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# **Consensus building on developing dysphagia competence: a North West of England perspective.**

**Key words:** dysphagia, competency, education, consensus

## **Declaration of interest**

None of the authors have any declarations of interest.

## **Abstract**

**Background:** Dysphagia has been an increasing area of practice for speech and language therapists (SLTs) for over 20 years (RCSLT, 2014) and throughout that period there has been debate about how practical skills in dysphagia can best be developed. The implementation of the new RCSLT framework was considered from a regional perspective seeking to establish consensus across different speech and language therapy settings.

**Aim:** This project aimed to explore practical solutions to the development of dysphagia competency in new graduates, whilst acknowledging the wide variation in staffing and clinical dysphagia experience across the geographical and clinical landscape in the North West of England.

**Methods and procedures:** A four phase study involved: a literature search; interviews with experts in the field of dysphagia; a survey to identify current practice; and a two round Delphi process.

**Outcomes & results:** Five themes emerged for dysphagia competency development, these being: development of practical skills; supervision; Clinical Excellence Networks; workforce planning and post graduate formal training. Challenges, and solutions to these, were identified through the phases of the study. A model for dysphagia competency development relevant to the NW context was achieved by consensus.

**Conclusions and implications:** There are many practical ways of developing dysphagia competency. The themes and model generated provide constructive support to services in adopting the most appropriate methods for their own settings.

### **What this paper adds**

#### *What is already known on the subject?*

In recent years the SLT profession has moved to a greater emphasis on dysphagia in SLT practice, and now incorporates a nationally standardised dysphagia curriculum in undergraduate programmes. Even though dysphagia is a required part of the curriculum, concerns can continue to be expressed about graduates' readiness for practical work in the field.

#### *What this study adds*

The study illustrates a consensus driven approach to developing dysphagia competence across diverse clinical settings and a commitment by practitioners to support and develop newly qualified SLTs (NQSLTs) through a variety of methods of supervision. Individually focussed approaches, with flexible time scales and supervision are recognised as being essential. The consensus driven approach complements existing dysphagia competency

frameworks by suggesting how dysphagia competencies can be achieved across different clinical settings.

*Clinical implications of this study*

The consensus model of dysphagia competency development will support clinicians in developing dysphagia competencies. It will be of interest to both newly qualified and more experienced SLTs in the North West and other regions.

## Introduction

Dysphagia has been an increasing area of practice for speech and language therapists for over 20 years (RCSLT, 2014) and throughout this period, there has been debate about how practical skills in dysphagia are best developed. Currently most qualifying courses in speech and language therapy across the world include some input on dysphagia (e.g. Netques, 2013), while entry to the profession in many countries is regulated, with programmes having to demonstrate that graduates are competent (e.g. HCPC, 2014; CAA, 2016). In Canada, there has been mandatory study of dysphagia since 1998 (CASLPO, 2014). Australia includes dysphagia practice as part of the preregistration competencies, and occupational standards state 'an entry-level speech pathologist must demonstrate competence in both the generic professional competencies and the CBOS (Competency Based Occupational Standards for Speech Pathologists) across the range of practice in speech pathology (including dysphagia) in order to achieve overall competency' (SPA, 2011: 8). Similarly, all graduates from the Republic of Ireland, from 2011 onwards, have been required to have a minimum standard of dysphagia management skills and are said to be 'competent to assess, diagnose and provide intervention for service users with FEDS (feeding, eating, drinking and swallowing) disorders as part of their clinical caseloads' (IASLT, 2012: 20).

These moves to a greater emphasis on dysphagia in pre-registration programmes have been encouraged by the various worldwide professional bodies, although even where graduate competence is a required part of the curriculum, concerns can continue to be expressed about graduates' readiness for work in the field (e.g. Smith *et al.* 2013).

The assessment and management of eating, drinking and swallowing (EDS) difficulties (dysphagia), is covered within the theoretical component of the United Kingdom (UK) Speech and Language Therapy (SLT) pre-registration curriculum, and since 2001 new UK graduates have been expected to be able to practise at a basic level with direct supervision (HPC/RCSLT,

2002). Pre-registration input to the knowledge base for dysphagia has recently been standardised across the UK (RCSLT, 2014). Some students also gain practical experience in the management of these difficulties through their clinical placements, however these opportunities depend upon the placements available and thus to date there is a variation in the level of practical competency in dysphagia management on graduation. A number of initiatives have been trialled to increase graduate level competency in the field (e.g. Stewart and Hall, 2014; Husak, 2016), although these are not UK wide. As a result, there continues to be variation in UK Speech and Language Therapists' (SLTs) working practice with clients with dysphagia and in how they develop their competency in this field. Newly qualified (NQ) SLTs usually need to develop practical competencies after graduation, which requires clinical supervision by experienced SLTs.

Two issues had been identified at the outset of the current study, these being context and supervision.

