Received: 9 March 2021 | Revised: 8 June 2021 | Accepted: 15 June 2021

DOI: 10.1111/1460-6984.12650

International Journal of Language & Communication Disorders

RESEARCH REPORT

Scoping opinion: Speech and language therapists' views on extending their role to the urgent ear, nose and throat pathway

Louise C. Occomore-Kent | **Ellie Hatch** | **Madeline Cruice**

Division of Language and Communication Science, School of Health Sciences, City, University of London, Northampton Square, Clerkenwell, London, UK

Correspondence
Louise C. Occomore-Kent, Division of Language and Communication Science, School of Health Sciences, City, University of London, Northampton Square, Clerkenwell, London EC1V 0HB, UK.
Email: Louise.occomore-kent@city.ac.uk

Abstract

Background: In the UK, there is increasing pressure on ear, nose and throat (ENT) clinicians and departments, which is anticipated to amplify in the coming months and years due to the coronavirus disease 2019 pandemic and other workforce pressures. In the context of a national drive to advance practice of Allied Health Professionals to address some key challenges facing the National Health Service, we explored whether UK speech and language therapists (SLTs) felt it is possible to utilize and extend their existing skills to patients on the urgent 2-week wait (2ww) ENT pathway.

Aims: To explore SLTs' views of extending their role to work with patients referred on the ENT 2ww pathway.

Methods & Procedures: Two separate focus groups were conducted using nominal group technique to generate and rank benefits and challenges of the proposed extension of role. Participants were invited to take part through Clinical Excellence Networks relevant to head and neck cancer and voice sub-specialties. Participants were competent in performing nasendscopy in at least a highly specialist role in voice or head and neck subspecialties.

Outcomes & Results: Nine SLTs from England, Wales and Northern Ireland attended two focus groups. All were employed in band 8 roles in head and neck and/or voice. Eight were competent to Royal College of Speech and Language Therapists' scoping level 3. Important benefits of the proposed novel service delivery model were generated and ranked by participants, with both groups identifying improved quality and efficiency of service for patients among the most important. Disadvantages were then generated and ranked across the two groups with potential for misdiagnosis ranked as the most important by both.

Conclusions & Implications: Participants responded that extending the SLT role into assessment of 2ww patients would provide benefits for quality of care, healthcare efficiency and the SLT workforce. The identified disadvantages require addressing if the proposed SLT-led model of service delivery is piloted in

the UK. These include practical matters such as referral and prescribing rights, alongside wider implications such as support, governance, indemnity, acknowledgement and remuneration for the extended role. Nationally agreed competencies and training for the role are required if this model is to be successful.

KEYWORDS
therapeutics, dysphonia, otorhinolaryngological diseases, healthcare quality, access and evaluation

What this paper adds

What is already known on this subject?

- International studies have shown that SLTs provide safe and effective assessment for routine ENT referrals with dysphonia and dysphagia, reducing ENT waiting lists in the process (Payten et al., 2020; Seabrook et al., 2019). The current study is the first, to the authors' knowledge, to explore views of the profession regarding SLTs' involvement in assessing patients on the more urgent ENT 2ww pathway in the UK, particularly in the primary care setting.

What this study adds

- The greatest benefits of SLTs assessing patients with dysphonia and dysphagia in the 2ww wait clinic were felt to be for patients through prompt, holistic consultation from a clinician with expert knowledge in their disorder. The greatest disadvantages were posed for the workforce such as potential to miss diagnoses, risk of litigation and the increased burden of responsibility. While advantages are clear for service users, the disadvantages must be addressed if such a model is to be implemented.

Clinical implications of this study

- Expert SLTs communicated strongly that SLTs would be a beneficial addition to the 2ww assessment clinic for patients with dysphonia and dysphagia. For this role to be piloted and implemented successfully, their concerns around increased responsibility, potential for litigation and missed diagnoses need to be addressed. If the SLT role is to be extended to the 2ww clinic, robust training, competencies, supervision, guidance and recognition are necessary to support clinicians in this role and protect patients. Some practical matters such as referral and prescription rights also require exploration.

INTRODUCTION

The problem: current model, workforce and service pressures

In the UK, patients with symptoms of possible head and neck cancer (HNC) are referred to an ear, nose and throat (ENT) clinic to be seen urgently within 2 weeks. Known as the 2-week wait (2ww) pathway, it is criticized for poor sensitivity and specificity in detecting HNC (Rimmer et al., 2012) with an average pick-up rate of 8.8% (Langton et al., 2016). The referral criteria, including persistent dysphonia and dysphagia, have poor positive predictive value and usually result in benign diagnoses. Rimmer et al. (2012) reported that HNC diagnosis was being delayed by the 'worried well' patients in the 2ww pathway. In the context of a shortage of HNC surgeons (York, 2004) and a 33% projected increase in oropharyngeal cancer cases by

2035 (Smittenaar et al., 2016), it is vital that ENT specialists and the 2ww pathway are used by those most in need. Inappropriate and incomplete referrals are described at some centres (Begum et al., 2015; Mitchell et al., 2019), further contributing to the 2ww pressures.

One of the 'red flag' symptoms is persistent hoarseness (NICE, 2015), which was patients' commonest presenting symptom (33.3%) on the 2ww pathway (Rimmer et al., 2012). However, it was also the commonest symptom of those patients who were discharged from the service (52.9%) without a malignancy, suggesting that hoarseness in isolation has a negative predictive value for cancer. Patients with dysphonia were most commonly diagnosed with laryngo-pharyngeal reflux disease, no abnormality, muscle tension dysphonia and globus sensation. Many of these patients require speech and language therapy (SLT) following their ENT assessment.

Ear, nose and throat clinicians are at high occupational risk of contracting coronavirus disease 2019 (COVID-19), which has led to recent rapid service reform such as telephone triaging with the use of a risk calculator (Paleri et al., 2020). Paleri et al. (2020) reported that 77% of 2ww referrals have been deferred or discharged without face-to-face contact since the COVID-19 outbreak and their outcomes will be followed up in 6 months' time to establish success with regards to cancer detection. This will result in many benign dysphonic and dysphagic patients requiring assessment and treatment for their symptoms in future, putting further pressure on ENT services (Edge Health, 2020).

