

RESEARCH REPORT

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Full Title

Improving transitions across SLT services in [Anonymised HB] for adults with long-term speech, language, swallowing or communication (SLSC) needs: a qualitative study of SLTs' and service users' views.

Short Title

Moving between Speech and Language Therapy teams

Funder

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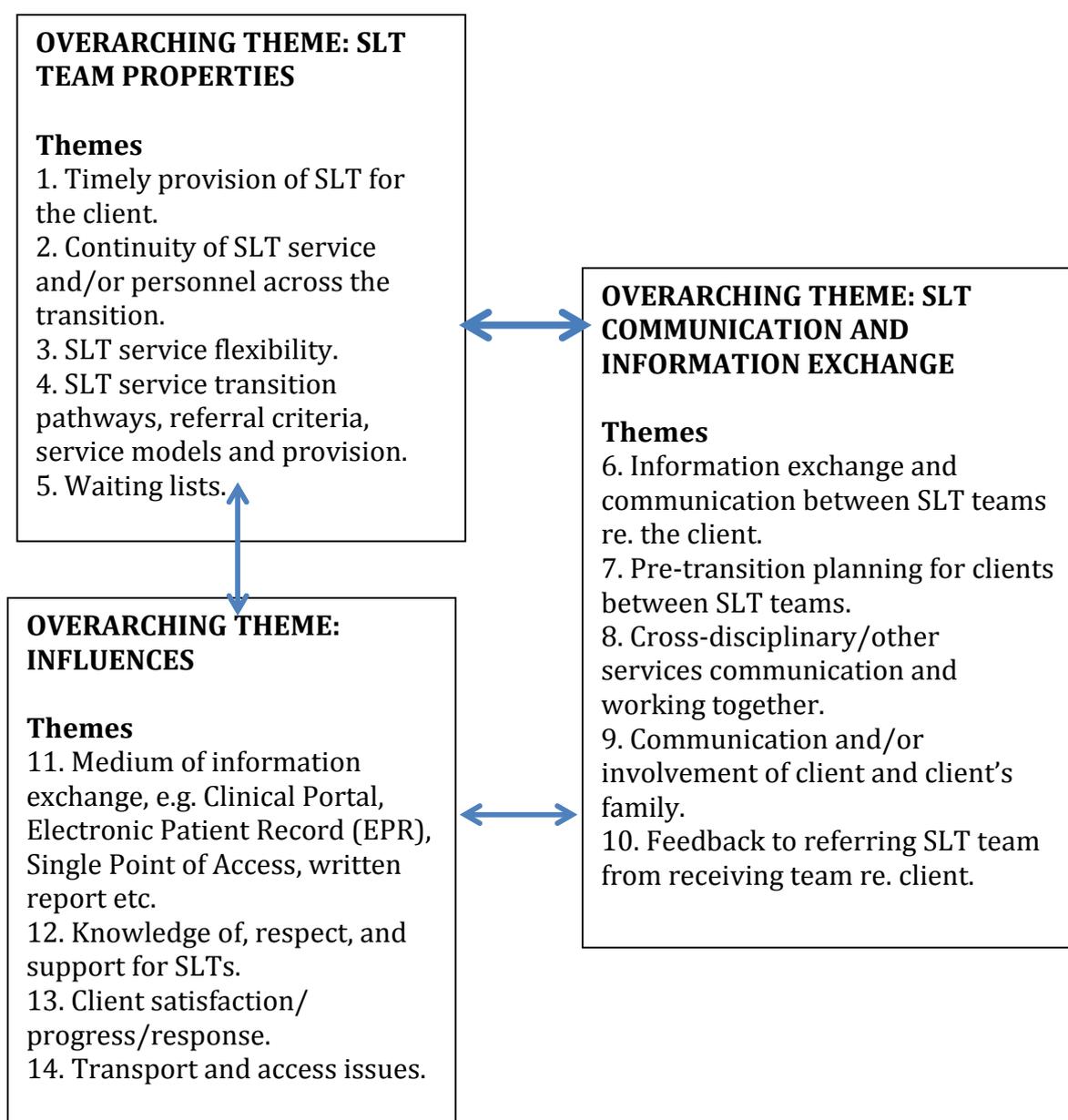
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Executive summary

Procedures

- The project investigated transitions for adult service users with long-term speech, language, swallowing or communication (SLSC) conditions across SLT teams within NHS [Anonymised HB] (NHS [HB]), reporting the views of service users and SLT staff.
- Volunteer participants were interviewed at convenient locations and asked to detail factors relevant to successful and less successful transitions.
- Twenty-one SLT teams involved in adult transitions were identified. They offered services to specified client groups and locations, and had a wide range of WTE SLT staff.
- Twenty-eight SLTs from twenty teams provided data on successful and less successful recent transitions. This approach will tend to elicit 'outstanding' instances, rather than usual or typical instances, and raise critical issues and risks that may be infrequent in practice but which suggest areas where procedures and decisions could be refined.
- SLTs provided in total fifty examples for analysis. Forty were transitions from one adult SLT team to another adult SLT team; twenty-three reported as successful, seventeen as less successful. They were mostly unplanned, as clients were admitted to and discharged from hospital following illness, and most involved hospital and community SLTs.
- Ten transitions were by school leavers from a paediatric SLT team to an adult SLT team, six reported as successful, four as less successful. These were mostly planned as clients left school and moved to adult health and care services. School-leavers were not usually in receipt of an open duty of care from paediatric SLT services, but the research protocol specifically included such school-leaver transitions.
- It proved difficult to recruit service users, and seven were recruited: five clients, one carer, and one service user support-group member who reported on the experiences of several clients. Service-user participants were not specifically asked to classify transitions as successful or less successful. All involved discharge from hospital on post-stroke pathways.
- Data extracts were coded and analysed. Fourteen themes comprehensively represented the coded data, describing both overall successful and less successful transitions, suggesting they reflected robust constructs. They are illustrated in the main report by selected quotations (Appendix 3).
- Three overarching themes emerged: Properties of SLT teams, Communication and Information Exchange between SLT teams, and outside Influences on SLT teams.

Transitions between SLT Teams in NHS [HB]: Thematic Map



Findings

Overarching Theme One – Properties of SLT teams: Adult to adult team transitions

- It proved difficult for the researchers to construct a list of NHS [HB] SLT teams and their remits, or criteria for client referral. There did not appear to be an up-to-date, publically available catalogue.
- Some community adult teams had small staff numbers, raising issues about capacity that affected timely provision and waiting times. One adult stroke team had no SLT, so that patients were referred there for physio- and occupational-therapy, but to a different team for SLT services. Other stroke teams offered a full range of services.

- It was unclear for how long a team would offer service. Some community teams offered short-term therapy (period unspecified) and further therapy service would require re-referral to a RAD SLT team.

Overarching Theme One – Properties of SLT teams: School leavers, paediatric to adult service transitions

- Pupils had usually been discharged from SLT service some time before leaving school, and had no SLT open duty of care at the time of transition.

Overarching Theme One – Properties of SLT teams: Service users

- Service users welcomed continuity of personnel across the transition when this occurred.
- Service users expressed concern about the amount of service offered, pre- and (particularly) post-transition. This was related to expectations of improvement with continued therapy, which may conflict with SLTs' assessment of prognosis.

Overarching Theme Two – Communication and information exchange: Adult to adult team transitions

- Essential information, such as the presence and management of dysphagia, was not always transferred to ward staff.
- Informal contacts and personal knowledge guided transition procedures.
- There was a need to clarify both prognosis and the amount of future therapy likely to be offered by the receiving SLT team.
- Information transfer was not always timely.

Overarching Theme Two – Communication and information exchange: School leavers, paediatric to adult team transitions

- Receiving SLTs wanted more exchange of information with paediatric services concerning pupils' earlier SLSC needs and previous SLT interventions, to guide assessment and anticipate needs.

Overarching Theme Two – Communication and information exchange: Service users

- There was concern from service users about how prognosis and potential for change was communicated to clients, and how this was related to termination of therapy provision.

Overarching Theme Three – Influences: Adult to adult team transitions

- During the research period, a major service development took place with the introduction of electronic patient records (EPR). Access was available to some but not all SLTs through an online Clinical Portal. This programme has since been extended.
- Concern was raised about the transfer of relevant referral information to the receiving SLT team through Single Point of Access procedures.
- Knowledge and respect for SLT colleagues facilitated appropriate referrals and effective communication and information exchange.
- Transport, including health service transport, and access issues influenced provision.

Overarching Theme Three – Influences: School leavers, paediatric to adult team transitions

- At transfer, SLT records may require to be accessed by education, social services and health service staff, and there were access limits.

Overarching Theme Three – Influences: Service users

- There was one positive comment about an electronic system for referring to a third-sector support group.
- Knowledge of and respect for SLTs and good personal progress were important to service users.

Key suggestions

Overarching Theme One – SLT team properties

- Shared, written and electronic information should be made widely available listing teams, their names, their remits, contacts, and any current capacity limits.
- Team capacity should be evaluated against service demand, to ensure that services and resources are available at point of need and to ensure equity across localities.
- Routine internal alerts should be issued when capacity falls due to illness or staff shortages and when waiting lists arise.

Overarching Theme Two – Communication and information exchange

- An SLT contact should be provided for use by hospital ward staff who suspect communication or swallowing difficulties for clients with SLCN.
- There should be shared, written and electronic information on transition procedures to be made widely available.

- There should be liaison between referring and receiving SLT teams as soon as possible.
- Comprehensive and up-to-date information on clients should be transferred to the receiving SLT team as soon as possible.
- There should be clarity for schools about which receiving SLT team to contact pre-transition.
- Pupils' school record should be flagged by the paediatric SLT service on discharge if SLT assessment is likely to be required at transition from school.
- There should be easy access to school-leavers' records for receiving SLT teams.
- There should be information for clients and carers about anticipated care pathways – the length of time SLT service is likely to be delivered, the frequency of contacts anticipated etc.
- There should be information for clients and carers about prognosis.
- There should be feedback to the referring SLT team about the success of the transition.

Overarching Theme Three – Influences

- An electronic patient data record should be accessible to all SLTs.
- An electronic patient data record should be accessible to social services and education staff as necessary.
- There should be a review of the Single Point of Access to facilitate accurate information transfer.

Introduction

Adults with long-term speech, language, swallowing or communication (SLSC) needs are sometimes known to SLT services from an early age and throughout their adult life, accessing SLT services at various periods, but SLSC needs can also arise later in life. Adults may require to access SLT services to develop their personal communication skills and/or to secure alternative and augmentative communication support, a clear and facilitative communication environment, and on-going support with eating and swallowing. The role of the SLT is often to advise others (such as volunteers, family and carers, health-care and other staff) on appropriate communication and safe swallowing approaches.

SLT services in NHS [Anonymised HB] (NHS [HB]) are offered from around 37 locations, managed within community and hospital, adult and paediatric services. Specialist SLTs work in teams serving specified populations.

As health needs alter, adults with long-term SLSC needs often move across SLT teams and effective procedures are needed to facilitate this process. This project is concerned with the care of adults with long-term SLSC needs as they move across SLT team boundaries.

The project aimed to identify factors that affect such transitions positively and negatively, from the perspectives of SLTs and service users. It also aimed to provide a model of transfer that would be effective across NHS [HB] SLT structures. SLT services in [Anonymised HB] are keen to find ways to smooth and support the service user's journey across SLT teams, and to build appropriate care pathways.

This project asked service users and SLTs to identify factors that tend to facilitate or impede transitions. It then suggests ways in which transitions could be further improved, and provides a model of good practice for transitions.

Background information and literature review

Health policies in Scotland note a: 'continuing shift in the pattern of disease towards long-term conditions, and growing numbers of older people with multiple conditions and complex needs'ⁱ, placing changing and increasing demands on the healthcare system. Health policies aim to develop and improve services for such adultsⁱⁱ, and also commit to the principal of equality of health provision, and of good communication, through disability legislationⁱⁱⁱ.

