communities were undertaken. One group was a mixture of Chinese women and Indian (Sikh) men and women and the other was a group of women from South East Asia. Both groups had received a hearing loss awareness presentation and been offered hearing checks. The feedback from both groups was that the talk has been very interesting and had raised their awareness about the issue of hearing loss. They felt

¹⁰ A separate evaluation of the use of translated resources was undertaken. This evaluation showed that these resources had mixed impact across the three areas but broadly had been successful at making the information more accessible to minority ethnic groups. However, there are regional differences in demand for resources in specific languages.

the information had been easy to understand for those with a good level of English but felt that for others it may have been useful to have the information in different languages. Most people attending the focus group had taken up the opportunity to have their hearing checked and of those, a significant number had been told that they had some degree of hearing loss. For the vast majority this was the first time they had had their hearing checked and were made aware of the problem. Most focus group participants said they would not have known where to get information on hearing loss from and would not have proactively asked for a hearing check. It is likely therefore that without this intervention most of these individuals hearing loss would have gone undetected. All those present welcomed the opportunity to have a check there and then.

Of those that had been advised to go and see their GP only a couple had followed this up. When asked why people had not made an appointment, responses varied from group to group. Amongst the group of South East Asian women the main reason was that people perceived that hearing aids would not necessarily 'fix' the problem, that they took time to adjust to and in some cases people felt they made the problem worse by over-amplifying sound. These perceptions were based on family and friends experiences of hearing aids. Those from the Indian (Sikh) community group talked more about the stigma of hearing loss as a barrier to addressing it. They felt that within their community disability of any kind was often hidden as it was perceived to be a weakness and that this was true of both sexes. In contrast feedback from the focus group with Chinese community was that there was not a stigma attached to hearing loss but that it was seen as part of the ageing process. There was also a perception amongst the group that Chinese men were less likely to address their hearing loss than women.

These different perceptions about hearing loss highlight there may be cultural differences which would need to be better understood in order to tailor appropriate interventions for different groups.

3.3c Care Homes and other residential care settings

Of the three target groups, engagement with care settings¹¹ has proved the most challenging. There was notable success in Scotland as a result of the partnership with Trust Housing Association in particular, however this has not been consistent across all areas of the project. Care settings have historically been a difficult environment for Action on Hearing Loss to engage with and the barriers to access are consistent with those faced by other projects. These challenges include:

- Getting buy-in from managers at an individual care home level as a result of competing demands and hearing loss not being seen as a priority particularly in settings where residents have multiple and complex needs.
- Training on hearing loss awareness is non-mandatory and not governed by regulation in most areas and therefore is not seen as a priority.
- The pressures on staff time to attend training, shift patterns, the rapid turnover of staff and poor communication from management about training sessions.
- Some care homes do not keep a record of residents with hearing loss and therefore do not know the extent of the issue within their setting.

¹¹ The term care settings is used to encompass any residential accommodation for older people where there is some level of care provided. This includes sheltered housing schemes.

The table below illustrates the success at engaging care homes across the three project areas. Once again, staff made significant progress in increasing engagement with care homes in the second half of the project. This is commendable given the ongoing challenges of working with care homes.

Table Three – Engagement of Care Homes

	Scotland	London & South East	Northern Ireland	Total
Care home setting	83	51	35	169
Care home staff	258	88	195	541
Care home residents	605	37	140	782

Achievements in Scotland have demonstrated that a more strategic approach to engaging care settings is likely to result in more sustained engagement. However, engagement with care homes requires significant resources and investment in time, and as such, it may be more appropriate to separate out this element in any future projects targeting care homes.

Learning from HTIAC suggests that the following should be considered in any future project:



To focus engagement on supported living settings e.g. sheltered housing schemes as opposed to individual care homes.



To target care home group managers who are in a position to mandate awareness training with the care homes within their group.



To develop a compelling evidence base, drawing on the evaluation findings of Action on Hearing Loss 'Hear to Care' project, about how any training delivered will support care setting staff and benefit their residents.