The problem: not addressing the symptoms

Many 2ww patients without cancer require high-quality, evidence-based SLT for their voice or swallowing symptoms following their ENT assessment, in addition to the exclusion of cancer. These symptoms can have high impact on patients' quality of life. During their lifetime, 29.9% of people will experience a voice disorder (Roy et al., 2005), increasing to around 82% of professional voice users during their career (Boltežar & Šereg Bahar, 2014). Female professional voice users, such as teachers, represent a large proportion of patients with benign dysphonia (Boltežar & Šereg Bahar, 2014) with an annual work absence of up to 30% (de Medeiros et al., 2012). Roy et al. (2005) found absenteeism (7% across all workers with a voice disorder) with an inability to fulfil their role (4.3%). Cohen et al. (2012) found that 2.1% of short-term disability (STD) claims in the USA between 2004 and 2008 were due to a laryngeal disorder, with a mean average work absence of 39.2 days. STD payments per annum totalled $US647 269.30 (£568 833.98 adjusted for inflation) and total lost wages in 12 months amounted to $US843 198.72 (£741 020.91 adjusted for inflation), presenting huge patient and societal burden.

Cohen and Garett (2008) found that two-thirds of people with dysphonia of likely laryngo-pharyngeal reflux aetiology had a condition requiring SLT treatment, and two-thirds of them subsequently improved with therapy. Some conditions become less amenable to therapy over time, for example, vocal nodules which harden and require surgical treatment, hence timely identification is beneficial. Mattioli et al. (2015) found significantly improved chance of unilateral vocal fold palsy recovery in patients who received early SLT input. Zabret et al. (2018) found lower incidence of postoperative dysphonia in patients who received preoperative SLT (15.1% vs 24.4%), and recommended prioritization of professional voice users to reduce work absenteeism and long-term effects. Given the prevalence of dysphonia, its impacts and the effectiveness of SLT treatment for many, the impact of prolonged waiting times on patients and society is far-reaching.

Evidence from abroad: the success of international SLT-led models

Seabrook et al. (2019) and Payten et al. (2020) implemented SLT-led assessment clinics for patients with dysphonia in Australia. In these novel models, patient referrals were triaged as high, medium or low risk according to local ENT criteria, and patients at medium or low risk were offered assessment by an SLT rather than ENT. Appointments took place within the hospital alongside parallel ENT clinics for a second opinion where necessary, and all images were recorded. They found that patients' waiting times decreased significantly by a mean average of 502.3 and 277 days respectively. This led to prompter SLT treatment for those who required it following their initial assessment (26% and 46.4%, respectively). Payten et al. (2020) also reported a mean average of just over two sessions of SLT intervention for patients who required it following assessment in the SLT-led clinic model. With the average voice therapy patient receiving 10.99 sessions and 7.68 h of face-to-face time in Europe (De Bodt et al., 2015), this is very low and further exploration is required to establish if shorter waiting time, SLT assessment and/or the 'one-stop' assess-and-advise model may have contributed to this outcome. If so, this may support a predicted reduction in pathway costs for patients seen in an SLT-led model. Informal discussions with the lead author of the Australian-based study confirmed that two sessions of voice therapy is lower in number than typically seen in their pre-existing ENT-led model, but no formal comparison of the data has been made to date.

A solution: UK SLTs have the skills

The National Health Service England (NHSE) recognizes Allied Health Professionals (AHPs) as a key workforce in meeting the NHS's objectives (NHSE, 2017). Nasendoscopy forms a significant part of the 2ww assessment for dysphonia and dysphagia within ENT departments. Performing nasendoscopy procedures for evaluation of laryngeal function is also integral to the job description of many senior highly specialist HNC/ENT SLTs across the UK. After completing extensive competencies established by the RCSLT (2020), they possess highly specialist clinical skills, usually in the areas of swallowing and vocal pathology related to HNC and/or benign ENT diagnoses. SLT-led nasendoscopy clinics for 18-week wait (routine) patients already exist in the UK and as discussed, recent Australian studies found that an SLT-led clinic for low-risk patients significantly reduced patients' waiting times with no adverse events (Payten et al., 2020; Seabrook et al., 2019). Furthermore, Payten et al. (2020) found a 27% reduction in staffing costs with the therapist-led model compared with the pre-existing ENT-led model.

Given SLTs' existing skills, it may be possible to extend these to 2ww patients referred with dysphagia and dysphonia at low risk of malignancy. Involving highly specialist members of the SLT workforce for low-risk 2ww pathway patients would reduce pressure on ENT colleagues affording them a greater focus on faster diagnosis of cancer in line with the NHS Long Term Plan (NHSE, 2019). Since the COVID-19 outbreak, Givi et al. (2020) recommended deferring assessment of low-risk 2ww referrals. Alternatively, Warner et al. referred their low-risk patients (31%) back to their general practitioner (GP) for follow-up, to reduce the future burden on secondary care services. With neither of these solutions addressing patients' dysphonia or dysphagia symptoms, and with GP and ENT services already under immense pressure, SLTs may have the skills to address this demand.

Advancements in technology and triaging tools

With increased use of videoconferencing since the outbreak of COVID-19, and the availability of recordable nasendoscopy equipment, an SLT-led model of care may be possible in a primary care setting. This may reduce pressure on secondary care clinics and estates and increase service accessibility for users. This aligns with the NHS Long Term Plan to develop community-based integrated care teams (NHSE, 2019).

Other technological advancements such as narrow band imaging (NBI) are being utilized more widely to augment clinical assessment. This makes diagnosis, and therefore exclusion, of carcinoma more reliable (Simo et al., 2014 Kraft et al., 2016). This technology may also provide further assurance that SLTs are assessing patients with dysphonia or dysphagia of benign aetiology.

As well as advances in technology, in recent years there have been efforts to refine 2ww referral criteria further to improve the positive predictive value for carcinoma (Tikka et al., 2016). With such refined criteria informing the recent risk calculator tool already discussed (Paleri et al., 2020), this may provide a robust solution to triage lower risk patients for SLT-led care.