*Context – geographical and clinical:* the UK includes wide variation in working environments. Some SLTs work in large teams in urban settings, others work across smaller towns and communities, and some cover wide rural areas with isolated patients. Accordingly, the degree of support and professional contact available for new graduates showed considerable variation.

*Supervision:* the provision of supervised practice for new graduates has been of considerable concern for SLT managers and employers who seek to employ graduates at band 5 requiring 'specialist' dysphagia skills as defined by Boaden *et al.* (2006) but not typically expected in new graduates (Cocks and Harding, 2011; Cocks *et al.* 2013).

### [Aims of the study](#)

The current project was instigated following local debate regarding how best to support NQSLTs in developing dysphagia competency, given the context of limited time and resources

for supervision. The project was proposed through Profnet, (the North West England Speech and Language Therapy clinical leads' network). Health Education North West commissioned the project in order to identify and meet the regional needs of the speech and language therapy services to develop dysphagia competence in NQSLTs.

The commission tasked the project team to investigate practical solutions for using regional collaboration to support competency development, while acknowledging the wide variation in staffing and clinical dysphagia experience across the geographical and clinical landscapes. This was explored within the context of all new graduates working through a generic competency framework (RCSLT 2007) in order to achieve full membership of RCSLT. This was dependent upon regular supervision for practical skills development.

The project was designed to be consensus based and to outline a model to support and inform competency development, with the specific aims of:

- Scoping current practice of developing competencies and the application of supervisory frameworks for the management of dysphagia for NQSLTs;
- Identifying the characteristics of current successful models of competency development;
- Recommending systems for NQSLTs to access the appropriate level of supervision to enable timely achievement of, post-qualification dysphagia competencies in the North West.

## Methods

To investigate current practice, exploring barriers and solutions for dysphagia competency development a literature review was initially conducted. This led to semi-structured interviews, which in turn generated the content of a Delphi process. Figure 1 illustrates the sequence of the project.

***Figure 1 Sequence of the project (insert here)***

A wide range of clinicians was included to reflect needs and concerns across different settings. The membership of the project team and steering group ensured representation of the different paediatric and adult caseloads including acute and long term conditions, developmental disability, physical and mental health specialisms.

Ethical approval was granted by the authors' University ethics committee. Anonymity was assured following the interviews and throughout the survey process. Details and responses were stored confidentially on encrypted systems.

### Phase 1: Scoping the literature

#### Data collection

The following databases were searched: CINAHL, PsychInfo, Pubmed, Web of Science (Web of Science, Medline, SciELO Citation Index), Google Scholar and Scopus, from 1995-2014 using the following search strategy, depending on the database permissions and processes: dysphagia or swallow\* and train\* or educat\* or competen\*.

An initial screen of the titles and abstracts of the studies identified by the search was carried out by a research assistant to determine eligibility. The full texts of 'relevant' or 'unclear' papers were then independently evaluated and agreed by the authors. In addition, citation tracking and checking of references from journal articles identified by the search were conducted. No study design restrictions were applied. Papers were included if there was any mention of education or training in dysphagia competence or their synonyms.

Grey literature was also sourced to investigate national and international initiatives. The search included overseas models of competency development in SLT and other allied health and nursing professions. Information was also sought from professional networks including UK universities who were exploring options for enhanced preregistration practical skills development in dysphagia (e.g. Cocks & Harding 2011; Cocks *et al.* 2013;) and oral



presentations at UK based conferences, where these presentations were available on conference or professional body web sites.

The literature review formed a background to the consensus building study and was not a systematic review. From the original search, a total of 83 publications concerned with dysphagia competence development or wider clinical skills learning were included. Fifty refereed journal articles included those from international sources (e.g. Davis, and Copeland, 2005; Logemann *et al.* 2000; Sheepway *et al.* 2014) and UK authors (e.g. Chadwick *et al.* 2014; Ilott *et al.* 2014). Magazine articles (8) were predominantly from the RCSLT Bulletin (e.g. Gratton, Jackson, Robinson and Hoffman, 2014). In addition one book (Cocks and Harding, 2011), 2 book chapters (McAllister and Rose, 2000; Pownall, 2004), 3 conference presentations (e.g. Stewart and Hall, 2014), 4 professional guidelines/models (Kings College Hospital, 2001/4; Boaden *et al.* 2006; COMPASS (McAllister *et al.* 2013); RCSLT (pre-publication 2014)), 15 professional standards documents and one undergraduate thesis, were reviewed.

### Analysis

A concept matrix (Webster & Watson, 2002) was developed for each article by identifying main themes. These themes were synthesised into logical groupings to create the overall matrix to identify the main themes of the findings of included research studies, magazine articles, and competency documents. A thematic network analysis (Attride-Stirling, 2001) was then carried out to describe the main findings. Themes from the literature review are presented in table 1 below and were used to create a topic guide for Phase 2.

