



Provision of Adult Balance Services – A Good Practice Guide’ DH Document: January 2009.

Response of the BSA Rapid Review Panel, March 2009

The panel welcomes this document and the focus it brings to balance problems that, in many areas, have been neglected and poorly managed for many years and for the issues it highlights in order to improve balance services throughout the NHS.

Summary

The document sets out an ambitious and far reaching plan for development of balance services and the idea of introducing balance services at primary care is seen as a good means by which more patients with balance problems could access help. However there are a considerable number of issues which need to be addressed in order to implement the proposals. The document highlights some of these (the need for education and training), but falls short on how they may be achieved in practice, how they will be funded and a timescale for implementation.

The concept of balance service networks with a local service, specialist centre and supra-specialist centre and with specific dedicated care pathways is considered a positive one, and the recognition in the document that there may be many different ways to achieve this, drawing on a variety of staff from different backgrounds is seen as a positive aspect.

Detailed Comments

Part 1: The challenge to transform services

The establishment of the networked model of care comprising local balance services, specialist balance centres and supra-specialist centres (paragraph 22) (not sub-specialist as stated in part of Figure 1), is considered to be a positive way by which more patients could access services, but this will require major re-structuring in many areas which will require substantial investment both in staff and equipment and the document does not recognise or comment on the extent of funding required or how it is to be provided. There maybe cost efficiencies and wider financial benefits to health and the wider economy as a whole following its implementation, but investment is required upfront in order to achieve these benefits.

The panel support the documents views that there maybe a number of different models by which good service delivery can be achieved and that this maybe dependent upon factors such as geography (city centre practices versus rural practices) and it is for local health care providers to develop a service that works within their area, 'building on current resources, local strengths, service provision and workforce (paragraph 23), where these exist.

The panel support the view that there should be an 'excellent interaction and liaison between Falls and Syncope Services and Balance Services' (paragraph 26), as there are concerns that referring these patients to a local balance service without appropriate medical investigations may not address their underlying and often multifactorial problems (paragraph 68).

1.1 Achieving the vision

'Introducing a competent, productive workforce, skilled in diagnosing and managing dizziness and balance disorders' is an admirable goal, but the challenge is seen as being able to provide the opportunity for staff to attend accredited training, where it exists and for it to be developed where it does not exist.

1.2 Workforce

The document recognises the importance of the range of staff that should make up a good balance service (paragraph 46) and at every stage rightly stresses the importance of the multi-disciplinary team,

but there is a great paucity of such a workforce. The key role of the GP is highlighted (paragraph 36 & 37) and for most patients, this is where the current service fails most prominently, but the “primary care physicians” and other clinicians “with a Special Interest and skilled and trained in balance disorders” (paragraph 46) do not currently exist in sufficient numbers. It is unclear from where they are going to be drawn.

The panel fully supports that physiotherapists form a vital part of the balance rehabilitation team, particularly in cases of multifactorial balance and that they should be an integral part of the multi-disciplinary team (paragraph 59). However there is a significant shortage of appropriately qualified physiotherapists and the document does not highlight the importance of the need for a clinical specialist, at primary care level, with interest in falls prevention and access to a geriatrician or falls clinic for the elderly.

The need for new and expanded roles such as “audiologist led balance clinics and development of audiovestibular medicine”, in terms of numbers, “to complement current surgical and audiological skills in the multi-disciplinary team” is recognised within the document (paragraph 49). The move within ENT to establish medical audiology as a sub-speciality may help this process and contribute towards the idea of establishing sufficient supra-specialist centres throughout the country. Collaboration between specialities within a multidisciplinary network is seen as vital to the advancement of this service.

The general lack of appropriately qualified workforce highlights the significant implications for training.

1.3 Education and Training

The document recognises a major practical problem, namely recruitment and training of an appropriately trained workforce. We agree that ‘well-informed primary care and local balance service staff will be key to the success of transforming or establishing an efficient and effective balance service’ (paragraph 51). However there is a lack of awareness amongst many GPs that many patients with these disorders are readily treatable. There are no current training courses in vestibular assessment and rehabilitation for staff at primary care level, such as practice nurses or GP’s and provision of these training modules will contribute towards achieving an appropriately trained workforce.