Aims/proposal

The outbreak of COVID-19 has strengthened collaboration between ENT-UK, the RCSLT, the British Laryngological Association and the British Association of Head and Neck Oncologists with rapid changes being made to multi-disciplinary clinical guidance in response to the pandemic. This enhanced working relationship provides a timely opportunity to explore and drive novel ways of working in an interdisciplinary way. With marked workforce implications as services resume their normal operations in the months, possibly years, after the pandemic, SLTs could extend their existing skills in nasendoscopy to assist in this surge in need. One of the biggest opportunities arising from the COVID-19 pandemic for the SLT profession is to develop new models of service delivery (Patterson et al., 2020).

With some SLTs already performing laryngoscopy, nasendoscopy and SLT-led voice clinics for routine cases in the UK, the authors wish to explore whether SLTs may have a role in the 2ww clinic in a screening or triaging capacity. Utilization of refined referral criteria (Tikka et al., 2016) and Paleri et al.'s risk calculator (2020) might make this feasible, but this requires careful exploration and research.

At this early stage, it is important to discuss what such a role would involve and the views of the profession in doing so. The authors aimed to explore views of SLTs with existing specialist skills in this clinical area using focus groups.

METHODS

Ethical approval was granted by City, University of London's Language & Communication Science Proportionate

Review Committee on 27 August 2019 (reference: ETH1819-1175). The research was conducted prior to the COVID-19 pandemic and was therefore a preliminary exercise to explore views of the profession at that time.

Participant recruitment was via email circulated to the RCSLT's Clinical Excellence Networks (CENs). All CENs in the UK in the clinical areas of voice and HNC were contacted via email using a list held by the RCSLT. Members were invited to email the research team if they were interested in participating, at which time they were provided with a consent form and participant information sheet. Participants were free to withdraw at any time prior to the focus groups. All three authors ('the research team') were present for both focus groups. Author 1 is a band 8a clinician and lecturer in HNC/ENT disorders. Author 2 is a qualified SLT working in the role of research assistant with clinical experience working with adults with acquired disorders. Author 3 is an associate professor with methodological expertise in involving stakeholders in SLT research and conducting focus groups; she is also an expert qualified SLT and researcher in the clinical area of aphasiology. Authors 2 and 3 did not have any prior relationships with any of the participants. One participant was an ex-colleague of author 1. Author 1 had no other prior relationships with any of the other participants.

Inclusion criteria

- Qualified SLTs of at least Agenda for Change Band 7[1]
- Working clinically with patients with HNC/voice disorders
- Competent in nasendoscopy in accordance with RCSLT
- Working in the UK

To maximize geographical representation, some participants attended using video conferencing. Two focus group dates were offered and conducted to maximize attendance by participants and achieve suitable group sizes for the methodology ($n \leq 9$).

Focus groups were conducted using nominal group technique (NGT) (Van de Ven & Delbecq, 1972). This approach ensures that all individuals' viewpoints are heard with equal time to speak, while capturing the collective views of the group with numerically ranked responses. NGT is used widely in Allied Health Research to reach a consensus of clinicians' opinions (Hitch et al., 2015; Harvey & Holmes, 2012; Potter et al., 2004)

Participants were seated around one table. Participants attending online were given resources in advance of the focus group and were positioned on a laptop so as they could be seen by the other members and vice versa. A brief presentation was given at the start of each focus group, which was scripted to ensure consistency across both focus groups. The presentation described the structure of the focus groups and a brief outline of NGT methodology. Participants were provided with some background to 'the problem', namely the low cancer pick-up rate via the UK 2ww pathway. The first author then proposed that SLTs might provide a solution by assessing these patients in a primary care setting. In accordance with NGT methodology, this was very brief and no particular model of care was proposed even if requested by the group members. This avoids narrowing participants' thought processes and responses to the research questions.

Two research questions were posed to group members:

What do you feel are the potential benefits of extending SLTs' scope of practice (i.e., assessing patients with dysphonia/dysphagia at low risk of head and neck cancer in a primary care setting)?

What do you feel are the potential disadvantages of extending SLTs' scope of practice (i.e., assessing patients with dysphonia/dysphagia at low risk of head and neck cancer in a primary care setting)?

Participants were guided through the four stages of NGT using a pre-prepared script to ensure consistency across both groups.

Step 1: The first author read question 1 aloud and participants had the question written on an A4 piece of paper in front of them. Participants were given 5 min of silent thinking time to write as many responses as came into their minds on their sheet. These were to be as concise with just a few words or a short sentence.

Step 2: The first author invited each group member in turn to call out one of their responses. Co-author MC wrote each item on a flipchart and numbered them consecutively. This process continued around the table until all contributions were heard, without interruption or discussion from other group members. Duplicates, identified by participants themselves, were omitted from the flipchart. Participants were permitted to write down new ideas that occurred to them during this time and contribute them.

Step 3: The researcher read each item aloud to the group. Participants were asked if clarification or discussion was needed about each item and any duplicates were removed, agreed by group consensus. Where two similar ideas were combined due to duplication, all efforts were made to retain participants' wording and were worded with group agreement.

Step 4: Participants were invited to individually select their top five priority items from the flipchart and to rank those in order of importance from 1 to 5. These rankings were collated across the group and the score for each item (e.g., 1, 2, 3, 4 and 5) summed across all participants to arrive at a group consensus of which items were most important to them with a numerical ranking.

The same process was then conducted for question 2.

Written field notes were taken throughout the focus groups including any useful points or observations made by participants during the process. These were anonymized and written with participants' consent.

RESULTS

Nine clinicians (all female, aged between 31 and 60 years) participated in the study. They were almost all working full-time with patients with both HNC and benign ENT/voice disorders in inpatient and/or outpatient hospital settings (table 1). Eight of nine had achieved level 3 nasendoscopy competency (RCSLT, 2020) and all were employed in highly specialist roles. Seven clinicians participated in group 1, with five in person and two joining via videoconferencing. Two clinicians participated in group 2,[2] both via videoconferencing. Technological difficulties affected the start of group 1, meaning the duration of the group ran over. Four clinicians continued on the day, and three clinicians joined group 2 for the second research question (RQ). As such, the data comprises responses from $n = 7$ for group 1 RQ 1; $n = 4$ for group 1 RQ 2; $n = 2$ for group 2 RQ 1; and $n = 5$ for group 2 RQ 2.