To explore the option of integrating a talk as part of a mandatory training session already being delivered through the care home and link this to wider professional development opportunities for staff or offer to run a hearing loss awareness talk at a Managers team meeting.



To target talks at agency staff.



To leverage existing legislation where it exists.

3.4 Variations across project locations

In terms of contribution to the stated outcomes of the project there was very little variation across the project areas. There were some geographical variations in delivery. The most distinct variation in delivery was that Northern Ireland was able to use longstanding volunteers which enabled them to make more progress at an earlier stage of the project. Scotland and London and the South East used volunteers less initially, however in London and the South East there was proactive recruitment of volunteers from BAME communities to increase the diversity of the delivery team and therefore extend reach into BAME communities and groups, resulting in much higher engagement with volunteers.

It is also notable that both Scotland and Northern Ireland teams successfully developed relationships with intermediary organisations in order to advance the delivery of the project specifically in relation to engaging the target communities. Specifically Scotland has been successful in forming strategic partnerships such as that with the mobile Library Service (in Stirling), which has enabled them to 'shortcut' access to remote rural communities.

3.5 The effectiveness of the service delivery model

The evaluation demonstrates that **there were four key aspects of the delivery model that made it so effective; delivery of face-to-face advice, use of volunteers, delivering to the general public, community groups and professionals, using the evaluation follow-up calls as a further reminder for people to address their hearing loss.**

3.5a Importance of face-to-face

One of the key strengths of the delivery model is the face-to-face nature of the service. This is consistently cited by project staff, volunteers and service users as being one of the aspects of the service that they value most. This is particularly relevant given the focus and nature of the service and the target demographic of the project. The face-to-face nature of the service enables it to be delivered in a friendly, responsive and supportive way, all characteristics that are highly valued by service users, particularly those that may be apprehensive or concerned about their hearing or reluctant to seek advice from medical professionals. Whilst alternative formats of information provision such as accessing websites or providing literature have their place, face-to-face delivery provides the opportunity to offer a personalised service where specific queries can be addressed in real time.

“I don’t know when I would have got around to seeing about my hearing if the opportunity had not been there. It is also much better speaking to someone face-to-face that can answer questions and anticipate the information required if you’re not quite sure what you’re looking for in the first place.” Service User

“Face-to-face is the way forward where these matters are concerned.”
Service User

“Talking to someone face-to-face meant the information was geared towards my issues and not generic.” Service User

“It is also much better speaking to someone face-to-face that can answer questions and can anticipate the information required if you are not quite sure you are looking for in the first place.” Service User

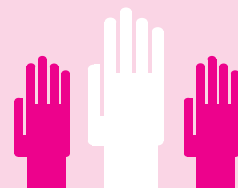
“It is a good idea to talk and explain the problem face-to-face. A person can understand more.” Service User

In addition, in many cases, face-to-face delivery offers the opportunity for people to take a hearing check at the same time as receiving information. This impromptu opportunity may mean that people are more receptive to having their hearing checked as it is something that can be done on the spot without the need to book an appointment or wait for results. Feedback from focus group participants strongly supports the theory that the majority of those tested would not have had a test had they not been offered it at the point of accessing the service.

3.5b Support from volunteers

3,289

volunteers hours were spent on the project.



Support from volunteers to deliver aspects of the service (primarily to run information stands) was a key part of the delivery model and fundamental in terms of extending the reach and capacity of the project. A total of 3,289 volunteers hours were spent on the project. Whilst volunteers were utilised successfully in Northern Ireland and London and South East and were seen as an integral part of the delivery model this was less evident in Scotland where volunteer numbers and hours were significantly lower in comparison. The challenges of recruiting volunteers to undertake information roles were not unique to this programme but were further compounded by the lack of dedicated project staff resource focused on volunteer recruitment. Volunteers also formed part of the project steering groups in each area which enabled them to contribute to the project in a more formal way, using their own experiences to help shape and steer the project.