Individuals with long-term SLSC conditions are benefitting from increased longevity^{iv}, which affects their use of services, and are at risk of developing further illnesses, such as sensory impairments, dementia and stroke. As their health needs alter, or if acute health difficulties develop, adults who have long-term SLSC move between specialist SLT teams as they access relevant health services. Three transitions are illustrated here: many others are

possible and were identified during the early stages of the project (see Objective One).

Transition Example One
team to a Community SLT team

Transition from an Acute Services SLT

Adults with long-term SLSC needs may enter hospital as a result of illness. They will be assessed and offered SLT treatment if necessary by acute SLT services during their hospital stay. Thereafter they are usually transferred back into the care of a community SLT team for continued intervention.

Transition Example Two

Transition from a Community Adult Learning Disability team to an Acute Services SLT team

Adults with long-term SLSC needs who enter hospital or other acute services may transfer from the care of a community team to an acute SLT team on a temporary basis. At the end of their episode of acute care, they may transfer back to the community team. Transition to an acute SLT service could be sudden or planned, according to the rapidity of onset of individual health needs.

Transition Example Three

Transition from a Paediatric Learning Disability SLT team to an Adult Community Learning Disability or Rehabilitation and Enablement team

Individuals who leave school with known on-going SLSC needs usually transfer from a paediatric SLT team to an adult community rehabilitation and enablement SLT team or to an adult community learning disability SLT team. They may have been discharged from paediatric SLT services during their school years if their needs are being well managed: if so a re-assessment or risk analysis may be required at transition. There are planning procedures detailed in the Additional Support for Learning (Scotland) Acts (2004, 2009)^v and resulting code of Practice (2010)^{vi} to ensure that the transition from school to post-school services is planned well ahead, with a lead professional named to liaise amongst relevant services. This is a one-way transition, and whilst in rare instances the school to post-school transition requires to be undertaken at short notice, there is usually time for advance planning.

Available research suggests that service users are likely to have difficulties at such transition points^{vii}.

The role of SLT services in managing transitions has been recognised. For example, a review of services for individuals with leaning disabilities noted:^{viii}

'[Allied Health Professionals] have a very significant role to play in services for people with learning disabilities. Many people will be able to use general community and hospital based services for specific treatment. Some people

with learning disabilities will need support to use these services. Children and adults with extra and complex needs will need ongoing services from a range of [Allied Health Professionals] linked to community learning disability services. Young people have had difficulty in accessing services when they leave school.'

Similar issues arise for adults with other long-term conditions. The need for SLT teams to inform and transfer care to a different SLT team in a timely and effective manner is clear.

The project therefore investigated transitions across SLT teams for the range of adult service users with long-term conditions. It sought the views of service users and SLT staff and used critical incident techniques to identify good practice and potential difficulties. Two of the key measures of quality cited in the Healthcare Quality Strategy^{ix} were therefore addressed, securing:

- 1 Service users' views of their healthcare experience, and the related measure of how they experienced access, and whether in fact they have been able to 'access the care they needed, when they needed it', by gaining feedback from clients, their carers and client support groups, and
- 2 Staff views, to 'provide another angle on the person-centeredness of the NHS' – by interviewing SLT staff.

These perspectives are summated to list identified factors that facilitate or impede effective liaison between and amongst SLT teams, and so affect access to appropriate services. To ensure the relevance of the study, perspectives were sought on transitions that had taken place thirty-six months or less before the start of the study.

Aims and Objectives

The project aimed to identify factors that tend to facilitate or impede transitions; to exemplify good information exchange, the services to be offered, and how service users' views are to be accessed at key transition points, and to suggest ways in which transitions could be further improved. It aimed further to develop a model to feed into the development of care pathways.

Aims

- 1 To identify the factors that facilitate or impede transitions between SLT services, according to the perspectives of adults with SLSC needs, their carers, service user support groups and relevant SLTs, and
- 2 To use these to inform a model of effective SLT transition practices.

Objectives

- 1 To document the range of possible transitions between SLT teams undertaken by adults with long-term SLSC needs in the NHS [HB] area, and the procedures currently in place.
- 2 To investigate the perceptions of relevant adult clients, their carers and service user groups about factors they report facilitate and factors that impede transitions across SLT teams.
- 3 To investigate the perceptions of relevant SLTs about factors they report facilitate and factors that impede transitions across SLT teams.

Feedback to the funders and to NHS [HB] SLT services will allow them:

- 4 To use the insights gained in 1, 2, and 3 above to identify any common factors, and to draft improved transition procedures.
- 5 To present draft improved transition procedures to SLTs and service users in an iterative process, and obtain their views.
- 6 To further refine the draft improved transition procedures in the light of 5 above, and to construct a model of improved service user journeys across transition points.
- 7 To plan for future revisions, and on-going monitoring of the model, and to feed information into developing managed care pathways.

Methodology and Procedures

The project used a participatory evaluation paradigm^x, employing qualitative methods to identify aspects of transitions that respondents consider critical to their perceptions of successful or unsuccessful transition practices. Critical incident techniques were used to elicit examples of successful and less successful transitions, with responses subjected to thematic analysis. SLTs were asked for an example of both a successful and less successful transition, which does not imply that these are equally frequent. Critical

incident techniques will tend to elicit 'outstanding' instances that 'stick in the mind', rather than usual or typical instances. This was intended to raise issues regarding exemplary and risky transitions. Interviews used open-ended questions allowing an inductive, data-driven approach to analysis, deriving themes from participants' comments.

Participants

Only transitions across SLT teams within NHS [HB] were considered, i.e. those not involving transfer to other Health Boards, or where consultant SLT services were involved only in supporting SLTs. All participants were willing volunteers who had consented to involvement in the study. Participants were sought who had information to offer on transitions across SLT teams managed by NHS [HB] that took place thirty-six months or less before the start of the project.

SLT participants

All SLTs employed by NHS [HB] who had experience of adults with long-term SLSC making transitions between services were eligible to participate as interviewees, reporting on individual cases. SLTs not employed by NHS GGC would be excluded. No potential SLT participants required to be excluded. SLTs were asked to give an example of one transition that they perceived to be successful and another that was less successful, and why, and the factors they considered to be critical for such outcomes.

Service user participants

Adults with long-term SLSC needs, their carers and user support group representatives were eligible to participate. Those whose transition experience was of SLT teams not entirely managed by NHS [HB], or whose information related to transitions more than 36 months before the start of the project, were to be excluded. Participants would also have been excluded had they been incapable of giving informed consent, of understanding the focus of the interview, or of responding to the questions. If in doubt, the Stirling Understanding Screening Tool^{xi} would have been administered. Proxy consent via carers was not accepted, although carers who met inclusion criteria could themselves volunteer as participants and share their own perceptions. No potential service user participants required to be excluded.

Recruitment Procedures

SLT participants

SLTs were recruited via email correspondence or telephone contact through staff lists, checked and amplified with lists of SLTs held by the funder. To meet the resources available to the project, a maximum of 50 SLT interviews could be undertaken. Recruitment was targeted to interview at least one SLT from each SLT team that transitioned adults with long-term SLSC across NHS [HB] teams.

Service user participants

The Alliance (formerly the Long-term Conditions Alliance)^{xii}, a Scottish Government-funded charity which aims to provide a voice for individuals with long-term conditions), advertised the project on their newsletter and emailed relevant service user support groups amongst their members and associates, Fliers were distributed to day centres, and professional contacts were approached.

Individual adults with long-term SLSC needs and/or their carers who had personally experienced a transition or transitions were invited to participate by SLTs or service user support groups. Information was presented in clear and simple language, with written support. Interviews could involve alternative and augmentative modes of communication as appropriate, but no such techniques were required. Consent was taken in person, to ensure the individual was capable of giving informed consent.

Interview schedules and interviewing

Interviews employed closed questions to elicit factual information, and open questions to elicit views, allowing an inductive, data-driven approach, with themes derived from participants' responses. Interview schedules are appended (Appendix 1). Responses to interview questions two to nine were used to ensure that the transition discussed was, as planned, for a client with long-term SLCN transitioning between NHS [HB] SLT teams within the three-year time scale, and the support available. Respondents were sent interview schedules as part of their participant information package, in advance of being interviewed. Interviews lasting 40-45 minutes took place between May 2013 and June 2014 at a location convenient for the participant, including SLTs' workplaces, a day centre, a service-user's home, and university premises. Interviews were audio recorded and transcribed. The transcript was returned to the participant for reading, checking and changing if necessary with the version returned used for analysis. Participants were identified by a research number to ensure confidentiality and data securely stored in line with University of Strathclyde procedures.

Data analysis

Transcripts were coded for relevant comments, and themes extracted. Themes were validated by both researchers checking a sample of themed extracts, resulting in themes agreed by both researchers. Data saturation was reached with fourteen themes established, which reflected issues relevant to both successful and less successful transitions.

Ethics

The project was advised by West of Scotland NHS Research Ethics Service that NHS ethical approval was not required for this service evaluation project, and full ethical approval was received from the University of Strathclyde Ethics Committee. Participant information sheets were approved as part of that process.

Results

Participants: SLTs

Twenty-one SLT services or teams (hereafter teams) were identified and are listed in Appendix 2. Teams offered a range of services to specified client groups and locations, and had a wide range of WTE SLT staff.

Twenty-nine SLTs from NHS [HB] were interviewed. Due to sick leave one was not able to review and agree the transcript of her interview, and so her responses were excluded. Results are based on the twenty-eight SLTs who reviewed and agreed their transcripts, who represent twenty of the possible twenty-one SLT teams. SLTs were asked to discuss two transitions, one successful and one less successful, and in fact discussed from one to three, depending upon whether they were involved in moves across several teams. Fifty transitions were analysed.

Participants: Service users

It proved difficult to recruit service users. Two were referred to the project by SLTs, one of whom responded in writing, and the others recruited via a service user support group. Transitions from one adult SLT team to another were provided by seven service users: five clients, one carer and one service user support group member, who reported on the experiences of several clients. All service users had transitioned between adult SLT teams following stroke.

Clients and conditions

Tables A, B and C within Appendix 3 detail the clients and their transitions and the support available to them,

Thematic analysis

Responses to Question One (*Would you begin by outlining any transition procedures that your service currently has in place for transitions between teams?*), Question Ten (*You judge this was a successful move? What factors made it successful?*), Question Eleven (*What things about the move did you think were not so good?*) and Question Twelve (*Looking back is there anything else about the move that you think should have been done differently?*) were coded and themed.

Analysis identified fourteen themes that comprehensively represented the themed data. The fourteen themes related both to transitions reported as successful overall and those reported as less successful, and to improvements that could be made.

Themes:

- 1 Timely provision of SLT for the client.
- 2 Continuity of SLT service and/or personnel across the transition.
- 3 SLT service flexibility.
- 4 SLT service transition pathways, referral criteria, service models and provision.
- 5 Waiting list.
- 6 Information exchange and communication between SLT teams re. the client.
- 7 Pre-transition planning for clients between SLT teams.
- 8 Cross-disciplinary/other services communication and working.
- 9 Communication and/or involvement with client and client's family.
- 10 Feedback to referring SLT team from receiving team re. client.
- 11 Medium of information exchange, e.g. Clinical Portal, Electronic Patient Record (EPR), Single Point of Access, written report etc.
- 12 Knowledge of, respect and support for SLTs.
- 13 Client satisfaction/progress/response.
- 14 Transport and access issues.

Themes are illustrated in Appendix 3 within Sections A, B and C by selected quotations, with editorial clarifications in square brackets. As SLTs were encouraged to report on their individual understandings of procedures and on both a successful and a less successful transition, quotes do not provide quantitative information on the frequency of themes or comments.

Each theme identified contained both negative and positive comments, suggesting they were robust constructs along which SLTs and clients evaluated transitions.

The next stage of analysis focused at a broader level and involved sorting the themes into over-arching themes. Visual representations were employed in this process to produce a thematic map of the data that illustrates the relationships between themes (see Figure One). Three over-arching themes were identified: Properties of SLT teams, Communication and information exchange between SLT teams, and outside Influences on teams.

OVERARCHING THEME: SLT TEAM PROPERTIES

Themes

1. Timely provision of SLT for the client.
2. Continuity of SLT service and/or personnel across the transition.
3. SLT service flexibility.
4. SLT service transition pathways, referral criteria, service models and provision.
5. Waiting lists.