Physiotherapy training at degree level does not provide sufficient training for managing the complexities of balance patients. The Association of Chartered Physiotherapists interested in Vestibular Rehabilitation, registered with the Chartered Society of Physiotherapy, run courses in rehabilitation, but these are not currently accredited. Investment in such courses offers the potential to address the current shortage of physiotherapy input into balance services.

The document doesn’t recognise the recent developments in Higher Training Scheme by the British Academy of Audiology in providing a clinical module on Balance Assessment and Rehabilitation which may offer a path for commissioning audiologists to develop relevant skills to help address some of the workforce issues. Many MSc students in Audiology struggle to find training places, due to lack of availability of funded places.

Perhaps provision of standardised, cross specialty/profession training and accreditation in assessing and managing vestibular disorders would be worthy of consideration. There is also a need for up-skilling in audio-vestibular matters, in other professional groups, such as radiologists, in some areas.

To overcome this problem, a massive programme of medical education is needed through engagement with the Higher Educational Institutions (HEI), and Royal Colleges to provide the ‘accredited dizziness courses’ required (paragraph 52), with appropriate funding, which is not addressed in the document.

Part 2: A new good practice commissioning pathway for balance disorder services

The panel support the existence of ‘clear criteria and protocols’ (paragraph 57) and referral pathways with medical ‘red flags’ to refer patients to the local balance team or specialist/ supra-specialist centre (paragraph 71). This needs extensive cross professional agreement in drawing these up and maintaining them to assure appropriate triage of patients (paragraph 24) and to achieve rapid access to specialist / supra-specialist centres. A balance service co-ordinator, within an area which has responsibility across the network of services, maybe an ideal way in which to achieve this. The panel is wary of the local balance service referring through for all the tests highlighted in paragraph 62 (e.g. EEG without reference to a neurologist) as this may lead to overburdening specialist clinics, unnecessarily, with time consuming diagnostic tests. There are also concerns regarding the difficulty in making cross boundary referrals and these issues will need to be addressed for specialist and supra-specialist referrals.

The panel support the scope of skills highlighted as required for the local balance service (paragraph 62), and support the proposal that migraine and BPPV could and should be dealt with in local balance services, but are concerned by the document also highlighting three pilot programmes, one of which was provided by an assistant technical officer, who probably wouldn't have the training to identify migrainous vertigo. There would need to be a clear definition of skills and scope of practice within the local balance service to avoid confusion as to its scope of provision (i.e. provision of exercise leaflets and instruction on how to do these, or investigation, identification and treatment of certain balance conditions such as BPPV and migrainous vertigo).

There are concerns within the panel that relying on significant and sustainable changes occurring as a result of GP education is unrealistic, due to enormous demands on their time that exist already and that realistically they can only be expected to detect the problem and pass the case along. This would leave the local balance service with the responsibility of diagnosis, which would require someone within the local balance service with diagnostic skills which could be a GPwSI from the practice or a clinical scientist or audiovestibular physician.

The panel support the greater involvement of psychologists within the local balance team (paragraph 60), but the lack of psychologists or available cognitive behavioural therapy and specialist vestibular physiotherapists is a major issue that the document has not highlighted.

The equipment required for the local balance service (Paragraph 64) will require a lot of local investment which is not commented on in the document.

Annex 1: Third sector and patient support groups

The document highlights a number of charities representing patients with balance problems. Engagement with such charities and patient support groups may provide some impetus in achieving service improvements.

CONCLUSION

The Guide sets out a very exciting vision for a possible future, but does not discuss responsibilities for bringing about these changes to service structure (i.e. Strategic Health Authority, PCT or local trusts) and unless significant resources are allocated and unless there is a substantial shift in the current attitudes of both commissioners and providers towards balance services, there is a danger this vision will not be realised.

PANEL MEMBERS

The panel consisted of experts within balance services, both BSA members and co-opted individuals with special experiences of balance work outside the area of Audiology.

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