The majority of volunteers who participated in the project had direct experience of hearing loss themselves either through their own loss or as a result of caring for someone with hearing loss. This first-hand experience of hearing loss gives invaluable insight into how it feels to experience hearing loss and the impact that it has on day-to-day life and relationships. This enables them to empathise with service users experiencing similar issues which builds trust and confidence in the information and advice being given. Whilst direct experience of hearing loss is not a prerequisite for recruiting volunteers, this aspect of the delivery model plays a key role in supporting and encouraging people to address their hearing loss.

“I have a hearing loss and for what we do we find that all the clients that come in to our service can easily talk to us because we have a hearing loss – not just the hearing loss but living with the family, how the family treat them and how they treat the family...people with no hearing loss would have no idea of the difficulties that we face in everyday life.” Volunteer

In Northern Ireland and London and the South East where volunteers are used routinely to support the Information Officers, staff have also benefitted greatly from working alongside volunteers with hearing loss.

“I’ve learnt so much about hearing loss through working with our volunteers. Their first hand knowledge and experience is invaluable.”

Information Officer

In London, there was also a specific intention to recruit BAME volunteers and as a result in the second half of the project, London and the South East were able to reach more BAME service users. It was felt that this was in part because BAME volunteers were more culturally aware and sensitive to issues that may prevent communities from accessing information and/or addressing hearing loss. In addition volunteers utilised their own contacts and networks to increase reach into BAME communities. This evaluation would endorse Action on Hearing Loss’s endeavours to recruit an ethnically diverse volunteer base and recommend that this approach is replicated in all areas of service delivery where volunteers are utilised.

3.5c Service delivery to the general public, community groups and professionals

A further key strength of the delivery model was that it targeted different groups of people who could have an impact on an individual addressing their hearing loss. Information stands targeted the general public and specifically people directly affected by hearing loss or people living or caring for someone that was affected. In addition to this, talks and presentations were given to community groups and in professional settings (e.g. in workplaces and care homes) which targeted a slightly different audience i.e. those whose service or business may be used by people affected by hearing loss. This broadening of the target ‘market’ for the project meant that more people affected by hearing loss could be reached. It also meant that community groups, care homes and businesses understood how their services could be adapted to make them more accessible to people with hearing loss.

3.5d Use of the evaluation follow-up calls

As part of the evaluation framework implementation follow-up calls were made to service users at 5-7 weeks and again at 9 months after receiving information at a talk or presentation. An unexpected outcome of these calls is that they acted as a key driver for people to take action to address their hearing loss. These calls also provided people with an opportunity to get further information on addressing their hearing loss. In the future, therefore, **it is recommended that a follow-up call features as part of the information service, partly to keep tracking the impact of the initial information received but also to remind service users of the need to take action and provide further information.**

3.5e Legacy of Hear to Inform and Connect

From analysis of evaluation data and in particular interviews with Action on Hearing Loss staff, we feel that the project leaves a strong legacy in the following ways:



It has embedded learning about how to implement a longitudinal evaluation framework that, although challenging due to the transitory nature of the service and the use of volunteers, can be done successfully.



The data generated by the evaluation provides robust evidence of the impact of the information service, which enables Action on Hearing Loss to make strategic decisions about the future of the service within the context of broader organisational development and changes.



The evidence of the importance of face-to-face delivery is clear. Being able to talk to someone about their hearing loss and receiving information verbally, influences a person's decision to go on and take action.



The project has demonstrated the need for specific strategies and approaches to reach target communities. If these approaches are followed in the future then Action on Hearing Loss has the potential to ensure greater accessibility of its services and ensure reach to a greater diversity of service users.

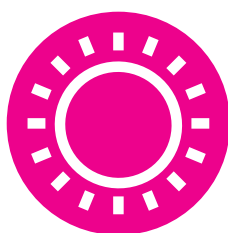
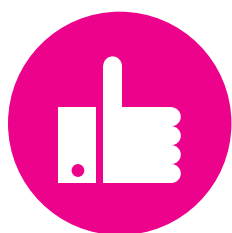
4. Conclusion and Recommendations

It is clear that Action on Hearing Loss successfully delivered the HTIAC project, which was highly effective at achieving the stated outcomes for the project. There has been valuable key learning that has emerged from the evaluation and the project leaves a strong legacy.