OVERARCHING THEME: SLT COMMUNICATION AND INFORMATION EXCHANGE

Themes

6. Information exchange and communication between SLT teams re. the client.
7. Pre-transition planning for clients between SLT teams.
8. Cross-disciplinary/other services communication and working together.
9. Communication and/or involvement of client and client's family.
10. Feedback to referring SLT team from receiving team re. client.

OVERARCHING THEME: INFLUENCES

Themes

11. Medium of information exchange, e.g. Clinical Portal, Electronic Patient Record (EPR), Single Point of Access, written report etc.
12. Knowledge of, respect, and support for SLTs.
13. Client satisfaction/progress/response.
14. Transport and access issues.



Figure 1: SLT Teams in NHS [HB]: Thematic Map

Discussion of results

During the period of the research interviews, a major service development took place with the introduction of electronic patient records (EPR). Access was available to some but not all SLTs through NHS [HB]'s online Clinical Portal. This programme has since been extended.

Presentation of results

Results are discussed in three sections:

- Section A discusses forty transitions from one adult SLT team to another adult SLT team, twenty-three reported as successful, seventeen as less successful. The transitions from adult to adult SLT teams reported in Section A were mostly unplanned, resulting from clients entering hospital as a result of acute illness and their subsequent discharge, and usually involved hospital and community SLTs.
- Section B discusses ten transitions by school leavers from a paediatric SLT team to an adult SLT team, six reported as successful, four as less successful. Transitions from paediatric to adult SLT teams reported in Section B were mostly planned, resulting from clients leaving school and moving to adult health and care services. These are covered by transitions procedures under the ASL Acts (2004, 2009). School-leavers were not usually in receipt of an open duty of care from paediatric SLT services, but the transfer to adult services was considered to be a transition within this project.
- Section C discusses service user transitions, These were not specifically classified by respondents as successful or less successful. All involved discharge from hospital on post-stroke pathways.

Illustrative comments on transition procedures and individual transitions appear in Appendix 3.

Whilst some respondents reported that most transitions progressed smoothly, the interview protocol obliged them to discuss one transition that was less successful as well as a successful example. Further, even where transitions were successful, respondents were asked about what could have been done differently. This raised critical issues and risks that may be infrequent in clinical practice but which are nonetheless relevant for service management, and suggest areas where procedures and decisions could be refined. These critical issues and risks are discussed below as related to Sections A, B and C, followed with a conclusion giving suggestions on how good practice maybe developed.

Section A: Adult to adult team transitions

Section A transitions were mostly unplanned.

Overarching Theme – SLT team properties: Section A

It proved difficult for the researchers to construct a complete list of SLT teams and their remits within NHS [HB]: there does not appear to be an up-to-date, publically available catalogue. The list that appears in Appendix 2 was constructed after extensive enquiry and checking with managers and respondents. It has remained difficult to establish the remit of each team, which clients would be referred to them, and for how long they offer therapy services.

The lack of a clear service model had impact for transitions, raising uncertainties about individual teams' functions and capacities amongst SLTs and clients (Theme Four). Addressing this issue would appear to be a priority, and producing a publically available chart of SLT services. This was noted particularly in Section A, but will also impact upon the information available to clients and families in all NHS [HB] SLT transitions.

Some community adult teams had small numbers of staff, raising issues about capacity that affect timely provision (Theme One) when there was 'no one to refer to', and waiting times (Theme Five). One adult stroke team had no SLT, so that patients were referred for physio- and occupational-therapy to that team, but to a different team for SLT services. Others offered a full range of services. The rationale for such variation, and its impact upon service delivery and client satisfaction, should be addressed.

There was also some lack of clarity about how long a team could offer service (Theme Four). Some community teams offered a short (but unspecified) time period for therapy, and if longer-term service was needed could re-refer to a RAD SLT team. SLTs exercise flexibility (Theme Three), so that client access needs and continuity issues may prompt the referring RAD SLT team to continue to offer out-patient services, rather than implementing a transition to a new team. This pragmatic approach secures client service, but may mask structural difficulties.

Specific suggestions were made about the benefits of sharing information on current capacity limits and current waiting times across teams, to help referring teams estimate and convey to families what services might be offered.

Overarching Theme – Communication and information exchange: Section A

The unplanned nature of many Section A transitions requires timely sharing of essential information, such as the presence and management of dysphagia, with ward staff. Where problems were signalled (Themes Six, Seven and Eight) they were around points where this had not happened. The transfer by

referring SLTs of contact information to hospital ward staff as well as to SLT teams on swallowing and communication needs requires consideration.

Respondents did not detail named or written transition procedures or care pathways. They did however describe procedures in use, with informal contacts and personal knowledge reported. However information is transferred, transition procedures could usefully be described and made available to SLTs and families. An addition to current procedures was the suggestion that feedback on client progress and the success of the transition would be offered back to the referring SLT team by the receiving team as a routine matter, perhaps by flagging relevant reports (Theme Ten).

Responses regarding communication with clients and their families (Theme Nine) raised the need to discuss both prognosis and the amount of future therapy likely to be offered by the receiving SLT team.

Overarching Theme – Influences: Section A

Electronic information transfer (Theme Eleven) was becoming more widespread at the time data was being collected, but acute/community service differences remained at the time of some interviews. These may be resolved in time, but currently there remains uncertainty regarding equal access to the same systems by community and hospital SLT teams, raising concern amongst some SLTs. Also of concern to some SLTs was the transfer of relevant referral information to the receiving SLT team through the Single Point of Access.

Knowledge and respect for SLT colleagues (Theme Twelve) facilitated appropriate referrals and effective communication and information exchange. However, the social capital networks involved remain vulnerable to staff changes and service re-organisations. Respondents mentioned existing relationships, but made no mention of team building or team bridging activities.

Transport and access issues (Theme Fourteen), including health service transport, influenced provision in Section A. Once again the scope of this issue and the need to plan for transport needs should be addressed.

Section B: School leavers, paediatric to adult SLT team transitions

Section B transitions were mostly planned, and followed transition procedures outlined in education acts. No issues were raised regarding SLT waiting lists (Theme Five), feedback to referring SLTs (Theme Ten) or transport (Theme Fourteen).

Overarching Theme – SLT team properties: Section B

Typically, children had been discharged from SLT service before their transition from school, and had no open duty of care at the time of transition. Respondents raised concerns using Themes One, Two and Four about the need to flag the files of students about to leave school so that the named person/lead professional knew to arrange an SLT assessment, even where the pupil had been discharged by the paediatric SLT team; and/or to inform the adult SLT team in such a way that they could determine whether further assessment was needed, to ensure continuity across the transition.

Overarching Theme – Communication and information exchange: Section B

Despite their discharged status, receiving SLTs wanted more exchange of information with paediatric services concerning pupils' earlier SLSC needs and previous SLT interventions, to guide assessment and anticipate needs. This would also allow them to inform new non-SLT adult service providers in good time. The responsibility for referring to post-school SLT services rests under the ASL Act with the named person/lead professional, usually a school senior manager, and there were concerns that they may not always understand the need to refer to adult SLT services for assessment, given the child's earlier discharge from paediatric SLT service (Themes Six, Seven and Eight).

A specific suggestion to deal with these issues was that names of children about to transition could be passed to the geographically relevant receiving SLT team ahead of school leaving. This would require the child's school and medical records to be flagged as above so that the named person would refer to the receiving team, and the family would be informed. The receiving SLT would then check the relevant notes and decide if they wanted to contact the previous SLT, if available (Theme Seven). Such timely information exchange would also support families and reduce their (often high) stress levels (Theme Nine).

Overarching Theme – Influences: Section B

Records for school leavers require to be accessed by education and social services staff, as well as health service staff. This introduces an element of complexity for electronic data exchange, and the feasibility and practical utility of widely shared access requires to be assessed (Theme Eleven).

Issues about knowledge of, respect and support for SLTs (Theme Twelve) were similar to those in Section A.

Section C: Service user transitions

Service users were all adults on post-stroke transition pathways. Their comments therefore are related to Section A transitions. Unsurprisingly, service users made no comments about flexibility (Theme Three), feedback (Theme Ten) or information exchange between SLT teams (Theme Six), to which they would not be privy. Indeed, one SLT commented that a client had received a good service as problems apparent to the referring SLT had been solved in time, and '[the client] knew nothing about it'. Waiting lists (Theme Five) and transport (Theme Fourteen) were not raised.

Overarching Theme – SLT team properties: Section C

Interviewees welcomed timely provision (Theme One) and continuity of personnel across the transition (Theme Two). But although interviewees made many positive comments, they also expressed concern was about the amount of service offered, pre- and (particularly) post-transition. This was related to expectations of improvement with continued therapy, which may conflict with SLTs' assessment of prognosis. Clarity for clients about the amount of service likely to be provided and about anticipated outcome is needed (Theme Four).

Overarching Theme – Communication and information exchange: Section C.

There was concern from service users about how prognosis and potential for change was communicated to clients (Theme Nine). SLTs' prognostic assessments will develop throughout the course of a client's recovery, but it is likely that transition home will be a key point at which prognostic information is sought. Both receiving and referring teams will have a role to play, and information exchange on this issue might form part of a clear transition protocol.

Overarching Theme – Influences: Section C

There was one positive comment about an electronic system for referring to a third-sector support group (Theme Eleven).

Knowledge of and respect for SLTs (Theme Twelve) and good progress (Theme Thirteen) were important to service users.

Conclusions: towards a model of good transition practice.

One SLT respondent summed up optimal transition procedures as:

- *In general, factors which make a transition successful include clear pathways, timely referral avoiding delay or lapses in therapy provision, and clear information for clients about the service which they are being referred to.*

The thematic model suggests that these are important, along with the other factors themed. Key suggestions resulting from analysis of respondents' comments are summarised here, for the consideration of SLT service managers.

Key suggestions

Overarching Theme – SLT team properties

- Shared, written and electronic information to be made widely available listing teams, their names, their remits, contacts, and any current capacity limits.
- Evaluation of team capacity against service demand, to ensure that services and resources are available at point of need, and to ensure equity across localities.
- Routine internal alerts when waiting lists rise, or capacity falls due to illness or staff shortages.

Overarching Theme – Communication and information exchange

- Shared, written and electronic information on transition procedures and pathways to be made widely available.
- Liaison between referring and receiving SLT services as soon as possible.
- Comprehensive and up-to-date information on clients transferred to the receiving SLT team as soon as possible.
- A contact SLT provided for use by hospital ward staff who suspect communication or swallowing difficulties for clients.
- Clarity for schools about which receiving SLT team to contact pre-transition.

- Pupils' school record to be flagged by paediatric SLT service on discharge, if SLT assessment is likely to be required at transition from school.
- Easy access to school-leavers' records for receiving SLT teams.
- Information for clients and carers about anticipated care pathways – the length of time SLT service is likely to be delivered, the frequency of contacts anticipated etc.
- Information for clients and carers about prognosis.
- Feedback to referring SLT team about the success of the transition.

Overarching Theme – Influences

- An electronic patient data record accessible to all SLTs.
- An electronic patient data record accessible to social services and education staff as necessary.
- A review of the Single Point of Access to facilitate accurate information transfer.

6 Appendices

Appendix 1 – SLT Interview schedule

Please anonymise the identity of the clients you mention by adopting a pseudonym for them. If we discuss more than one client, I will fill out a new sheet for each.

1 Would you begin by outlining any transition procedures that your service currently has in place for transitions between teams?

Based on your own experience would you describe a client's SLT service transition that you think went well?

2 Can you begin by telling me what sort of problems the person who was moving had with speech, language, swallowing and/ or communicating?

3 What caused these problems (clinical diagnosis)?

4 When did the person move from one SLT team to the other?

5 How was the person managing to communicate at that time?

6 Which SLT team did the person move from?

7 Which SLT team did the person move to?

8 What was the reason for that move?

9 Did someone help the person to organise the move?

10 You judge this was a successful move? What factors made it successful?

11 What things about the move did you think were not so good?

12 Looking back is there anything else about the move that you think should have been done differently?

Would you answer the same questions for a client's service transition that you feel was not so successful?