Group 1 participants generated 15 benefits of which nine were ranked (table 2) and group 2 participants generated 12 benefits of which seven were ranked (table 3). Group 1 participants generated 17 disadvantages of which 10 were ranked (table 4) and Group 2 participants also generated 17 disadvantages of which 12 were ranked (table 5). Ranked benefits (table 6) and disadvantages (table 7) from both groups were combined where possible. For example, the two similar advantages 'Efficient use of skills (AHPs into Action)' and 'Aligns with AHPs into Action framework' were combined. This was carried out by mutual consensus between authors 1 and 3.

On reviewing the data, authors 1 and 3 applied broad themes of 'patient', 'service' or 'workforce' to each item for the purpose of analysis and discussion. These were refined on further discussion and consensus between the authors to include sub-themes such as 'cost' or 'efficiency' where the authors felt more specific themes were required.

DISCUSSION

The strengths and weaknesses identified by participants can be organized and discussed using a SWOT approach (Strengths, Weaknesses, Opportunities, Threats; Helms & Nixon, 2010) when considering the development of a novel, SLT-led service in the UK for patients with dysphagia and dysphonia.

Strengths

Both focus groups felt that early and highly specialist intervention by SLTs are important strengths of the proposed new model, with potential to improve the quality of patients' care and experience. Evidence that demonstrates improved voice outcomes in patients who receive early SLT input supports this (Mattioli et al., 2015; Zabret et al., 2018). The potential that fewer sessions of SLT may be required with earlier, specialist assessment and advice provision also requires further investigation as discussed previously. Overall, the enhanced speed and quality of targeted care given to patients with voice disorders early on in their pathway through this model may address the personal and societal financial impact of voice disorders (Cohen et al., 2012). Absenteeism and loss of income should be a key outcome measure when evaluating the feasibility of this model of service delivery. Given the concern over the number of 'worried well' (Rimmer et al., 2012) patients accessing the 2ww pathway, the opportunity to see a talking therapist such as an SLT may be of benefit to these patients and reduce pressure on ENTs. Relevant advanced care practice (ACP) nursing literature reports benefits of ACP-led consultations including greater 'talk time' with focus on holistic care and a more conversational style (Seale et al., 2006). Discussion was significantly greater around advice and treatment and ensuring patients' ability to follow these. Pearce and Breen (2018) also found high levels of patient satisfaction in ACP-led clinics stating 'consultations are thorough; patients report feeling that they were listened to and feeling confident in the outcome of the clinical consultation'. Patient experience should therefore be evaluated when assessing feasibility.

More efficient, cost-effective and strategic use of staff across SLT and ENT, consistent with a national drive to extend AHPs' working remits (NHSE, 2017), were also mutually anticipated strengths. These proposed strengths align closely with the benefits already realized by similar novel models of care in Australia such as reduced waiting times, cost efficiencies of 27% and faster access to SLT (Payten et al., 2020; Seabrook et al., 2019). Potential to achieve similar outcomes in the UK warrants further evaluation.

Weaknesses

While referrals would be triaged to identify low-risk patients for the proposed new SLT-led clinic, SLTs were concerned that SLTs may miss a diagnosis. With adequate training and supervision to adopt this role, comparable models of care abroad have found no incidences of missed diagnoses suggesting that this is a safe role

TABLE 1 Participant demographics ($n = 9$)

		Group 1 ($n = 7$)	Group 2 ($n = 2$)
Sex	Female	7	2
Age	31–40 years	3	0
	41–50 years	1	2
	51–60 years	3	0
Current NHS banding	8a	5	2
	8b	2	0
Highest qualification	Honours	3	1
	Masters	4	1
Caseload	Head and neck	1	0
	Benign ENT/voice	0	1
	Both	6	1
Working pattern	Full time	7	1
	Part time	0	1
	Other	0	1 (private)
Years practising[3]	6–10 years	2	0
	11–15 years	1	1
	16–20 years	1	1
	More than 20 years	3	0
Geographical area	Scotland	0	0
	Northern Ireland	0	2
	Wales	1	0
	Greater London	2	0
	South East England	1	0
	South West England	0	0
	Midlands and East England	3	0
	North England	0	0
Setting(s) (tick all that apply)	Inpatient/acute	6	0
	Outpatient (hospital)	7	2
	Outpatient (community)	1	0
	Community and domiciliary	2	0
	Other		1 (private)
Nasendoscopy purpose	Voice	0	1
	Fibreoptic endoscopic evaluation of swallowing	2	0
	Both	5	1
	Other	2 (laryngectomy)	
Royal College of Speech and Langauge Therapists nasendoscopy competency level	1 (working towards my first 60 scopes)	0	0
	2 (working towards my first 150 scopes)	1	0
	3 (more than 150 scopes)	6	2

extension for SLTs to date in those settings (Payten et al., 2020; Seabrook et al., 2019). Technological advancements in NBI will also help to mitigate this risk (Simo et al., 2014 Kraft et al., 2016). The knowledge and skills required to be competent in this role, along with how these competencies should be evidenced and maintained needs to be established to maximize safety and avoid missing diagnoses. A key potential weakness identified by both groups is that, as non-diagnosticians, SLTs require a second opinion of recordings of any concerning observation or lesion,

TABLE 2 Potential benefits of extending SLTs' scope of practice from group 1 ($n = 7$)

Potential benefit descriptor	Score	Rank
Increased quality (holistic consultation, attracts Speech and Language Therapists (SLTs) with specialist expertise)	30	1st
Increased flow (frees up slots, speed of treatment)	26	2nd
Speeds up care continuum (triage, signposting or treatment)	20	3rd
Avoiding more costly procedures	10	4th
Efficient use of skills (*AHPs into Action*)	8	5th
Interesting role: consultancy, progression, job satisfaction	7	6th
Cheaper	2	7th
Increased quality of General Practitioner (GP) referral to 2ww	1	8th
SLTs to fulfil therapeutic potential	1	8th
Unranked potential benefits generated during the nominal group discussion		
Patient reassured more quickly		
Care close to home		
Increased awareness of SLT		
Competency development		
Increased responsiveness to increased incidence of head and neck cancer		
Opportunity to get involved in research		