In particular, the high percentage of people that went on to take action (within the timeframe of the project) after receiving information is impressive. The change that this will have made to people's lives should not be underestimated. It is also undoubtedly the case that by taking action people will have also improved their wider health and wellbeing. The evaluation data tell us that people feel less lonely and isolated, as a result of addressing their hearing loss, and better connected to family and friends. It would be interesting to assess the cost effectiveness of addressing a person's hearing loss, for example does it mean that the need to access other NHS services is in some way mitigated or that when other services are accessed it results in better health outcomes as communication barriers are removed?

The evaluation also highlights the importance of a strong delivery team who are able to deliver information 'face-to-face'. The skills, experience and expertise of staff and volunteers has been invaluable. The project could not have been delivered in the same way without the contribution of volunteers and Action on Hearing Loss should continue to find ways to value its volunteers, offer appropriate training and also actively encourage a more diverse volunteer base. The evidence suggests that 'face-to-face' delivery leads to more people taking action to address their hearing loss and is certainly more appreciated by the older demographic that were targeted through the project. In addition the availability of 'on the spot' hearing checks is effective at identifying people new to the hearing loss pathway and encouraging early action to address hearing loss. This is perhaps even more the case given the absence of a national hearing screening programme.

Finally, the project has also demonstrated the importance of investment in evaluation, not only does it give strong evidence to funders that outcomes have been met but it also generates learning that has the potential to affect strategic decisions within Action on Hearing Loss. **Evaluation data suggests that the key ingredients of success for HTIAC; skilled staff, trained volunteers, effective information, face-to-face delivery and the availability of hearing checks, should all feature in delivery of the Information Service in the future.**



Recommendations

1	'Face-to-face' delivery of the Information Service is offered whenever possible. The importance of 'face-to-face' delivery in encouraging people to take action to address their hearing loss is evident in the evaluation data. In future it would be interesting to collect data to find out to what extent users of the service were digitally engaged.	
2	Trained volunteers continue to be recruited to deliver information about hearing loss and a more diverse volunteer base is developed which reflects the diversity in local communities.	
3	The evaluation methods used to assess the impact of the project continue to be used for the Information Service and all other appropriate projects within Action on Hearing Loss. In particular, the 'follow-up' calls should become an integrated part of the service and used as much to prompt the service user to take action as to assess the impact of information received.	
4	Specific strategies are developed in order to increase diversity. Wherever possible partnerships are developed with organisations who already have established relationships with key target groups as a way of supporting increased reach.	
5	Any future delivery model should retain elements of central co-ordination such as the collection and co-ordination of project data/service user feedback but still retain local ownership and flexibility of project delivery in order to reflect the local context.	
6	The Information Service should continue to target the general public, community groups and businesses and other professionals. This broad 'target market' is likely to lead to better understanding of hearing loss and to more accessible services and environments.	
7	Hearing checks should continue to be offered alongside the provision of information. This gives the individual direct insight about their hearing and is perhaps the most powerful catalyst for someone deciding to take action to address their hearing loss.	
8	Action on Hearing Loss should seek external funding to commission research to further understand the cost benefits of early intervention to address hearing loss and also if this leads to other positive health outcomes.	
9	In future the service should consider how it can more effectively capture data to help track the rural v urban reach of the service.	

Appendix One HTIAC evaluation methodology

Data collection and methodology

The following activity was undertaken to inform the evaluation:

Policy briefing and review of external focus of evaluation with Heads of Service

As a key focus of the evaluation was to use the learning and findings emerging from the research to influence external policy and practice, Heads of Service were engaged at the start of the interim evaluation, which was taken mid-way through the project, in a policy review. This was to ensure that the priorities set out in the original funding application were still relevant and reflected existing regional policies and priorities.