For less successful transitions, questions were repeated on a separate sheet with a separate transition number. Question 10 became 'You judge this was a less than successful move? What factors made it less successful?'.

Appendix 2 List of NHS [HB] SLT teams

Adult Mental Health Services
Adult Learning Disability Team North West
Adult Learning Disability Team South
Adult Learning Disability Service West [Location 1]
Adult Forensic Mental Health Team
Care Homes Team
Community Rehabilitation Team North West
Community Rehabilitation Team North East
Community Rehabilitation Team South East
Community Stroke Team
Community Treatment Centre for Brain Injury
Paediatric Learning Disabilities Team
Physical Disability Rehabilitation Team [Location 2]
Rehabilitation and Enablement Team [Location 2]
Rehabilitation and Enablement Services [Location 3]
Rehabilitation and Assessment Directorate (RAD) Elderly Rehabilitation Team
Rehabilitation and Assessment Directorate (RAD) Head & Neck Team
Rehabilitation and Assessment Directorate (RAD) Medical Surgical Associate
Specialties Team (MSAS)
Rehabilitation and Assessment Directorate (RAD) Neurological Team
Rehabilitation and Assessment Directorate (RAD) Physical Disability
Rehabilitation Unit
Rehabilitation and Assessment Directorate (RAD) Stroke Team

Appendix 3

Section A - transitions adult SLT to adult SLT team

Section A reports on forty transitions from one adult SLT team to another, twenty-three reported as successful and seventeen as less successful. These are summarised in Table A which reports on clinical diagnosis, communication status, referring and receiving SLT teams, reason for transition and personal support available, taken from responses to interview Questions Two to Nine. 'Young' indicates an individual under sixty-five.

Table A. Transitions between Adult SLT Teams NHS [HB]

Patient / Client	Transition from SLT Team	Transition to SLT Team	Reason for Transition	Support with Transition
Woman with aphasia post stroke	RAD Stroke Team	Community Rehabilitation Team	Hospital discharge with ongoing need for SLT service.	'I would assume the hospital SW would have overseen the move'
Young woman with aphasia post stroke	RAD PDRU/Neuro Team	Community Rehabilitation Team	Hospital discharge with ongoing need for SLT service.	'No – [she's] on her own'.
Young woman with cognitive and communication needs following brain injury	RAD Neuro Team	Team still to be confirmed (at time of research interview).	Hospital discharge with ongoing need for SLT service.	'Yes - a family member'.
Young man with cognitive communication needs following traumatic brain injury	PDRU Team	Community Rehabilitation Team	Hospital discharge with ongoing need for SLT service.	'His mother and father were very much in attendance'.
Woman with learning difficulties, communication needs and dysphagia	Adult LD Team	RAD in-patient Team	Hospital admission - broken bone in arm.	'Yes – care staff from her supported accommodation'.

Young woman with MS, cognitive and swallowing problems	RAD PDRU Team	Community Rehabilitation Team	Hospital discharge with ongoing need for SLT service.	'Yes – her mum and sister'.
Man with communication and swallowing needs post stroke	RAD Stroke Team out-patient service	Community Stroke Team	End of episode of hospital based SLT with ongoing need for SLT service.	'Yes - his wife'.
Young woman with Friedrich's Ataxia	Community Rehabilitation Team	RAD Out-patient Team	Consultant neurologist referred client.	Not known.
Adult with MS, post stroke dysphagia, dysarthria and cognitive communication needs	RAD (in-patient) Team	Community Rehabilitation Team	Hospital discharge with ongoing need for SLT service.	'Yes - hospital staff'.
Woman with dysphasia post CVA	RAD Stroke Team	Community Rehabilitation Team	Hospital discharge with ongoing need for SLT service.	'She lives with her husband and has good support from two daughters'.
Person with Huntington's disease, dysphagia and communication needs	RAD Neuro Team	Rehabilitation and Enablement Team	Hospital discharge with ongoing need for SLT service.	Not known
Young man with communication and behaviour problems	Forensic Team	Adult LD in-patient Team	Moving on to a different specialist service with ongoing need for SLT.	Yes – supportive relative.
Man with learning, language and motor speech difficulties	Forensic Team	? no Forensic outreach SLT to transition to.	Hospital discharge.	'Nobody specific looking out for him'.
Young man with learning difficulties high level language and pragmatic difficulties	Adult LD Team	Forensic Team	Acute need for specialist services with ongoing need for SLT.	Support from care staff in the unit he was living in.

Man with aphasia and dysarthria following stroke (primary brain tumour)	RAD MSAS Team	Community Rehabilitation Team	Hospital discharge with ongoing need for SLT service.	'Yes – well supported by family and relatives'.
Man with severe dysarthria and dysphagia associated with Huntington's disease	Community Rehabilitation Team	RAD MSAS Team	Acute admission for swallowing difficulties.	'Yes he had his Mum who was very much advocating for him on admission'
Woman with dysarthria of unknown origin	RAD Voice Team	RAD MSAS Team.	Admitted to hospital after a fall.	'[She was] quite capable and didn't really need any help'.
Young woman with learning difficulties, minimal communication and significant swallowing issues	Adult LD Team	RAD MSAS Team	Admitted with acute chest infection.	'Family or carers with her at all times – so well supported'.
Young woman with severe aphasia post stroke	RAD Stroke Team (in-patient)	RAD Stroke Team (out-patient)	Hospital discharge with ongoing need for SLT service.	'Yes – husband was brilliant'.
Man with severe aphasia post stroke	RAD Stroke Team (in-patient)	RAD Stroke Team (out-patient)	Hospital discharge with ongoing need for SLT service.	'Some support from family members'.
Man with aphasia after stroke	RAD Stroke Team	Community Stroke Team	Hospital discharge with ongoing need for SLT service.	'Yes – family'.
Man with aphasia after stroke	RAD Stroke Team	Community Stroke Team	Hospital discharge with ongoing need for SLT service.	Family
Man with aphasia after stroke	RAD Stroke Team	Community Stroke Team		'Yes – his sister'
Young person with severe aphasia after stroke	RAD Stroke Team (in-patient)	RAD Stroke Team (out-patient)	Hospital discharge with ongoing need for SLT service.	'Very supportive family'.
Man with dysarthria after stroke	RAD Stroke Team (out-patient)	Community Stroke Team.	Domiciliary service required.	'Wife supportive'.

Person with cognitive communication needs following traumatic brain injury	RAD Neuro Team	Community Treatment Centre for Brain Injury.	Hospital discharge with ongoing need for SLT service.	'No'.
Woman with aphasia after stroke	RAD Stroke Team	Community Stroke Team.	Hospital discharge with ongoing need for SLT service.	'Yes – supportive family'.
Man with aphasia following stroke	RAD Stroke Team	Community Stroke Team.	Hospital discharge with ongoing need for SLT service.	'Yes wife and daughters'.
Woman with communication needs and dysphagia head & neck post-surgery	RAD Head & Neck Team	RAD Head & Neck Team (different location [HB])	Hospital discharge with ongoing need for SLT service.	'Supportive husband'.
Man with dysphonia and severe dysphagia post-surgery	RAD SLT Head & Neck Team	RAD Head & Neck Team (different location)	Follow-up required after episode of specialist care.	Yes – wife and daughter.
Woman with aphasia following stroke	RAD Stroke Team	Rehabilitation and Enablement Team	Hospital discharge with ongoing need for SLT service.	'Yes – she did have family support'.

Themes relevant to Section A transition procedures, the reported transitions, and what might have been done differently: positive and less positive comments

Overarching Theme: SLT team properties Section A

1 Timely provision for the client

Transition procedures: positive comments

- *If the person meets their criteria, [the receiving team] see people for 6 – 8 weeks after discharge, so if somebody can work on rehab. needs within that time they would – the person has to be on a Stroke Pathway i.e. seen by a stroke consultant on the ward for stroke team medical care otherwise it's slightly more difficult to refer to the [team].*

Transition procedures: less positive comments

- *Sometimes [the referring team] were maybe having to follow up the person a couple of times in the interim by phone, text or visit because they needed seen sooner than [the receiving team] could pick them up.*

Transitions: positive comments

- *Yes – I was able to pre-empt his discharge – I knew when he was going home – so I was able to go to the ward have a chat with him and his family – let them know a clear plan as to what was happening – who I was referring on to – did make it clear that he wouldn't be seen right away – so had conversation about expectations and about why SLT would be involved.*
- *I am juggling my in-patients and day Hospital – but with people like [client's name] I thought it important that we got her here and got her here quite quickly – we did it for the week following discharge.*
- *I got an ASeRT [Adult Service Request Team - same as single point of access] referral. These referrals are processed within about an hour so that same day the acute service SLT and I were in touch by phone – she advised me on the priority for this man - give them a call – let them know you are there so they have a name and number and reassurance that they will be seen and maybe ask the family about timing.*

Transitions: less positive comments

- *I think I would maybe like to have phoned up the lady or family earlier – introduced myself and said what the time frame might be – it would allow the patient a bit of a dialogue and a bit of control over when they would be seen – and that didn't happen.*
- *Delayed discharge held things up for this patient.*
- *We say that he will be seen in a day or two but when he comes out of hospital - that's 3 days later his sister emails me and it's 5 days later someone [receiving SLT team] actually goes to see him.*

Suggestions about what might be done differently

- *One of the problems is we don't always hear back - I would like to know how quickly the person was seen after transition – how often they are being seen – when they are going to be discharged and get a copy of their discharge report.*

2 Continuity of SLT service and/or personnel across the transition

Transition procedures: positive comments

- *Therefore if a patient is expected to need long-term services, they may not move to [another team] but continue with [the current team]. This is to prevent patients seeing to many different SLTs, which they tend not to like, and unnecessary disruption.*

Transition procedures: less positive comments

- *We sometimes receive referrals for patients with mild aphasia or mild dysarthria only which may resolve quickly, also patients on Texture E diet. These types of patients would be better being kept and contacted by telephone by the ward therapist. If they require further input then they can be added to the outpatient waiting list.*

Transitions: positive comments

- *The ability to keep the client with SLTs he knew, and to foster his links with a new SLT.*
- *.....but I think communication and the fact it's the same person [is positive] – when you are transferring a patient to another service - you're referring these patients out and it's in somebody else's hands - it's not your responsibility and you've just got to*

hope that things happen – when it's you - you know it's going to happen and can organise it – the familiarity helps.

- I've been up to the Unit that he's in now – I know the SLT there very well – that's what we'll do so he gets to see me and the family get to see me a wee bit – they can see that I'm working in that collaborative approach to make the transition back to me easier.*
- They [referring SLTs] hadn't been able to trial oral intake in the [referring team setting] – the man was quite confused and unsettled – so would that be able to be done in the [receiving team]? - that was the purpose of referral to introduce some oral trials for comfort - so then I met him and have been working with him since - things worked well for the family.*

Transitions: less positive comments

- It took a while to build the relationship with him – his wife and I had a great relationship – he had trust in what I was doing with him – then when he was transferred someone else needed to try and build that at a point when he'd gone home and got his confidence up – he rejected further intervention – he could have done that anyway I think he would have rejected me as well – but I wonder if that happened quicker because he had to change to somebody else – the continuity of care is broken.*
- Not successful - it was all very disjointed when I spoke with her husband he said the input they received at home was all around AAC and using an iPad – the patient indicated to me that she didn't want AAC she wanted SLT to work on her speech – she felt she had been overlooked in aid of this iPad being set up and lots of apps being downloaded and tried with her – she wasn't able to cope with it and she didn't really want it.*
- The client fits into the criteria for [another team – lists criteria]. The referring key worker who is part of that team did not approach [that team's SLT] nor ask the client. The client has no [receiving team appropriate] needs. Accepting her to [receiving team] risks fragmentation of her care.*

Suggestions about what might be done differently

- At the moment there's the acute and there's the Community/RES we need something to link them up better.*

3 SLT service flexibility

Transition procedures: positive comments

- An open referral system like ours can assist especially with those patients who have changing long term needs.*

Transition procedures: less positive comments

None identified.

