

Primary Care Audiology: What can be learnt from other roles in Primary Care?

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Background

General practice has been described as being 'in crisis' due to a significant increase in workload without the necessary increase in resourcing (1,2). Various reports in 2015 - 16 promoted a role for other professionals in the primary care team to both reduce the demand for GP appointments and improve the quality of care patients receive (1,3,4,5). In addition to medical and nursing roles, a number of registered practitioner roles have been introduced, as shown in figure 1. Despite the successful introduction of Primary Care Audiologists in Wales in 2015, this has not been adopted in England (6, 7, 8). In Scotland, a public consultation showed that over 70% would like to have access to an Audiologist in primary care (9), but no reports of this being planned or piloted could be found. There has been considerable work carried out by some professional bodies to support and promote these roles.

This policy and practice review was carried out to see what can be learnt about the introduction of other roles into primary care to inform the potential role out of Primary Care Audiologists in England, and if there are significant evidence gaps.

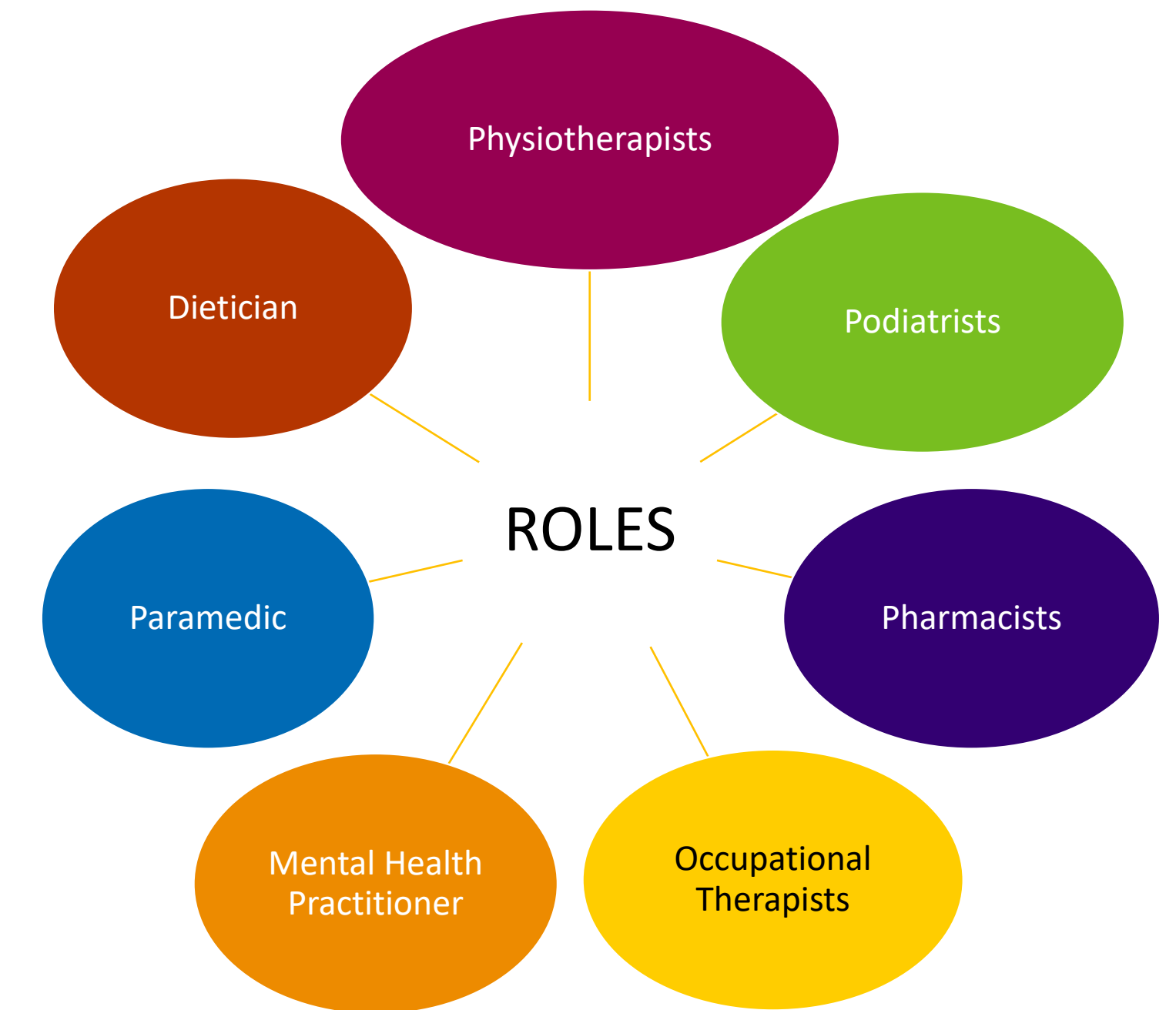


Figure 1 Primary Care Roles registered practitioners excluding medical and nursing)