Data collection

Data was collected from a range of project stakeholders who were involved in or were supported by the project, to ensure that the monitoring and evaluation approaches used were inclusive. Alongside this, the project collected core data that was needed to track progress against the quantitative project targets and deliverables.

a) Collecting data to track progress towards project targets and KPIs

Through the use of a coversheet completed for every information intervention undertaken the following data was collected in order to track and monitor the core key performance indicators (KPIs) attached to the project. This included the following data:

- Number and type of activities delivered (e.g. information stands, information talks, hearing checks, resource room appointments)
- Total number of active volunteers and number of new volunteers recruited in that period
- Number of volunteer hours provided to the service
- Number of local community groups and organisations supported.

The number of service users was collected through the use of number counting clickers and was recorded for every activity delivered.

b) Collecting data from service users

A tiered approach was adopted to collect data from service users, with data collection occurring at three different time points:



The three tiered approach was vital for ensuring that Action on Hearing Loss could measure the long-term impact of its face-to-face information services and evaluate whether the information services had supported service users to take action to address or manage their hearing loss. The aim was to collect point of contact data from all service users who accessed the face-to-face information service. This included collecting data at information stands, information hubs, resource room appointments, hearing checks, information talks and product demonstrations.

Service users were defined as people aged 50+ with unaddressed or addressed hearing loss who accessed information for themselves. The term service users also refers to people who accessed the service to collect information on someone else's behalf e.g. a family member, friend or someone they care for.

Even at information activities, such as information stands, where interaction with the service user was often very fleeting, information staff and volunteers were encouraged to implement the recommended data collection approaches. To facilitate this, data collection tools were developed that were quick and accessible for service users, staff and volunteers to use at the point of contact. These comprised of a 'feedback form' (Appendix C) designed to elicit key demographic information from the service user (including gender, ethnicity and age) as well as to ask questions which addressed the key outcomes of the project.

The 'feedback form' asked for consent to follow-up with the service user 5-7 weeks later, to find out what they had gone on to do since accessing the information service e.g. had a hearing test, been fitted with a hearing aid, sought further support from another relevant voluntary organisation, contacted the Information Line, attended a hearing aid maintenance service and/or purchased an assistive product. The follow-up also established:

- why the person had or had not taken action
- whether the model for providing information had been useful
- whether they required further information or support to take action.

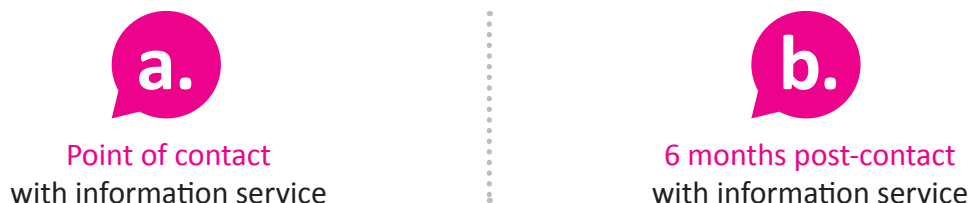
The 5-7 week follow-up took the form of a postal survey, email survey or a telephone survey, depending on the preferences of the service user, identified at point of contact. At the 5-7 week follow-up, further consent was sought to follow-up with the service user at the 9 month time point. The aim of this follow-up was to:

- find out what additional action the individual had taken since they were last contacted
- find out what encouraged or stopped them from taking further action
- measure the impact that taking action had had on their lives socially and emotionally as well as on their wellbeing.

All follow-up for the project at 5-7 weeks and 9 months was co-ordinated centrally for all three information services, by a dedicated Feedback Coordinator.

c) Collecting data from local community groups and organisations

Data to measure the impact of the face-to-face information services on local community groups and local social and health care organisations (including care homes), was collected at two different time points:



To collect point of contact data, a 'feedback sheet' was used at the end of all information talks that were delivered to people who work with older people/older people with hearing loss (e.g. care home staff and staff who run community groups for older people). As with the 'feedback form', the 'feedback sheet' asked questions which addressed the key outcomes of the project, along with a few additional questions asking attendees to rate the quality of the talk, usefulness of the information provided etc.

6 months after the information talk, follow-up was undertaken via an email survey to the Service Manager (e.g. the care home manager, leader of the community group). The survey explored whether the information they received had supported any changes in the accessibility or inclusivity of their service or setting for older people with hearing loss, as well as to find out any perceived barriers to change. The follow-up email survey was sent by the Feedback Coordinator.