TABLE 3 Potential benefits of extending SLTs' scope of practice from group 2 ($n = 2$)

Potential benefit descriptor	Score	Rank
See right clinician at the right time	10	1st
Reduces waiting time and anxiety	4	2nd
Saves Ear Nose and Throat (ENT) for complex cases	4	2nd
Getting treatment earlier	3	3rd
Extends SLT skills and encourages more staff and funding	3	3rd
Aligns with *AHPs into Action* framework	2	4th
Avoiding exacerbation during the wait	1	5th
Unranked potential benefits generated during the nominal group discussion		
Potential for 'one stop clinic' without further SLTs appts		
Reduced demand on ENT		
Reduced overall cost		
Utilizing existing skills and extending		
Next logical step from a Continuing Professional Development (CPD) perspective		

and the role would increase their responsibility level. In primary care, this presents a further weakness as ENTs would likely not be on-site. To address this, an agreed method of prompt communication and sharing of assessment images between the SLT and ENT would be required to avoid delays for patients and provide ongoing supervision for SLTs in this role. Without this, clinicians felt that patient experience could be negatively impacted if they do not receive diagnosis and feedback immediately following the assessment. Participants also reported a primary care setting as disadvantageous in an emergency situation. Complications associated with flexible nasendoscopy are rare, with low incidence of mild epistaxis reported, and fewer than 1% incidence of laryngospasm usually occurring in the context of a severe, acute airway issue such as epiglottitis (Alvi & Harsha, 2021) which would not usually present in a low-risk clinic such as the one being described. Patient safety is of paramount importance and clear

TABLE 4 Potential disadvantages of extending SLTs' scope of practice from group 1 ($n = 4$)

Potential disadvantage descriptor	Score	Rank
Potential to miss diagnoses (need consultants to carry out other assessment, as not just flexible nasendoscopy (FNE))	19	1st
Increased responsibility (Will it be covered by professional body guidance guidance? Litigation and indemnity?)	12	2nd
Storage and transfer of patient data and potential for further delay	6	3rd
Lack of support for SLTs in emergency situations	4	4th
Challenging for workforce planning: enough SLTs at appropriate level and increased vulnerability during maternity or sick leave	4	4th
Concern whether increased skill and burden would be financially compensated	4	4th
Difficulty finding SLTs with adequate voice *and* dysphagia experience	4	4th
Patients not feeling reassured by SLT assessment and request consultant	3	5th
Equipment concerns (portability, sterilization, cost, back up if broken)	2	6th
Issues around SLT prescription rights: referral to consultants	2	6th
Unranked potential disadvantages generated during the nominal group discussion		
Being drawn into other remits and roles in clinical care		
May not be cheaper: SLTs perhaps more thorough and require longer time slots		
Pressure and stress burden: isolation of role		
May de-skill ENT colleagues and therefore face ENT resistance		
Budget available for ongoing training and support, including support staff for clinics		
Pressure on videofluoroscopy/other SLT clinics		
Monitoring quality control and consistency		

TABLE 5 Potential disadvantages of extending SLTs' scope of practice from group 2 ($n = 5$)

Potential disadvantage descriptor	Score	Rank
Risk of wrong diagnoses	20	1st
Potential for delay (needing to add a step/referrals)	16	2nd
Triage may not be effective, i.e., patients may be too high risk or inappropriate (ear and nose)	8	3rd
Long-term supervision/ongoing access required to ENT needed	7	4th
Primary care setting not set up for flexible nasendoscopy and associated risks (decontamination, support staff)	7	4th
Workforce competency development maintenance and succession planning	4	5th
(Northern Ireland) SLTs cannot refer to other Allied Health Professionals (AHPs) or prescribe	4	5th
Patients may not receive immediate end of consult feedback	4	5th
SLTs may assume they have greater skills than they have	2	6th
SLTs need to be valued in primary care (not always currently valued/understood)	2	6th
Equipment required and data storage risks	2	6th
Untested: no parallel clinic first so ENT not in the building	1	7th
Unranked potential disadvantages generated during the nominal group discussion		
Potential isolation from SLT team and risk to maintaining skills		
Reduced visibility and presence of SLTs around ENT		
Acceptability of SLT in this role from the patient perspective and other AHPs accepting referrals		
May be more expensive		
Commissioners/others may not see this as an extended/advanced role		

TABLE 6 Merged group 1 and group 2 data for potential benefits with categories applied ($n = 9$)

Potential benefit descriptor/s (combined where similar)	Score	Rank	Category
Increased quality (holistic consultation, attracts SLTs with specialist expertise) AND See right clinician at the right time	40	1st	Patient
Increased flow (frees up slots, speed of treatment) AND Saves ENT for complex cases	30	2nd	Service: efficiency
Speeds up care continuum (triage, signposting or treatment) AND Getting treatment earlier	23	3rd	Service: efficiency and patient
Avoiding more costly procedures	10	4th	Service: cost
Efficient use of skills (*AHPs into Action*) AND Aligns with *AHPs into Action* framework	10	4th	Workforce
Interesting role: consultancy, progression, job satisfaction	7	5th	Workforce
SLTs to fulfil therapeutic potential AND Extends SLT skills and encourages more staff and funding	4	6th	Workforce
Reduces waiting time and anxiety	4	6th	Patient
Cheaper	2	7th	Service: cost
Avoiding exacerbation during the wait	1	8th	Patient
Increased quality of General Practiitioner referral to 2ww	1	8th	Patient

procedures to minimize and manage any adverse events is vital despite the likely low level of risk. Concern was raised over current professional indemnity and pay banding not reflecting such an increase in responsibility. This should be assessed, benchmarked and agreed at a national level to achieve parity and fair remuneration reflective of the role and its responsibilities both within the SLT profession and in the context of other, similar, advanced practice AHP roles. Pearce and Breen (2018) report issues with transient staffing of nursing ACPs due to being offered greater remuneration by other employers. As well as financial remuneration, expert clinicians want the role itself to be appropriately recognized. Pearce and Breen (2018) emphasize the importance of ACPs not being 'second-rate medics' or in professional competition with medical colleagues. They advise that 'ACP-/nurse-led clinic' is not an appropriate term and an ACP clinic should have its own title. They highlight the importance of identifying the model as ACP, consultant SLT or an SLT-led clinic under medical supervision when making such a decision as this relates to the level of autonomy of the practitioner.