Transitions: positive comments

- [If a client became too old for a team's criteria] I think I would argue a case for her - that she would stay with SLT - with me – with the team – she can't get out very easily – it would be madness for her to try and make her way in to [a hospital setting] – or even for someone else to try and get in to see her – with her specific access arrangements – it would just be complicated for a new SLT coming in.*
- We've kept her on our books (we wouldn't do it with everybody) – because of this lady's vulnerability and isolation.*
- This person opted not to go to [a new team] following her discharge home – she felt she had established a good relationship with the SLTs here [hospital based SLT] – at*

the time [the receiving team] was very busy and the patient in question needed quite intensive input but didn't need to be in hospital - she had no physical needs – [the receiving team] at best were going to offer once a week whereas we could offer twice a week here because we had two therapists – so the patient made her own informed choice.

Transitions: less positive comments

- *So if they [the receiving SLT team] are short staffed and can't see people it might have been better if we could have phoned the patient maybe a week after discharge to see if he was still having problems and then referred him – but we can't do that at the minute.*

Suggestions about what might be done differently

- *We will consider when and over what period therapy is offered, and open-access review to support patient self-management, and the need for keeping an 'open door'.*

4 SLT service transition, referral criteria, service model and provision

Transition procedures: positive comments

None detected.

Transition procedures: less positive comments

- *It [length of treatment episodes] varies. In my understanding [receiving team] was set up with the intention that it would be for six weeks but it does vary depending on the patient – it's something we are trying to seek clarity on at the moment – they've been very over subscribed.*
- *There's a little bit of – I don't know if uncertainty would be the word – sometimes we've just got to work around – clarifying where the best place is even to make an initial enquiry, and then a referral.*
- *There are so many teams, that I think for - not so much for the patients – but I think for the professional referrers and my SLT colleagues in [referring team] it's quite hard sometimes for them to know who to phone.*

Transitions: positive comments

- *In general, factors which make a transition successful include clear pathways and clear information for clients about the service which they are being referred to. Discussion before the referral is made can be useful in many cases to avoid inappropriate referral or the client being passed from one service to the next unnecessarily.*

Transitions: less positive comments

- *I think there was a bit of misunderstanding between ourselves and the referring SLT as to our role - and what as [receiving team] SLTs we could offer and what they were looking for us to offer – there was just a bit of confusion.*
- *We sometimes receive referrals for patients with mild aphasia or mild dysarthria only which may resolve quickly, also patients discharged on Texture E diet. These types of patients would be better being kept and contacted by telephone by the [hospital] ward therapist. If they require further input then they can be added to the outpatient waiting list.*

Suggestions about what might be done differently

- *Maybe if we had a better overview of how many people are waiting [for receiving team] and how quickly people are getting seen – just having more information about that so we can give the patients a little more information.*
- *Most transitions work well at least 7 out of 10 – if the system was more concise the occasional poor transition would be less likely - also if the role of each team was clearer and there was more information about each SLT team to give to people.*
- *There should be clear client criteria which are comprehensive, known and adhered to, for allocation to the relevant team. If additional factors arise, they should also be explained. Otherwise, [team] becomes a 'bucket', trying to handle everything, and offering a poor service.*

5 Waiting list

Transition procedures: positive comments

None detected.

Transition procedures: less positive comments

- *Configuration of the [named] teams is slightly different – their service is for under 65 years - we take over 65s as well – that's a big difference and why we have a waiting list, and we deal with care homes also.*
- *If the person meets the criteria for follow-up by the [team] there can still be a four-week wait for them to be picked up – so unless you're picking up four weeks before discharge they are going to be discharged.*

Transitions: positive comments

- *In the past people were picked up quickly to be assessed and then it was - sit on waiting list - whereas now – I don't have a waiting list at the moment - now we tend to pick people up and take them on immediately – we tend to try and avoid having anyone delayed.*

Transitions: less positive comments

- *I think we've got quite a long waiting list - we do communicate with the [referring team] so that patients' expectations are appropriate and tell them about the [waiting list] – what the time frame might be.*

Suggestions about what might be done differently

- *If there was a system where we could just access information [e.g. about waiting time] without phoning or maybe if we could phone the [receiving SLT team] - it doesn't have to be the SLT who gives us information but maybe a centralised system or someone who can give us an overview of just how things would be.*
- *Maybe if we had a better overview of how many people are waiting [for an SLT team] and how quickly people are getting seen – just having more information about that so we can give the patients a little more information – maybe there could be better communication between us and the [SLT team therapists] just so we're more up to date with how things are going – that's all time consuming again but that could be an option.*

Overarching Theme: SLT communication and information exchange

Section A

6 Information exchange and communication between SLT teams.

Transition procedures: positive comments

- *Nothing [is] set – it's fairly flexible, informal, we don't have set paperwork we specify.*
- *So it's a big part of our job to make sure we do have communication between us and local services or other SLT services local to these people – there's no standard protocol, we always try and phone the SLT.*

Transition procedures: less positive comments

- *Sometimes the community SLT knew the person had gone into hospital but not exactly which ward or which SLT team - they would make a generic phone call to say this person's in hospital but we don't know which ward they're in – it took me a little bit of time to find out exactly which ward the patient had gone to – is it one of my wards and should I be looking at that person?*
- *[Procedures] tend to be mainly just a telephone call – or a limit to the amount of information that's in a referral – and there usually has to be a bit of telephoning to get more information – there rarely is anything written.*

Transitions: positive comments

- *We discuss patients regularly – again that's an open channel of communication – we get a lot of patients from that area [team] - a regular percentage of our patients are from there.*
- *Yes successful - there were umpteen meetings about her.... because we did have the open discussions round the table and a lot of the issues were raised then - we were then able to address them.*
- *....to be honest we are pretty good at communicating between ourselves in the SLT profession.*

Transitions: less positive comments

- *Lack of relevant information [from referring SLT team] about client's treatment in hospital and current needs prior to discharge home.*
- *It was an assumption from the notes as to what had been going on with him – in terms of the finer details - things that had been discussed within the team – it wasn't really that easy to get information from them about that – that wasn't their fault they just didn't have the SLT available - and also they didn't know he had been admitted so hadn't thought that they would have to pass on that information – so it just took quite a long time to find out first of all who knew him - then get in touch with them –*

then find a good time to speak to them – get the information – then know what to do with it [the information] afterwards – so quite difficult.

- *[When] patients come back in [to hospital] through acute - the ward phones up and says 'This patient says he's on a sloppy diet and thickened fluids at home but I don't know any more than that' and you have to phone and find out who his SLT was – 'What's he on?' – there's no way of knowing that unless the person [client] can tell us.*

Suggestions about what might be done differently

- *In my role as an SLT I contact my SLT colleagues within the hospital to pass on information - what I'm less clear of is what their priorities are for who they would see and not see – so perhaps me phoning the SLTs is not the best way to do it – perhaps I need to be phoning the ward sisters/charge nurse.*
- *A more comprehensive discharge summary should have been given by [referring] SLT service.*

7 Pre-transition planning for clients between SLT teams.

Transition procedures: positive comments

- *[Receiving] SLTs often visit clients pre-discharge on wards.*

Transition procedures: less positive comments

- *[the team] don't have robust protocols and procedures for [transitions] happening – very often these things will not be planned – just because of the nature of the population, so they'll happen quite fast and needs driven by the patient's condition.*
- *It's quite hard when you've got a transition of somebody who's on your ward but you're not doing anything for them [...] because it's not appropriate, but they still need community SLT and follow up at discharge – it's hard to keep the Community SLT updated when that person's not actively on your daily case load.*

Transitions: positive comments

- *I received a recent referral – very full and detailed discharge report – tuned me in quickly to patient – that's very useful if you are transferring somebody on – gives you something to go on otherwise you are going to see them without much information – you may have to start the whole assessment process over again – when there is no real need to do that.*
- *Important point re. [SLT team] in this area – they get to know patients before discharge, have met and worked with them on the ward – provides continuity for patient and professionals involved.*
- *She [the referring SLT] knows me well – she's bridging the relationship with SLT so that when he comes back into the community I can start working with him rather than having to spend weeks getting the family to trust what I'm doing.*

Transitions: less positive comments

- *The [receiving team] aim to see the person either the day they go home or the next day – that's the whole point of the service - so if they are short staffed and can't see people it might have been better if we could have phoned the patient maybe a week after discharge to see if he was still having problems and then referred him – but we can't do that at the minute - it's a lot of paperwork.*
- *When I explain to people what [the receiving team] is I can't say to them it's going to be six weeks – you'll be seen once a week, [or] you'll be seen twice a week – I don't have that knowledge to give to them.*

Suggestions about what might be done differently

- *This experience will affect our service's clinical planning about length of therapy - it would have been better to have planned therapy over the longer term. We will consider when and over what period therapy is offered, and open-access review to support patient self-management, and the need for keeping an 'open door'.*

8 Cross-disciplinary/other services communication and working.

Transition procedures: positive comments

- *I would always send written information out to a nursing home which I would often copy to the nursing home's SLT and send on to her – some of that was patient dependent rather than a specific protocol that was in place.*

Transition procedures: less positive comments

- *Nurses will say they do the water swallow tests which I think is their protocol for whether they refer to SLT within the hospital – but for a lot of people that I support they have got quite complex health needs and the water swallow test isn't necessarily going to work for them [...] - a one off water swallow test may not provide all the relevant information for a patient with complex eating and drinking needs.*

Transitions: positive comments

- *Because she was complex and there were a lot of issues going on I sent a report to the receiving SLT – so it was in writing and also – the Social Worker wanted it in terms of feeding requirements for carers in the Care Management Plan etc. so there was a bit of additional work for her.*
- *I phoned the SLT specifically to let her know that he was coming – and in this case sent a written summary as well – there was so much going on with him – I would have copied his GP into the report as well - the Community SLT was quite happy to take him on and knew the situation.*
- *The transition process was quite typical of what we do here [in this SLT team] – we work with the Care provider – they came to meetings here – our regular Care Programme approach meetings – they were invited where they would hear the reports and the on-going work prior to his final discharge. During that process we had opportunity to provide training to the care providers – giving them access to the communication passports with the patient's permission – the whole communication profile and detailed description of the kinds of things to look out for – we alert them of what to look out for.*

Transitions: less positive comments

- *When she aspirated on her medication – at home she gets her medication given in teaspoons – not even a full teaspoon – in hospital it was given from a syringe into her mouth – she didn't have the tongue control for that – had the SLTs known about that before it happened – they would have said – 'Stop!' – and was it just a one off? – was it just the system at that particular time? - she had been in hospital [for a number of days] and was ready to be discharged.*
- *The goals identified for patient could not easily be met - there was information about the patient and family that should have been made known to the receiving SLT service prior to visiting - lack of accurate information provided by nursing and medical staff.*
- *He was somewhere between hospital and community Dieticians as well – all a bit messy I felt – the local/Community Dietician ended up calling me whereas she should have been calling his local SLT.*

Suggestions about what might be done differently

- *I should have had a better transfer from the hospital – the Care Home referred and I phoned the hospital for information – I don't think that should have happened – the hospital hadn't transferred on to me that should have been the first thing that happened – the hospital SLT should have referred on to me and should have notified the Rehab Consultant that I was the named SLT.*
- *Had we taken a bit more time and discussed it a bit further – maybe over a couple of conversations [with the referring team] rather than one phone call we might actually have got to the bottom of what was really being looked for before we had opened that episode – confused the family – confused the nursing staff.*

9 Communication with and/or involvement of client and client's family

Transition procedures: positive comments

None identified.

Transition procedures: less positive comments

None identified.