Quarterly reviews and analysis of the data collected across the project was undertaken through analysing the:

- data from the presentation/talks feedback forms and service user forms (point of contact forms) and
- follow-up tools (5-7 week and 9 month service user follow-up and 6 month community service manager follow-up).

This enabled the quantity and quality of the data to be monitored on a regular basis and for emerging trends and findings to be highlighted throughout the project. The data collected as part of these quarterly reviews was shared at each of the area-based knowledge and sharing events, the programme-wide event and with the Project Board.

d) Collecting data from project volunteers

Although the project did not have a specific objective to measure the impact of the project on the volunteers who were supporting its delivery, feedback was collected from project volunteers to strengthen understanding of the broader impacts of the project and to better understand the effectiveness of 'volunteer-led' approaches to delivering information outreach interventions.

Volunteers were asked to complete a project specific volunteer survey in spring 2019 to find out the perceived benefits of volunteering, personal impacts of volunteering, benefits of the delivery model, and volunteers perceptions of the impact of the project on beneficiaries.

Volunteer focus groups were also undertaken with a sample of volunteers as part of the monitoring and evaluation work.

e) Additional data collection activity

Focus Groups

Nine focus groups were undertaken across the three project areas to collect qualitative information on the impact of the project in each locality and data on the effectiveness of the delivery model. Separate focus groups were held to collect data from people from the three target communities for the project. Due to practical issues it was only possible to undertake one focus group with people living in care homes and other residential care settings. The findings of these focus groups have helped to inform key aspects of the final evaluation.

Knowledge sharing and learning events

Knowledge sharing and learning events were held with each of the information services this year. The focus of these events was to explore what was and wasn't working in terms of project delivery and to share best practice. It was also an opportunity to update each service on the progress of the project and to share with them findings emerging from the evaluation and discuss collective solutions to challenges presented by the project.

In addition to these geographically focused events a programme-wide learning and sharing event was held that brought together staff from the three delivery areas. This was an opportunity to:

- Share learning and best practice from across the project first hand
- Collectively discuss wider operational and delivery challenges specifically in relation to engaging the three target communities
- Agree recommendations for adjustments or changes to the delivery of the project.

Learning and feedback from both the local and programme-wide events was used to inform the onwards delivery of the project.

Appendix Two

Policy context

The key priority of the Hear to Inform and Connect project evaluation, is that it enables Action on Hearing Loss to evidence the core funded outcomes of the project and provides robust evidence about the long-term impact of the organisations information outreach services. The intention is that this evidence will be used to inform and support future applications for funding.

Alongside this, the evaluation presents a key opportunity to achieve a range of broader goals for the organisation which include helping to inform future plans, policy influencing, funding priorities, service development and longer-term provision for people with hearing loss. To support this aspect of the evaluation a set of strategic objectives for the evaluation have been developed.

Strategic objectives of the project evaluation

Evidence gathered through the evaluation should help Action on Hearing Loss in the short term to:

1. Generate additional evidence to support the need for face-to-face information for older people with hearing loss which will help Action on Hearing Loss influence the NHS to provide more and better information through GPs and Audiology.
2. Help Action on Hearing Loss to influence and shape policy related to supporting people with hearing loss through demonstrating the benefits and impact of face-to-face information provision and enhancing the current evidence base to ensure that face-to-face support is available for older people and for those who are digitally excluded.
3. Generate additional evidence to support the need for locally based information provision in community settings, to help build Action on Hearing Loss's case for support when applying for future funding and to help inform what they would do differently for a future UK scale up.
4. Generate additional evidence to support the need for volunteer-led community information services, to help strengthen future funding applications and inform what they would do differently for a future UK scale up.
5. Enable Action on Hearing Loss to support implementation of NICE and NHS England guidance relating to practice and provision for older people with hearing loss.
6. Provide evidence which supports the Department of Health Northern Ireland 'Transforming Your Care' and 'Delivering Together' policies which focus on keeping people living independently for longer.
7. Generate evidence to help influence the Regulation Quality Improvement Agency (RQIA) Northern Ireland's standards for Nursing Care to include hearing loss as a health priority.
8. Provide additional evidence to demonstrate that a basic hearing check can lead to longer-term action (i.e. if a hearing aid is required) and that hearing check improves health and wellbeing; this will help Action on Hearing Loss to present a stronger case to GPs and other NHS services on the need for early intervention to identify and diagnose hearing loss.
9. Enhance Action on Hearing Loss's understanding of the specific challenges and barriers for care homes and other residential care settings in supporting residents with hearing loss which will help them to influence and shape policy and provide evidence to support NHS England with developing and implementing 'good practice' guidelines for care homes.