Method

Key databases and websites were systematically searched using pre-agreed search terms. The inclusion criteria were:

- Published in English language
- Roles funded by the NHS and provides the first point of contact for patients, providing new expertise and increased capacity to general practice (10)
- Regarding: Physiotherapy, Podiatry, Paramedic, Dietetics, Occupational Therapy, Audiology

This resulted in 65 research and evaluation reports to review, plus guidance and promotional documents from NHS and professional bodies.

Training & careers

It is generally accepted that these roles need master's level qualifications, but there have been challenges accessing training (11,12). A portfolio route has been developed to enable on-the-job training, but this has been found to be overwhelming for some (12). These roles are usually taken on by more experienced staff and a broad range of prior experience was beneficial and led to greater confidence (11, 13, 14). Skills required include a knowledge of co-morbidities, the ability to assimilate information and make decisions quickly, and the use of clinical reasoning models were found to be advantageous to maintain vigilance (15). These roles are seen as an option to advance their career without having to take a managerial role, and are rewarding and satisfying (14, 16). However, burn out and stress have been reported due to workload (11, 16, 17,18).

Role scope & service models

The scope of roles varied considerably particularly with regard to prescribing and issuing 'fit notes' (15, 19, 20). There are a wide variety of service models, with some practitioners being employed direct and others working out from an existing service team, with the latter being found to work better, and the more time spent in each practice challenges reduced (11, 16, 19, 21, 22, 23).

Most services rely on reception staff to book each patient in to see the most appropriate professional, however, it is recognised this will never be 100% accurate or capture all the appropriate patients (16, 24, 25, 26). Self referral and referral from other professionals in the practice is also common (23, 27).



Outcomes

There are no known randomised controlled trials of GP lead services compared to First Contact Practitioner services. Studies report promising outcomes with high patient satisfaction but drop-out rates are often high, outcomes limited to short term and often no comparator (19, 21, 29).

When reported, numbers referred onto the main service (e.g. Community Physiotherapy) vary between 9 – 27%, with over 40% (30, 31).

Benefits to practices have been the upskilling of other staff by providing training (19, 32), saving costs through seeing a different professional, reduced referrals, medication changes, reduced investigations and fewer follow-ups (27, 32). With regard to increasing GP capacity, evidence is very limited. One study reported there was not enough First Contact Physiotherapy capacity to 'unburden' GPs, particularly at sites where the provision was low, however one practice manager reflected how they would "struggle" if the service was taken away (19).

Implementation

There have been few studies looking at implementation. Challenges include care navigation, understanding of the role by other practice staff, appropriate space and resourcing. Facilitators included the positive buy in of existing clinical staff and close working relationships with other clinicians, availability of appropriate resources such as space and IT access. Sustainability was thought to be facilitated by recognition of the role by other clinicians, the ability to expand current roles and responsibilities (16, 17, 18, 28).

Senior leadership has been highlighted as critical on a national level, to influence strategic development of first contact physiotherapy roles, and also at a more operational level to provide structure to the support practitioners receive (16). Recommendations for successful implementation are given in figure 2 (18).

Conclusions

- The model of service being provided from an existing Audiology Team is preferential, as opposed to direct employment by the GP practice or another organisation.
- The training needs specific to Primary Care Audiology need to be explored to determine if they are currently fit for practice and if further training is required / should be developed.
- Further investigation is needed into how best to implement Primary Care Audiology roles, given the mixed experience by other professionals and barriers at some surgeries.
- Further research is needed looking at outcomes and in particular long-term outcomes for both patients and services with Primary Care Audiologists.
- There is a need to carry out a more detailed evaluation of the experience of Audiologists working in Primary Care.
- Further qualitative evaluation of the services provided in Wales looking at staff and patient experience has been proposed plus exploration of views in England, and grant application submitted to fund this work. There is a need for further research to be carried out looking at outcomes.



Figure 2 – Recommendations for successful implementation

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