Transitions: positive comments

- *There was a lot of family involvement – because people were apprehensive about the discharge as well – there was extra effort to make sure everybody was here that needed to be here and that was driven as well from the community side.*
- *I knew when he was going home – so I was able to go to the ward have a chat with him and his family – let them know a clear plan as to what was happening – who I was referring on to – did make it clear that he wouldn't be seen right away – so had conversation about expectations and about why SLT would be involved – talked that through and gave his family something to work on in the meantime e.g. using the iPad more like a communication passport – so they felt they were working on something while waiting for his SLT input.*
- *Supportive family involved in decision making re. discharge and follow-up therapy – they also had a good relationship with us – the situation was a very emotive one and the patient and her family appreciated not having too many new faces involved - so patient made her own informed choice.*

Transitions: less positive comments

- *[Patient]'s coming in to see me [receiving SLT] – she's had all this input – I don't know her and I'm a brand new face at this late stage – I'm having to tell her prognosis is not very good for further improvement – I'd rather be doing that when I've got to know somebody rather than being a new person having to break that sort of news to somebody.*
- *We couldn't tell him when he'd be seen – so we are giving him the leaflet and telling him he'll get rehab when he gets home but I couldn't tell him when he would be seen – how often he'd be seen – it's a bit worrying for the patient 'cause he's going back to his job and wants to know exactly what the service is.*
- *You can't give any promises – you're saying you'll be seen at some point by someone [receiving SLT service] – people do worry 'cause they're about to go home – you want to be able to give that information and be quite concrete about what the plan is.*

Suggestions about what might be done differently

- *I think that was a piece of work almost that needed to be done again with the family [explaining long-term dysphagia management and prognosis] and they found that hard – so maybe some sort of system in place to be more aware of what meetings have been happening with the family.*

10 Feedback to referring SLT team from receiving team re. client

Transition procedures: positive comments

None detected.

Transition procedures: less positive comments

None detected.

Transitions: positive comments

- *Yes – we talk about these patients every Tuesday with our Stroke Liaison Nurse and Consultant – we get lots of feedback re what’s happening at home – and that patient does remarkably well considering the extent of her communication difficulty.*
- *Really being realistic with patients and carers with potential for long term communication changes and disabilities are probably our main areas of concern and what we try to communicate back to the SLTs in the hospitals.*

Transitions: less positive comments

- *In terms of anyone to support him speech and language wise when he’s out [in the community] – there’s nobody there at the moment [from a specialist team] – however I would hope that if the need arose contact would be made with the [community SLT team] to support him.*

Suggestions about what might be done differently

- *One of the problems is we don’t always hear back - I would like to know how quickly the person was seen after transition – how often they are being seen – when they are going to be discharged and get a copy of their discharge report.*

Overarching Theme: Influences Section A

11 Medium of information exchange, e.g. Clinical Portal, Electronic Patient Record (EPR), Single Point of Access, written report etc.

Transition procedures: positive comments

- *Ultimately everybody in Scotland will have access to the same types of systems – at the moment SLT is ahead of the game and are very well organised so we are on Clinical Portal, EPR and we’ve got our Therapy Outcomes app which is going to go on the portal – we’ve got all of that organised ahead of our other AHP colleagues so that will break down barriers once everybody is on it.*

Transition procedures: less positive comments

- *Part of [the delay] comes from it not being a shared community and acute referral system – Electronic Patient Records is not in place yet, there’s still heavy reliance on the medical notes – access to EPR is due soon.*
- *EPR has been delayed – when it goes live I’m not sure if the community SLTs will be able to access the in-patient notes in the same way.*

Transitions: positive comments

- *... we sent a copy of the multi-disciplinary team report electronically to all the therapists that he was moving on to – so they had that before he transferred – so we spoke with our counterparts and we sent the written report as well prior to discharge.*
- *We got referral information and additional information on the immediate discharge letter from the referring SLT Team – we would typically look up the CT or MRI results as well [on Clinical Portal].*

- *Yes – successful - a lot of information had to be passed to and forth [between SLT teams] – all this information was on Clinical Portal [CP] – both SLT Departments involved are using Clinical Portal and EPR – I would phone the other Department when the patient was discharged back to them and they would see my notes on EPR – I'd phone just to make sure he was picked up.*

Transitions: less positive comments

- *The stressful thing I found is that at no time do I actually know who I'm referring to – you spend all this time making referrals to Single Points of Access not actually speaking to your SLT colleague and then it's the wrong referral anyway – that is very challenging.*
- *In this area with the single point of access the quality of information we get is not as good as it used to be.*
- *[Re. single Point of Access] Yes – it's a one way system – we have to put everybody who goes to the Community through that it's an admin secretarial person you speak to - I don't know what their qualifications are – you need to spell everything out – it's frustrating – we telephone this person but because they ask none of the right questions I also have to send a separate email to whoever I know is going to be picking up the referral — I email the relevant SLT to say I'm referring the person, give a summary of their history, why I'm making the referral – it's duplication – quite frustrating – the first bit is a waste of time – the SPA/ASeRT bit - just use the email – but this is the way it is – has been for two years now.*

Suggestions about what might be done differently

None identified.

12 Knowledge of, respect and support for SLTs

Transition procedures: positive comments

- *There are professional linkages between [referring team] and [receiving team] SLTs such as mentoring and clinical support, and [team] SLTs attend [other team] meetings, but no managerial relationships, such as workload allocation or Key Skills Framework discussions.*
- *I would do a transfer report – because I know some of the therapists involved in those services I also phone anyway and have a discussion with them – that's where it's helpful to know the people involved – can't always do that – staff change of course.*

Transition procedures: less positive comments

- *I don't always know the SLTs working in a certain hospital – maybe try to find them on the global address book.*

Transitions: positive comments

- *We [SLTs] both worked on the same site - it was quite easy to transfer notes – quite easy to pick up the phone – and we know each other reasonably well and worked quite well together.*
- *Yes – I thought this was successful – due to a combination of things - I know the SLT who was about to take over her care very well so I just emailed her [the patient's] status on the last day I had seen her.*
- *One thing that makes transition easy is a common level of respect and being professionally amiable – I find other SLTs more than amenable to receiving transfers or discussion of forward planning.*

Transitions: less positive comments

None detected.

Suggestions about what might be done differently

- *I think there's an issue about how we support people [SLTs] with a varied case load how we enable them to maintain and develop skills – if we want a patient led service with patients able to access it near their homes we can't really resolve that by centralising too much. I suppose you've got the SIG advisors but on a practical level that doesn't always give the answers they [generalist SLTs] really need – they want to be able to phone someone and say 'What do you do with nodules?' I've been involved in setting up clinical networks and they really worked quite well – that was before the geography [of NHS [HB]] changed - I'd like to see us do something like that.*

13 Client satisfaction/progress/response

Transition procedures: positive comments

None detected

Transition procedures: less positive comments

None detected

Transitions: positive comments

- *Yes – I thought this was successful – due to a combination of things - she [the patient] was doing well.*
- *He was managed very well [by our team] he came in on a lot of medication and went out on very little medication if any – he settled well - he subsequently went into the community.*

Transitions: less positive comments

- *We get patients who may have been in-patients for one night or five or six months and it's not until they get home and they come to us that we feel that anyone's had a serious chat with them about prognosis and chronicity – we are dealing with patients and families who are shocked that we can't fix them – so unrealistic expectations at the point somewhere of being referred on to us and ... quite often an expectation that lots of impairment based input will make a big difference to function.*

Suggestions about what might be done differently

- *Really being realistic with patients and carers with potential for long-term communication changes and disabilities are probably our main areas of concern and what we try to communicate back to the SLTs in the hospitals.*

14 Transport and access issues.

Transition procedures: positive comments

None detected

Transition procedures: less positive comments

None detected

Transitions: positive comments

- *If we could have a conversation with the patient I'm sure she would say she would prefer SLT at home – coming out in an ambulance twice a week is not ideal – but you have to look at the positive benefits that I think she does gain from coming here and interacting.*
- *Suitable environment provided by Day Hospital – ambulance service prepared to provide transport.*

Transitions: less positive comments

- *Not successful - we used to be able to book ambulances for patients we can no longer do that - either the patient has to do it themselves or through their GP.*
- *The ambulance might collect them very early in the morning just when there's an ambulance in their area and the same thing for going home – this gentleman was actually 40 minutes late for his appointment - he had been picked up 2 hours earlier and had to wait 3 hours for an ambulance home – so transport was a big issue for him.*
- *So in this case the ambulance service did not work – his mobility in getting from the ambulance to here was very poor at that stage.*

Suggestions about what might be done differently

- *None detected.*

Section B - School leaver paediatric team to adult team transitions

Section B reports on ten transitions from a paediatric SLT team to an adult SLT team, six reported as successful and four as less successful. These are summarised in Table B which reports on clinical diagnosis, communication status, referring and receive from responses to interview Questions Two to Nine. All of these transitions involved some family support in addition to support from school, social work and other relevant agencies.

Table B. School leaver transitions from paediatric SLT team to adult SLT team

Client	Transition from SLT	Transition to SLT
School leaver with cerebral palsy, communication and swallowing needs	Paediatric Team	Community Rehabilitation Team
School leaver with cerebral palsy, communication, eating and drinking needs	Paediatric Team	Adult LD Team
School leaver with Down's syndrome, autism and severe learning difficulties, communication needs and dysphagia	Paediatric Team	Adult LD Team
School leaver with autism communication needs and challenging behaviours	Paediatric Team (autism specific)	Adult LD Team
School leaver with dysarthria and dysphagia	Paediatric Team	Community Rehabilitation Team
School leaver with cerebral palsy and severe dysarthria	Paediatric Team	Community Rehabilitation Team
School leaver with learning difficulties and severe speech apraxia	Paediatric Team	RAD Team
School leaver with communication needs and dysphagia	Paediatric Team	Adult LD Team
School leaver with cerebral palsy, able but non-speaking	Paediatric Team	Community Rehabilitation Team
School leaver with deteriorating health condition and communication needs	Paediatric Team	Community Rehabilitation Team

Themes reported to influence transitions: positive and less positive comments, and what might have been done differently to improve transitions

Ten of the fourteen themes described in Section A were reported in Section B.

Overarching Theme: SLT team properties Section B

1 Timely provision for the client

Transition procedures: positive comments

- *We knew them well in advance – received written information – written summaries – and were able to put them on to our waiting list – just waiting to be picked up as soon as the were discharged – so it was quite smooth and there wasn't any delay in the transition.*

Transition procedures: less positive comments

- *Legally transition planning should start at fourteen years re. needs assessment, funding – available adult service etc. But it is completely ad-hoc [whether child is referred to SLT at time of transition] – it does depend on somebody else.*
- *That's a big issue for us – we know these people are coming through but we don't necessarily have a new [non-SLT] placement identified in enough time – due to issues with organisation of funding – clients can 'suddenly' be moved/transitioned with little warning and lack of time to plan.*

Transitions: positive comments

- *So part of that was something else that was going on – a couple of years previously it wouldn't have been quite so easy – so in part that was just about how services are organised for us – I think that that's what made it successful - we were able to respond [as the receiving team] - make a timely response – there was no delay.*

Transitions: less positive comments

- *None detected*

Suggestions about what might be done differently

- *Some families don't know what's out there for their child to go to – if they did they might be able to plan the transition earlier- years earlier – if there was easily available advice.*

2 Continuity of SLT service and personnel across the transition

Transition procedures: positive comments

- *None detected.*

Transition procedures: less positive comments

- *You get the occasional one who slips through the net – some professionals and some parents are more pro-active than others.*

Transitions: positive comments

- *He was showing signs of being able to benefit from changes in technology – so I did suggest this might be looked at quite imminently after leaving - so I had to forecast*

the need for change in relation to his device and the finance – that eventually took place.