Expert SLTs' opinions should be considered in naming this clinic model to ensure the workforce feels their expertise is appropriately recognized. One group also discussed the issue of patient triage being a potential weakness if inappropriate patients are referred into the SLT-led service; however, with recent advancements in this area, triage is becoming increasingly more robust (Paleri et al., 2020; Warner et al., 2020). The issue of establishing and maintaining competencies, joint working relationships and supervision in the context of a remote working relationship between SLTs and ENTs is valid, and the effect of running such a clinic remotely in primary care requires further evaluation. Exploring feasibility of the model in the UK in parallel with a hospital ENT clinic is necessary prior to evaluating whether this can be extended to a primary care setting. Clinicians felt that primary care-based healthcare professionals may have comparatively little understanding of an SLT's role with patients with ENT conditions, raising this as a weakness.

Opportunities

Both groups identified workforce opportunities that this new model of service delivery may present. Discussion among the group revealed that some SLTs operating at a highly specialist level may feel that they have reached a ceiling of practice that they are unable to supersede. This can result in a lack of job satisfaction and difficulty retaining staff within the profession or growing as a professional service within an organization. An opportunity to develop skills in assessing 2ww patients at low risk of malignancy may attract more people to the profession and provide opportunities to grow professionally and to retain staff in the SLT workforce. This has been realized following

TABLE 7 Merged group 1 and group 2 data for potential disadvantages with categories applied ($n = 9$)

Potential disadvantage/s descriptor (combined where similar)	Score	Rank	Category
Potential to miss diagnoses (need consultants to carry out other assessment, as not just FNE) AND Risk of wrong diagnoses	39	1st	Workforce
Potential for delay (needing to add a step/referrals)	16	2nd	Service: efficiency
Increased responsibility (Will it be covered by RCSLT guidance? Litigation and indemnity?)	12	3rd	Workforce
Equipment concerns (portability, sterilization, cost, back up if broken) AND Primary care setting not set up for FNE and associated risks (decontamination, support staff)	9	4th	Service: resources
Triage may not be effective, i.e., patients may be too high-risk or inappropriate (ear and nose)	8	5th	Service: efficiency
Storage and transference of patient data and potential for further delay AND Equipment required and data storage risks	8	5th	Service: resources
Challenging for workforce planning: enough SLTs at appropriate level and increased vulnerability during maternity or sick leave AND Workforce competency development maintenance and succession planning	8	5th	Workforce
Long-term supervision/ongoing access required to ENT needed	7	6th	Workforce
Patients not feeling reassured by SLT and request consultant AND Patients may not receive immediate end of consult feedback	7	6th	Patient: experience
Issues around SLT prescription rights: referral to consultants AND (Northern Ireland) SLTs cannot refer to other Allied Health professionals or prescribe	6	7th	Workforce
Lack of support for SLTs in emergency situations AND Untested: no parallel clinic first so Ear Nose and Throat not in the building workforce/service?	5	8th	Workforce and service
Would the increased skill and burden be financially compensated?	4	9th	Workforce
Difficulty finding SLTs with adequate voice *and* dysphagia experience	4	9th	Workforce
SLTs may assume they have greater skills than they have	2	10th	Workforce
SLTs need to be valued in primary care (not always currently valued/understood)	2	10th	Workforce

similar nursing ACP opportunities (Pearce & Breen, 2018). The opportunity to work more closely with GPs was also cited as a chance to improve the quality of referrals to the pathway as this existing issue adds to pressure on the 2ww system (Begum et al., 2015). This opportunity may also address the issue outlined in 'Weaknesses' of a lack of understanding of the SLT's role in primary care.

Threats

Both groups discussed practical barriers to the proposed model to be addressed for successful piloting. Equipment concerns were raised by both groups, especially if the service operates within primary care. Issues such as storing and transferring patient data, sterilizing equipment, and purchasing and maintaining the necessary devices were all anticipated barriers to the model's success. A workforce shortage was also raised as a threat, with concern that few SLTs may be operating to the necessary competency level to staff the proposed new service model. Research is required to explore the size of the workforce across the UK with the necessary prerequisite skills and experience to extend their practice. Interest among more junior SLTs of taking on such a role later in their career would also be of benefit. As discussed, formalized national competencies are required for this role extension, which also need to be maintained through support and supervision. The

feasibility of this also warrants exploration. Imison et al. (2016) emphasize that an adequate number of staff with the correct skill set and an established succession plan for training is vital to reshape the workforce to meet patients' needs. Given the level of expertise required for such a role, and the increased level of responsibility, participants felt the role may not attract sufficient workforce without adequate banding and remuneration, which may pose a further threat as already discussed. Other foreseen practical issues included SLTs being unable to prescribe medications or to refer to consultant-led services, for example, if a scan or other opinion is required. Some of these practical barriers differed by region; for example, in Northern Ireland SLTs are currently unable to refer to other AHP-led services such as dietetics. With non-medical prescribing being quite commonplace among nurses and growing among some AHPs (Cope et al., 2016), the inclusion of such a qualification in the competencies for this role could mitigate this issue and needs further exploration.

Summary of findings

The expert clinicians involved in the focus groups identified many potential strengths to the proposed SLT-led model of service delivery for 2ww patients with dysphagia and/or dysphonia in a primary care setting. Improved quality and prompt care for patients by highly skilled professionals was a unanimous theme, with participants expressing the perceived benefits of extending SLTs' scope of practice for patients, their profession and health services more widely.