Appendix Three

Monitoring and Evaluation Overview against Outcomes

Outcome	Indicator	Data Collection	Led by/When
An increase in the number of older people with hearing loss who feel better informed about hearing loss	50,000 older people received information	Clicker information	Staff/volunteers During session
	70% of older people report feeling better informed about hearing	Point of contact information (T1a)	Staff/volunteers During session
An increase in the number of older people with addressed and unaddressed hearing loss who take action	70% of older people who received information report feeling better informed on how to take action	Point of contact information (T1a)	Staff / volunteers During session
	60% of older people with an unaddressed hearing loss report that they will take action to address or manage their hearing loss	Point of contact information (T1a)	Staff / volunteers During session
	50% of older people who received information who report taking action to address or manage their hearing loss	Telephone interviews (T2a + T3a) Online survey (T2b +T3b)	Evaluation volunteers or staff (T2a) 4-6 weeks post intervention Evaluation consultants (T3a) 9 months post intervention

Outcome	Indicator	Data Collection	Led by/When
Older people with hearing loss feel better connected to families, friends and the world around them	70% of older people who received information report feeling better informed on how to access support for their hearing loss in their community	Telephone interviews (T2a) Online survey (T2b)	Evaluation volunteers or staff (T2a) 4-6 weeks post intervention
	50% of older people who received information report feeling more included in social interaction or activities	Telephone interviews (T3a) Online survey (T3b) Focus groups (T3c)	Evaluation consultants (T3a) 9 months post intervention
	25,000 people who received information report increased ease and confidence in communicating	Telephone interviews (T3a) Online survey (T3b) Focus groups (T3c)	Evaluation consultants (T3a) 9 months post intervention
Community groups are better informed about hearing loss	360 community groups receive information	Monitoring spreadsheet Online survey (T1b and T4a)	
	70% of community group leaders report feeling better informed	Online survey (T1b and T4a)	
	130 community group leaders report taking action to enable their groups to be more inclusive of older people with hearing loss	Online survey (T1b and T4a)	

Appendix Four

Table One – How the project performed against its targets

Change indicator(s)	Indicator	Actual
Number of older people with hearing loss who receive information	50,000 older people received information	55,374
Number of older people who report feeling better informed about hearing loss	70% of older people report feeling better informed about hearing loss	96%
Number of older people who report feeling better informed on how to take action	70% of older people who received information	92%
Number of older people who report taking action to address or manage their hearing loss	50% of older people who received information	63% of those surveyed at 9 months
Number of older people with hearing loss who report feeling more included in social interaction or activities	50% of older people who received information	10% of those surveyed at 9 months
Number of people reporting increased ease and confidence in communicating	50% of older people who received information	18% ¹² of those surveyed at 9 months
Number of community groups who receive information	360 community groups received information	1,952
Number of community group leaders who report feeling better informed about hearing loss	70% of community group leaders report feeling better informed	100% of those surveyed at 6 months
Number of community group leaders who report taking action to enable their groups to be more inclusive of older people with hearing loss	36% (130) community group leaders report taking action	95% of those surveyed at 6 months

¹² It should be noted that not everyone that came into contact with the service will have had a need to take action as their hearing check may have revealed that they did not have an issue with hearing loss. Follow-up calls were undertaken with a sample which included people that had some level of hearing loss identified through their hearing check and those that did not.



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The evaluation was conducted by Impact Consultancy & Research