- *There was a follow-up contact – [the client] knew who that was - that was myself. This week we've done the actual transition – where the client has had her first couple of days in her [new adult placement] and by that time I felt confident that I understood.*

Transitions: less positive comments

- *None detected.*

Suggestions about what might be done differently

- *None detected.*

4 Service transition pathways, referral criteria, service models and provision

Transition procedures: positive comments

- *If they've got for example a working dysphagia report then all that information should be passed over at transition and should be implemented by the new service provider- they wouldn't necessarily need SLT to review it- unless there were problems.*
- *For the next four to six weeks we will be reviewing the pathway and the success or not of the process to see what happens next – this has been piloted in line with all the other changes within services.*

Transition procedures: less positive comments

- *We would get phone calls from our SLT colleagues in [referring team] but often social work weren't aware of them or social work would make referrals to us and we weren't aware through [referring SLT team] – so we were getting a myriad of different referrals coming from different areas and we weren't entirely sure which ones were appropriate for the service,*

Transitions: positive comments

- *None detected.*

Transitions: less positive comments

- *I have had absolutely no SLT information about her [transitioning client]– nothing even about her swallowing needs – and certainly nothing about her communication – That is because [referring] team use Care Aims – in their view there has been no clinical risk for years.*
- *Families can ask your advice - because you're aware of the system you feel 'Should I be giving this advice?' – it's not your role as an SLT to be doing that – but if all professions are saying that?*
- *I wonder if the patient and mother were prepared for the difference in the services [paediatric to adult] - they had had very regular input from qualified AHPs – sounded like the patient and his mother could call on the staff when they felt they needed them. – That's not the case in Adult Community Services – we're quite goal focussed - intervention focussed - and when that intervention's finished they're discharged.*
- *He falls between the criteria for different [SLT] teams - I should move him on but I am still trying to get services for him. [The SLT added to the transcript that transition had been completed satisfactorily by the end of the study].*
- *Neither the [potential receiving team] not the [other potential receiving team] were able to take this referral as the client did not meet their criteria. Eventually [a third team] took his case and were able, eventually, to identify funding for his device and help him to understand how to use it functionally.*

Suggestions about what might be done differently

- *None detected.*

Overarching Theme: SLT communication and information exchange Section B

6 Information exchange and communication between SLT teams

Transition procedures: positive comments

- *These are not terribly formal ... but they have worked as far as I am aware.*
- *We can just make a phone call [to the referring team] and say 'Have you heard of this person?' or vice versa – she will phone us up - 'This person's coming your way – can you transfer reports over?' – that's always worked very well.*

Transition procedures: less positive comments

- *We used to have a very robust system where we used to find out which children were on the books and were leaving school and we would tell adult services – make sure paperwork got passed over – that was before we were re-designed into this sort of impact driven service and we were not able to keep children on as a precaution. I think this is right ... but it has made [transition] more difficult.*
- *There was a process to follow – there was paperwork to be completed – parents were informed that this was happening – we either just passed paperwork or we tried to have the opportunity to meet person to person as SLTs - either in a group or individually and that did work quite well for most children or for some children for a number of years – that has been given up on just now.*
- *The biggest issue was ... [that] by the time they get to school leaving age they're no longer on the STL caseload.*
- *But I know they'll be at least a couple [of clients] that I either didn't know were leaving school or where things that were working in school will go pear-shaped. - The care providers will be on the phone saying 'The eating and drinking plan says this but we're not too sure if that is current 'cause you wrote it three years ago.'*
- *Because we work in episodes and we don't work with children unless we're doing something for them- a lot of these children won't be known to us by the time they leave school – so that's where we have bit of a problem because they're not live cases when they leave school.*

Transitions: positive comments

- *The school SLT gave me a lot of time to see [client] in her classroom – and to talk about her communication – and her communication aid – and to see her being supported to eat.*

Transitions: less positive comments

- *I think not in SLT terms – I have had absolutely no SLT information about her – nothing even about her swallowing needs – and certainly nothing about her communication. - [The client's] down to the Day Centre with no bit of paperwork - There is no information exchange. - Even to talk about it in terms of risk – yes all right she is at no risk at school because everybody knows her – she's been there for years everybody know her - nobody knew her in the Day Centre – nobody would even have known that she couldn't eat a soft meal.*

Suggestions about what might be done differently

- *It would have been nice to meet – to go along to a transition planning meeting at the school.*
- *... what we [previously] tried to set up was identifying people who had a LD and they were leaving school ... and this [paperwork] was being given to SLTs who worked*

within [HB] - So it's just capturing the right children and the right therapists on one side of the fence - going to the right therapists and living in the right areas on the other side of the fence.

- *We do or we should know these people are coming through the system so – why don't we have a list of names – why don't we know – and why can't we start that earlier and make it slightly easier for these families?*

7 Pre-transition planning for clients between SLT teams.

Transition procedures: positive comments

- *The procedure has been that the [referring] SLT will contact us well in advance maybe in the middle of the person's final year at school to give us the heads-up about them coming out.*
- *[Referring team will provide] information that can come – if it's worked before and it's been working well in school – 'What were you doing?' - and we'll get the adult folk to do something similar.*

Transition procedures: less positive comments

- *Again I had to chase information – got just a referral with a name – a diagnosis – nothing else – I had to track down information and get them [referring SLT team] to expand on everything.*
- *Very limited information from [referring] SLTs unless I chase it – I suppose I was expecting a big comprehensive report and I didn't get it – instead I had to chase information.*

Transitions: positive comments

- *The school SLT gave me a lot of time to see [the client] in her classroom – and to talk about her communication – and her communication aid – and to see her being supported to eat.*
- *I have in the past had the opportunity to meet with an SLT at that last review meeting and that gave a more personal link if you like.*
- *The SLT to SLT is usually the bit that works quite well for me.*

Transitions: less positive comments

- *None detected*

Suggestions about what might be done differently

- *Provision of information to [receiving] team well in advance of actual transition would have been useful, Also more information from the [referring] SLT, including background information would have been helpful.*
- *An SLT report from the [referring] team re. the patient, AAC requiring replacement, and recommendations based on their knowledge of the patient.*
- *The most effective [transition] would be SLT to SLT and hopefully happening from the beginning of the school leaving year – January / February-ish – so there's enough time – the children are leaving school end of May – there's enough time for paperwork between school SLT – adult SLT and parents – time for the adult SLT to do a visit to the school – before the child leaves school and – time for links with other adult team members - or social work – or knowing what the child's future service is going to be about – and how communication and dysphagia would fit in to what there future adult service would be – just to make the links.*
- *I think it's the reassurance for parents – to know that there is a link there – to know that [receiving team] are picking upon past information.*
- *There's so much work done at school and that that information [should] just not [be] lost – we shouldn't be having to start all over again with assessment – I think there's*

a need for update – children, they're bigger – they're in a different setting – but [receiving team] should know what's gone before.

8 Cross-disciplinary/other services communication and working. Positive comments

Transition procedures: positive comments

- *The school should have enough information from us to know what they should be telling people.*
- *What has been set up in paediatrics is the way the carers, the teachers, have to work to promote [clients'] communication [and] the way they've to feed to make eating and drinking safe – [when] they move to a new service they're going to have different people doing both of these jobs – and it just needs to be reinstated.*
- *Because my job now is to make sure the people who will be actually supporting her day to day can also feel confident in what they're doing - so what I have to do now is support the people who will be feeding her at lunch time – to do that and feel OK about it. ... I think there will be [communication needs] – but she's not going to die if we get that wrong – so I'm just prioritising just now. Let people get to see her and know who she is first of all - get her feeding sorted out – then we'll look at communication.*
- *No matter what age – if they come to the multi-disciplinary health team there should be a screening assessment and some identification of what the needs are.*

Transition procedures: less positive comments

- *When people were referred to us through social work then all the work that had perhaps been done with [referring SLT team] hadn't necessarily gone with them depending upon which service provider they had gone to.*
- *We work with many different providers – Sense – Quarriers – Enable- they will all have a transitions protocol in place ... Then we have this health pathway and social work have a transitions team and their own way of dealing with transitions ...quite difficult to co-ordinate- there's lots of wee bits but they don't always join up.*

Transitions: positive comments

- *So I asked if I could go over and see her [in school environment]. That was not a problem.*
- *This was a successful move – his final review meeting at school which would be his forward planning, future needs type review – I came with my report summarising his input over the years – a summary of the progress he'd made – what I anticipated the risk to be on transition – the nature and extent of the support he'd need with his device.*
- *There was also information from the physiotherapist - there was a lot of information available – clearly the school were anticipating the sort of needs during that transition period and they had done quite a bit of work and the SLT was clearly part of that.*
- *I then went to three transition meetings at the school – so a lot of opportunity to talk and to get the information - this week we've done the actual transition – where the client has had her first couple of days in [adult placement] – and by that time I felt confident that I understood.*
- *Staff in MDT had to support each other in order to cope with the mother's stress – helpful that the referral came to MD team rather than SLT only.*
- *I'm able to do that [discuss] with the college course lecturers when they're going to the AAC course – so I'm able to do it in some contexts within Further Education and that does work well when we are able to meet together and discuss particular cases and forecast what we think might be the best way to manage clients/students access to the course – and with teachers who support them as well – so we've got that sort of dual role – we're not just transferring to a Health Team but to an Education and Social Work funded team as well.*

- *She [the client] was involved with the adult multidisciplinary team for Physio and environmental OT- lots of agencies were involved with her*

Transitions: less positive comments

- *.... lack of liaison with school and lack of clarity re who was responsible for collation of relevant information gathered about the client.*
- *it can also be difficult to get in touch with some of the private providers - they have their own experts who are giving advice e.g. for communication, for autism, for challenging behaviour – what are their qualifications? – there may be more of that in the future.*
- *Some providers will say ‘We get to know them [the client] our own way and are doing our own paperwork.’ so don’t necessarily take it [the SLT report] on board – so all that work’s been done - and they don’t really need a re-assessment to know how to support them because all of that’s in a perfectly decent report and they just need to implement it – if they have difficulties with that - that’s when they should come back to us – can be very frustrating for families when things have been working at school and home but the new people are not necessarily taking it on board – it’s very difficult to tease out why that should be – you can end up thinking – this is not my job to find out where the report is – that can be very frustrating – and it must be for families – but the problems can’t be specific to SLT.*
- *We are health employees and it’s still seen as a health need - if social work care managers have the lead role in transition - then we’re leaving this health need for them to flag up – and they are also extremely short staffed – so they are very pushed as well.*

Suggestions about what might be done differently

- *To train the staff at the Centre – which is what we have to do to make sure that the people who’ll be working day to day have the right information.*
- *More discussion about who was managing advice to the care home to ensure clarity around this and [a] new eating and drinking plan should have been completed to ensure that care home staff knew exactly what was safe.*
- *The final guideline recommendation report [previously used] was making three important people – being the School – the Paediatric Care Manager and the GP – these people knew – then when it came to transition – even if the SLT wasn’t involved – then communication and dysphagia should be flagged up at the time of transition and that [the] Discharge Report should say – ‘Please come back to this at the time of transition.’ - and flag it up.*

9 Communication with and/or involvement of client and client’s family

Transition procedures: positive comments

- *In particular dysphagia – we always keep an open door – we run a consultation service alongside our active therapy service – so parents all know we’ve got a helpline and you can always phone the SLT that’s been involved with your child – it’s on every discharge report.*

Transition procedures: less positive comments

- *The more complex people were still for some reason the ones that tend to get missed - If you’re a [receiving team] SLT and it’s the first time you’re meeting the family it’s not necessarily the best place to do it – you’re also not going to be the people who’re working with them on an on-going basis.*
- *we would agree that across agencies there’s a lot of information and it’s a difficult position for families to be in – and schools - it can be really bitty especially with self directed support - so a massive lot of things going on around this one person to try and co-ordinate.*

- *The parents – at every point of transition the grief will come back – that’s recognised – the recognition that you have a child who is going to be dependent and their parents are getting older at this stage – it’s more stressful for them.*

Transitions: positive comments

- *The family were there when I went to visit – at that time the Mother was able to help [now unwell].*
- *The family - you can gain so much information about what the person needs from a service even from what the family think is a wee chat – they are able to give such a description of their children - this mum and dad were very able to do that.*
- *He was a very bright boy - they (family) took nothing for granted – they knew that he would reach his potential – we were able to identify quite quickly that he had such potential.*

Transitions: less positive comments

- *I had been to see her [client’s] mother and had all the information from her mother – but it assumes that her mother has reached the same conclusions about her eating and drinking as the SLT – which certainly wasn’t true in X’s case so – let’s hope it’s right in Y’s – until I can reassess.*
- *I have heard that she no longer uses the AAC device [in her mid-20s] - I am not sure that was due to lack of SLT - I think her mother had made the decision that the exertion it required was too extreme for her – she could maintain a lot of her social skill and social interaction through non-verbal communication.*
- *This transition impacted negatively on the family [more so than the client] – their stress levels were extremely high - This family wanted to know why services hadn’t been put in place earlier for their son – when everybody knew about him and his needs.*