To be successful, clinicians raised some practical issues they could foresee such as the required equipment, staffing, support and supervision, and the need for referral and prescription arrangements. They also wanted assurance that such a role extension would be supported by their professional and regulatory bodies and be suitably acknowledged and remunerated.

Strengths and limitations

While the number of participants in this study is small, the diverse nature of the participants with regards to age, education, years of practising and geographical location is broad and as representative of the UK as possible given the small numbers. A wider, national survey of SLTs is now required within the sub-specialty across all bands to explore some of the points raised in this focus group further. This study was conducted 3 months prior to the outbreak of the COVID-19 pandemic and as a result some of the limitations of this study have already been addressed by rapid changes in the field both clinically and in the literature. As the field continues to advance since the pandemic, this study identifies clinicians' perceptions about feasibility of utilizing SLTs in the assessment of low-risk 2ww patients. This is in response to some of the service challenges that are now presenting while harnessing the advances being made in diagnostics and triage to potentially enhance the safety and reliability of novel models of care.

Clinical implications

While the perceived benefits for patients with regards to quality and prompt expert care were unanimous, if such a model is to be piloted, some of the potential weaknesses and barriers need to be addressed. These include evaluating the reliability of any triage system employed; ensuring rapid and easy access to ENT for prompt second opinion and supervision; clear training, competencies, job description and role recognition with regulatory and professional bodies; and processes to manage logistical issues such as prescribing, referring for tests and procuring and cleaning of equipment among others. Exploration of a suitable workforce now and in the future is also required.

CONCLUSIONS

The strengths identified by clinicians of an SLT-led service for 2ww patients with dysphagia and dysphonia align well with the positive findings of similar services already piloted and implemented abroad (Payten et al., 2020; Seabrook et al., 2019). Given current ENT service pressures due to the global COVID-19 pandemic, and the national agenda to extend AHPs' scope of practice, it seems timely to explore the feasibility of SLTs assessing 2ww patients with dysphonia and dysphagia. Participants identified some specific barriers that may need to be addressed when piloting such a service in the UK. The rapidly emerging availability of novel triaging criteria and tools to identify patients with likely benign conditions, along with the positive results from similar SLT-led models of care in Australia, serve to potentially address some of the weaknesses and barriers discussed in the current study. Feasibility of such a model in the UK requires careful exploration.

ORCID

Louise C. Occomore-Kent https://orcid.org/0000-0002-6212-5461

Madeline Cruice https://orcid.org/0000-0001-7344-2262

NOTES

[1] Bands are national salary scales in the UK NHS system dependent on level of knowledge and skill of a clinician in their clinical area. Newly qualified SLTs commence employment at band 5. Specialist SLTs operate at band 6, highly specialist roles are band 7, and clinical leadership roles and above fall within band 8.

[2] Two further participants had indicated they would participate in this group but did not confirm initial expression of interest or attend on the day.

[3] With the specified relevant caseload.

ACKNOWLEDGEMENTS

The authors wish to thank the SLTs who gave their time to participate in the focus groups. The authors acknowledge the University Research Pump Priming Fund at City, University of London, which funded the research including focus group running costs and research assistant time. We acknowledge the invitation from the RCSLT and Mr Taran Tatla (Consultant Head and Neck Surgeon) in 2016, which prompted the first author to begin undertaking research in this field.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

REFERENCES

Alvi, S. & Harsha, P. (2021) Flexible Nasopharyngoscopy. In: *StatPearls* [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan. Accessed 23 February 2021. https://www.ncbi.nlm.nih.gov/books/NBK539740/

Begum, J. Davies, M. Lawson, J. & Burke, E. (2015) Two audits on the two-week wait head and neck suspected cancer referrals: is the referral form being filled in correctly and is this contributing to inappropriate referrals? *International Journal of Surgery*, 23(1), S67.

Boltežar, L. & Šereg, B.A.H.A.R.M. (2014) Voice Disorders in Occupations with Vocal Load in Slovenia. *Zdr Varst*, 53(4), 304–310.

Cope, L.C., Abuzour, A.S. & Tully, M.P. (2016) Nonmedical prescribing: where are we now? *Therapeutic Advances in Drug Safety*, 7(4), 165–172.

De Bodt, M., Patteeuw, T. & Versele, A. (2015) Temporal Variables in Voice Therapy. *Journal of Voice*, 29(5), 611–617.

De Medeiros, A.M., Assunção, A.Á. & Barreto, S.M. (2012) Absenteeism due to voice disorders in female teachers: a public health problem. *Int Arch Occup Environ Health*, 85(8), 853–864.

Cohen, S.M., Kim, J., Roy, N., Asche, C. & Courey, M. (2012) The impact of laryngeal disorders on work-related dysfunction. *Laryngoscope*, 122, 1589–94

Cohen, S.M. & Garett, C.G. (2008) Hoarseness: is it really laryngopharyngeal reflux? *Laryngoscope*, 118, 363–366.

Edge Health. (2020) COVID-19 impact on waiting times for elective procedures. Accessed 1 March 2021. https://www.edgehealth.co.uk/post/covid-19-impact-on-waiting-timesfor-elective-procedures

Givi, B., Schiff, B.A., Chinn, S.B., Clayburgh, D., Iyer, N.G., Jalisi, S., et al. (2020) Safety recommendations for evaluation and surgery of the head and neck during the COVID-19 pandemic. *JAMA Otolaryngol Head Neck Surg*, 146(6), 579–584.

Harvey, N. & Holmes, C.A. (2012) Nominal group technique: an effective method for obtaining group consensus. *International Journal of Nursing Practice*, 18, 188–194.

Helms, M.M. & Nixon, J. (2010) Exploring SWOT analysis - where are we now?: a review of academic research from the last decade. *Journal of Strategy and Management*, 3(3), 215–251.

Hitch, D., Taylor, M. & Pepin, G. (2015) Occupational therapy with people with depression: using nominal group technique to collate clinician opinion. *Scandinavian Journal of Occupational Therapy*, 22(3), 216–225.

Imison, C., Castle-Clark, S. & Watson, R. (2016) Reshaping the workforce to deliver the care patients need. Nuffield Trust. Accessed 23 February 2021. http://tinyurl.com/y93zoabc

Kraft, M. Fostiropoulos, K. Gurtler, N. Arnoux, A. Davaris, N. & Arens, C. (2016) Value of narrow band imaging in the early diagnosis of laryngeal cancer. *Head Neck*, 38(1), 15–20.

Langton, S. Siau, D. & Bankhead, C. (2016) Two-week rule in head and neck cancer 2000–14: a systematic review. *British Journal of Oral and Maxillofacial Surgery*, 54(2), 120–131.

Mattioli, F., Menichietti, M., Bergamini, G., Molteni, G., Alberici, M.P., Luppi, M.P., et al. (2015) Results of Early Versus Intermediate or Delayed Voice Therapy in Patients With Unilateral Vocal Fold Paralysis: our Experience in 171 Patients. *Journal of Voice*, 29(4), 455–458.

Mitchell, O. Cottam, S. & Sharma, S. (2019) Analyzing the reasons behind inappropriate referrals on the 'two week wait' head and neck cancer pathway. *British Journal of Oral and Maxillofacial Surgery*, 57(10), e22. NHS England, 2019, NHS Long Term Plan. Accessed 24 June 2020. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

NHS England. (2017) AHPs into Action. NHS England. Accessed 24 June 2020. https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf

NHSE. (2019) The NHS long term plan. NHSE. Accessed 19th July 2021. https://www.longtermplan.nhs.uk

NICE. (2015) Suspected cancer: recognition and referral (NG12). *National Institute for Health and Care Excellence*. Accessed 24 June 2020. https://www.nice.org.uk/guidance/ng12

Paleri, V., Hardman, J., Tikka, T., Bradley, P., Pracy, P. & Kerawala, C. (2020) Rapid Implementation of an evidence-based remote triaging system for assessment of suspected referrals and patients with head and neck cancer on follow-up after treatment during the COVID-19 pandemic: model for international collaboration. *Head and Neck, Special Issue*, 1–7.

Patterson, J.M., Govender, R., Roe, J., Clunie, G., Murphy, J., Brady, G., et al. (2020) COVID-19 and ENT SLT services, workforce and research in the UK: a discussion paper. *International Journal of Language & Communication Disorders*, 55(5), 806–817

Payten, C.L., Eakin, J., Smith, T., Stewart, V., Madill, C.J. & Weir, K.A. (2020) Outcomes of a multidisciplinary Ear, Nose and Throat

Allied Health Primary Contact outpatient assessment service. *Clin Otolaryngol*, 45, 904–913.

Pearce, C. & Breen, B. (2018) Advanced clinical practice and nurse-led clinics: a time to progress. *British Journal of Nursing*, 27(8), 444–448.

Potter, M., Gordon, S. & Hamer, P. (2004) The nominal group technique: a useful consensus methodology in physiotherapy research. *NZ J Physiother*, 32, 126–130.

RCSLT. (2020) *Fibreoptic Endoscopic Evaluation of Swallowing (FEES): The role of Speech and Language Therapy*. RCSLT. Accessed 24 June 2020. https://www.rcslt.org/-/media/docs/RCSLT_FEES-postion-paper.pdf?la=en&hash=A2A4C8F2FD5C1F8B593720384FDAD52948F75EF7

Rimmer, J. Watson, J. & O'flynn, P. (2012) A Head and Neck 'Two-Week Wait' Clinic: cancer Referrals or the Worried Well? *Ann R Coll Surg Engl*, (Suppl), 94, 1–4.

Roy, N., Merrill, R.M., gray, S.D. & Smith, E.M. (2005) Voice disorders in the general population: prevalence, risk factors, and occupational impact. *Laryngoscope*, 115, 1988–1995.

Seabrook, M. Schwarz, M. Ward, E.C. & Whitfield, B. (2019) Implementation of an extended scope of practice speech-language pathology allied health practitioner service: an evaluation of service impacts and outcomes. *Int J Speech Lang Pathol*, 21(1), 65–74.

Seale, C., Anderson, E. & Kinnersley, P. (2006) Treatment advice in primary care: a comparative study of nurse practitioners and general practitioners. *Journal of Advanced Nursing*, 54(5), 534–541.

Simo, R. Bradley, P. Chevalier, D. Dikkers, F. Eckel, H. Matar, N., et al. (2014) European Laryngological Society: ELS recommendations for the follow-up of patients treated for laryngeal cancer. *Eur Arch Otorhinolaryngol*, 271(9), 2469–2479.

Smittenaar, C.R. Petersen, K.A. Stewart, K. & Moitt, N. (2016) Cancer Incidence and Mortality Projections in the UK Until 2035. *Brit J Cancer*, 1147–1155.

Tikka, T. Pracy, P. & Paleri, V. (2016) Refining the head and neck cancer referral guidelines: a two centre analysis of 4715 referrals. *British Journal of Oral and Maxillofacial Surgery*, 54, 141–150.

Van De Ven, A.H. & Delbecq, A.L. (1972) The nominal group as a research instrument for exploratory health studies. *American Journal of Public Health*, March, 337–342.

Warner, E., Scholfield, D.W., Adams, A., Richards, P., Ali, S., Ahmed, J., et al. (2020) North East London coronavirus disease 2019 protocol for diagnostics in two-week wait head and neck cancer patients. *The Journal of Laryngology & Otology*, 134(8), 680–683.

York, A. (2004) Shortage of head and neck surgeons could threaten treatment. *The Lancet*, 5(10), 582.

Zabret, M., Hočevar Boltežar, I. & Šereg Bahar, M. (2018) The Importance of The Occupational Vocal Load for The Occurrence and Treatment of Organic Voice Disorders. *Zdravstveno varstvo*, 57(1), 17–24.

How to cite this article: Occomore-Kent, L.C., Hatch, E. & Cruice, M. (2021) Scoping opinion: Speech and language therapists' views on extending their role to the urgent ear, nose and throat pathway. *International Journal of Language & Communication Disorders*, 1–14. https://doi.org/10.1111/1460-6984.12650