Suggestions about what might be done differently

- *I watch my physiotherapy colleague – close colleague – who in the same circumstance would have phoned the school physiotherapist and they would have been working jointly – going to visit the parents, the school therapist introducing the adult one – ‘Here’s my colleague’ – passing over to you – here’s the information. It would have reduced the mother’s anxiety.*
- *Mother and client could possibly have been better prepared – made more aware of the new [adult] service and how it works.*
- *There were an awful lot of professionals involved saying this is the way to do it – the family didn’t necessarily feel listened to.*
- *Remembering there was a mum as well as the SLT involved – the mum’s still quite anxious. I could have spent more time with mum. I’m going to the house on Monday to see how they feed her.*
- *Dad’s views were not taken into account as they should have been early on in the process – he repeatedly said what he wanted and was repeatedly told there’s not the money for that – I think the involvement of the family should have been much more equal – and I think things should have started earlier.*

Overarching Theme: Influences Section B

11 Medium of information exchange, e.g. Clinical Portal, Electronic Patient Record (EPR), written report etc.

Transition procedures: positive comments

- *If reports are sent to the GP then at least it is in the medical file - then at least you can access what that report was in days gone by if you were able to get in touch with the GP.*

Transition procedures: less positive comments

- *The [receiving adult team] can use our database to find out whether a child is/has been known – we can't use their database but they can use ours. I believe when the electronic patient records come in that will be easier. [Now] the acute service is not on the same system so it won't tell us when children are in hospital for instance. Community services (that's health and social work) will be able to tap into the same records but not acute.*
- *[When] adult teams pick up people that we've seen in the past and then we've got to go and find the notes and find out what we last did.*
- *In [geographical area] we had a practice review development group with regards to the transitions pathway – some people feel it's a bit too bureaucratic with regards to paperwork.*

Transitions: positive comments

- *None detected.*

Transitions: less positive comments

- *It's not –[easy to access case notes] - if we could access the paediatric SLT case notes that would make a huge difference you'd know exactly what assessments had been done and the results – e.g. people with Down's Syndrome: we might never have heard of them till they start to get early onset dementia – if we knew what assessments paediatrics had done we could replicate them without starting from scratch at the point they get referred to us - which could be a long time after transition – so access to those case notes would be hugely beneficial.*
- *Yes – like clinical portal – not everybody's on it – we're definitely not – it is so much easier to go on and see if e.g. a VF's been done and what the outcome is rather than chasing up the acute SLT across hospitals and them getting back to me.*
- *Clinical portal is NHS - I suppose it will depend on whether your SLT's NHS or education employed – that's another issue – a centralised system for all of these things would be great.*
- *So we just phone up the SLT and ask 'Can you send a report?' and that depends on where the case notes are – you spend a lot of time making phone calls and doing that kind of bureaucratic work – once you've got the report - if it's still valid and meeting the needs - it allows communication with the right person and/or the family - and it reassures them we know what happened in the Paediatric service.*

Suggestions about what might be done differently

- *None detected.*

12 Knowledge of, respect and support for SLTs

Transition procedures: positive comments

- *[My colleague and I] have both been here for a while now and our colleague on the [referring team] side's been there for quite a while so we know who each other are now – so it works quite well.*
- *It's worked better since we've been co-located with [relevant SLT team] – the fact that we can actually talk to each other without jumping through red tape.*

Transition procedures: less positive comments

- *I know where my colleague is and I can pick up the phone but I didn't know that when I first started here.*

Transitions: positive comments

- *I have in the past had the opportunity to meet with an SLT [receiving SLT] at that last review meeting and that gave a more personal link if you like.*
- *The adult rehabilitation team and SLT for his area happens to work here some of the time - so it was a face to face on a very regular basis – that was exceptional – that’s what made it exceptionally good for me because I could talk her (SLT) through all of the information and the anecdotal information that sometimes contributes to how families are going to be able to support children.*
- *I know the paediatric SLT who works in the area – the SLT who mostly works with the more complex cases - so I know where to find her – if she left it would get more difficult – I wouldn’t know in terms of managers or team leaders – it is a personal connection – contact that you’ve made over the years – when that goes then that’s more difficult.*

Transitions: less positive comments

- *None detected.*

Suggestions about what might be done differently

- *None detected.*

13 Client satisfaction/progress/response

Transition procedures: positive comments

- *None detected.*

Transition procedures: less positive comments

- *None detected.*

Transitions: positive comments

- *They got what they needed – a new piece of equipment – very quickly - in part that was due to a new development within [HB] around providing communication aids - so we’ve been able to provide them much more efficiently.*
- *He transitioned with little fuss and was OK during the first six months.*
- *Yes – successful new phase in client’s life and development - moving on to college course - developing new and more diverse range of social contacts - new communication device required.*
- *I then got feedback about how this young man was doing and discovered that within six months they were applying for a new device for him – his college place was going well – his family were continuing to support him on the nuances of the new device – as each device is slightly different – he was able to easily transfer – he was a very interesting case – he had not had what we would have seen as the traditional pathway through education – perhaps because of that he was able to accommodate and take advantage.*

Transitions: less positive comments

- *Outcome was satisfactory but it took a full year from SLT’s first contact with the client until the need [communication aid] was supplied.*

Suggestions about what might be done differently

- *None detected.*

Section C – service user transitions

Table C summarises transitions undertaken by service users, listing the interviewee and their clinical diagnosis, the referring and receiving SLT teams, the reason for the transition and any personal support available. This summarises responses to interview Questions Two to Nine. Clients were all adults on a post-stroke pathway.

Table C. Service User transitions

Service User	Transition from SLT	Transition to SLT	Reason for transition	Support for Transition
Carer of post-stroke client	RAD Stroke Team	Rehabilitation & Enablement Team	Hospital discharge with ongoing need for SLT service.	'[My relative] had excellent family support'.
Client post-stroke & wife	RAD Stroke Team	Community Stroke Team	Hospital discharge with ongoing need for SLT service.	'Extremely well supported by wife'.
Client post-stroke & wife	RAD Stroke Team	Community Stroke Team	Hospital discharge with ongoing need for SLT service.	'Very well supported by wife'.
Client post-stroke & daughter	RAD Stroke Team	Community Stroke Team	Hospital discharge with ongoing need for SLT service.	'Well supported by family and daughter'.
Client post-stroke	RAD Stroke Team	RAD Stroke Team (as out-patient)	Hospital discharge with ongoing need for SLT service.	'Yes – well supported by family'.
Client post-stroke	RAD Neuro Team	Community Stroke Team	Hospital discharge with ongoing need for SLT service.	'Yes – someone did'
Service User Support Group Member (reporting on a number of clients post-stroke)	Various hospital based teams	Various community based teams	Hospital discharge home, to care home, or other community based residence with ongoing need for SLT service.	In some cases person was supported.

Themes reported to influence transitions: positive and less positive comments, and what might have been done differently to improve transitions

Nine themes accounted for service-users views.

Overarching Theme: SLT team properties: Section C

1 Timely referral and provision for the client.

Transitions: positive comments

- *Once home there was not a long wait before [receiving team] visited – she [SLT] could be readily contacted if required.*
- *The SLT from the [receiving team] visited the client at home quite soon after his discharge from hospital.*
- *When patients are discharged from hospital they are generally picked up/seen soon by the [receiving SLT team].*
- *Outpatients appointments were organised while I was still in hospital.*

Transitions: less positive comments

- *None detected.*

Suggestions about what might be done differently

- *None detected.*

2 Continuity of SLT service and/or personnel across the transition

Transitions: positive comments

- *Good continuity of care in relation to all services including SLT.*
- *I saw the same speech language therapists in the ward then as an out-patient – comfortable - a stranger coming in would not have been comfortable - I had built up trust with my SLT.*

Transitions: less positive comments

- *There was a lack of continuity in the speech and language therapy provided – seen by four different SLTs over a period of time.*

Suggestions about what might be done differently

- *None detected.*

4 Issues re. service transition pathways, service models and provisions

Transitions: positive comments

- *It has been a great service for my situation.*
- *The SLT provided good support and materials to the client and family.*
- *[Client received] two appointments a week – four or five months later one appointment a week – I was happy with that.*

Transitions: less positive comments

- *The SLT set up a communication app on the client's iPad which is useful when he has a specific problem getting his message across. However, he does not use it for the purpose of general everyday communication.*
- *Some duplication of the materials provided but this was not a real problem.*
- *The amount of SLT provided did not seem sufficient to the client and his wife.*
- *The client feels he had an untimely discharge from the service [would have liked more SLT input].*
- *Post-stroke community services [including SLT] provided were good but there was not enough of them – once a week at best and this did not continue for long.*
- *Many patients feel they do not get enough SLT in either setting [hospital and community] so would like more and over a longer period of time.*

Suggestions about what might be done differently

- *There should have been more SLT input provided and this should have continued for a longer period of time.*
- *Daughter feels her father [the client] would continue to benefit from therapy input [including SLT] and that the lack of it is not good for his motivation and continuing recovery.*

Overarching Theme: Team communication and information exchange Section C

7 Pre-transition planning for clients between SLT teams.

Transitions: positive comments

- *The client felt positive about the SLT team transition.*

Transitions: less positive comments

- *The client had been in hospital for three months and there was a good deal of uncertainty associated with his return home.*
- *[There was] lots of preparation required and arrangements to be made in relation to all aspects of client's care not just SLT.*

Suggestions about what might be done differently

- *None detected.*

8 Cross-disciplinary/other services communication and working.

Transitions: positive comments

- *Patients are picked up quickly by the In/Outreach Co-ordinator and can be directed to the most suitable service – home visiting or group. SLTs can also contact their local Chest, Heart and Stroke Scotland Group Co-ordinator directly.*
- *[The client] was then referred to Chest, Heart and Stroke Scotland and a home visiting volunteer was provided – this arrangement has also worked very well.*
- *The client was ultimately referred to Chest, Heart and Stroke Scotland and has appreciated the services of a home visiting volunteer and communication group.*

Transitions: less positive comments

- *[There was] lots of preparation required and arrangements to be made in relation to all aspects of the client's care, not just SLT.*

Suggestions about what might be done differently

- *None detected.*

9 Communication with and/or involvement of client and client's family.

Transitions: positive comments

- *The client and his family were very positive about the SLT's visit soon after his return home and about the SLT input he received once a week following it.*
- *Hospital SLT provided good support and advice in preparation for client going home.*

Transitions: less positive comments

- *[the client] was keen to return home but he and his family were also very apprehensive about the transition (all aspects).*
- *The client and his family felt they were very much 'left to their own devices' when he returned home which was quite stressful for all of them [not specific to SLT services].*
- *Some patients find it difficult to deal with being told that 'You've reached your potential.' - This is sometimes the message they receive, explicitly or implicitly, at the end of their SLT input which can be demoralising for them.*

Suggestions about what might be done differently

- *None detected.*

Overarching Theme: Influences Section C

11 Medium of information exchange, e.g. Clinical Portal, Electronic Patient Record (EPR), written report etc.

Transitions: positive comments

- *When SLTs wish to refer a patient on to [support group] services there is an electronic referral system which works well.*

Transitions: less positive comments

- *None Detected*

Suggestions about what might be done differently

- *None Detected*

12 Knowledge of, respect and support for SLTs

Transitions: positive comments

- *The client and his family had a good relationship with the SLT whom they thought was very helpful.*

Transitions: less positive comments

- *[Receiving team] SLT's insight and understanding of Mr X's condition was not as good as expected.*

Suggestions about what might be done differently

- *None Detected*

13 Client satisfaction/progress/response

Transitions: positive comments

- *Generally the transition went well.*
- *The client and his family were very positive about the SLT's visit soon after his return home and about the SLT input he received once a week following it.*
- *It went very quickly and smoothly.*
- *Feedback from patients about the SLT they receive in hospital and in the community is generally very good.*
- *Mr and Mrs X were very satisfied with the input they received from the SLT and found it helpful.*
- *The client was pleased to have SLT sessions in his own home.*

Suggestions about what might be done differently

- *None Detected*

Transitions: less positive comments

- *The service could have been better.*

Suggestions about what might be done differently

- *None detected.*

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