**Table 1 Themes from the literature review about here**

## Phase 2: Interviews

### Participants and recruitment

Expert SLTs were recruited from professional networks, selecting those with experience and current involvement in competency development in new graduate SLTs. These were invited to participate in a semi-structured interview. The 12 experts who consented to interview were SLTs from a range of clinical specialisms including adult learning difficulties, paediatric, adult acquired conditions, and mental health. Interviews were between 45 and 90 minutes duration, either by telephone or face to face as convenient for participants, and were carried out by one of the authors.

### Procedure

Topics in the semi-structured interview schedule were generated from the literature review and also included issues from the original drivers for the project. The topics comprised exploration of current practice in each expert's location, concerns regarding acquisition of skills and knowledge, and discussion of barriers and solutions to achieving good practice in developing dysphagia competency.

### Analysis

The interviews were transcribed and a thematic network analysis was used to derive themes from the interviews (Attride-Stirling, 2001). The global theme and several organising themes remained the same as those derived from the literature review above, but additional organising and basic themes reflected the practical issues identified within these interviews as indicated in table 2 below.

**Table 2 Themes from experts' interviews about here**

### Phase 3: Pre-Delphi survey

#### Participants and recruitment

To elicit a widespread contribution from the profession, a second recruitment drive invited all SLTs working in northwest England to respond to a pre-Delphi survey and to be involved in the subsequent Delphi process. SLT recruitment included: all NHS SLT departments in the northwest of England; local third-sector SLT departments; members of regional RCSLT Clinical Excellence Networks (CEN); invitations cascaded through managers employing SLTs; and an invitation to the Association for SLTs in Independent Practice (ASLTIP). Further contacts were approached through the host university clinical educator administrator who acted as gatekeeper contacting SLTs who were clinical educators across the region, to ensure wide inclusion. The website for the project was promoted widely giving information, a link for the survey and inviting responses from NHS, independent and other organisations.

Third and fourth year SLT students at regional universities and experienced AHP and nursing professionals who manage speech and language therapy services were also invited to respond.

#### Procedure

The themes from the literature review and expert interviews were collated to produce questions for this pre-Delphi survey. An electronic survey format (Qualtrics, Provo, UT, 2014) was used for data collection. Topics covered current working situation and general demographic information. The survey then explored available options for competency development; elicited current concerns and barriers; and finally asked respondents to suggest solutions.

#### Analysis

Responses from this phase were collated with the themes from Phases 1 and 2 to create the final Delphi surveys. The survey software allowed cross tabulation analysis, which enabled identification of areas for these Delphi surveys. Examples analysed included variation in caseloads, working situation and access to supervision.

## Phase 4: Delphi process

### Participants

SLTs who expressed an interest in continued involvement and had experience of dysphagia competency development either from recent personal experience as a new graduate, or as a more experienced SLT working with dysphagia, were identified from the Phase 3 survey. This included a representative sample of regional SLTs (considering geographic location, size of department, NHS and non-NHS, and clinical specialism).

### Procedure

A Delphi approach (Linstone and Turoff, 2011) was used to develop a consensus on dysphagia competency development. Participants were asked to vote on options for developing competency from topics generated by the Phase 3 survey. Voting used a five point scale from “strongly agree” to “strongly disagree” with a midpoint of “neither agree nor disagree”. Participants were then asked to comment giving their rationale for each decision. This facilitated exploration and understanding of the different viewpoints.

Participants were encouraged to add free text describing their ideas and opinions in an attempt to elicit wide-ranging solutions for each aspect of competency development. The Delphi survey process enabled respondents to consider factors outside their own setting and to challenge ideas about practice (Bolger & Wright, 2011).

### Analysis

Consensus was set at 75% as recommended by Linstone and Turoff (2011). This was confirmed using the Qualtrics software (Qualtrics, Provo, UT, 2014). Thematic networks (Attride-Stirling, 2001) were derived from the data. These were discussed between the first two authors and reviewed and agreed by the third author. To enhance credibility, the themes were also presented and agreed at SLT specialist groups and stakeholder meetings.

## Results

The interviews and surveys offered a varied overview of dysphagia practice by SLTs in NHS, third sector departments, and different service settings.

We present here the outcome of the Delphi process. In addition to the consensus counts reported below, we present free text comments to illustrate decision-making and rationale for voting across the different stages. The numerical coding indicates the survey, question and comment number.

### Pre-Delphi survey: A snapshot of current practice

In this survey, respondents were asked to describe current practice and comment on barriers and solutions to dysphagia competency development. For the initial survey 70 responses were received from qualified UK SLTs and 30 from SLT students. Respondents represented wide-ranging work settings and multiple clinical specialisms covering paediatric and adult caseloads, rural and urban settings and hospital, school, community and domiciliary settings. Many SLTs worked in more than one clinical setting. The survey was anonymous so it was not possible to track all to indicate specific location however the responses suggested a representative spread across the North West of England. The majority of comments referred to general issues, very few described challenges and solutions specific to clinical settings. More comments reflected on the size of the SLT team than on the clinical specialism.

One third of qualified SLT respondents had been working with dysphagia for less than 2 years, and the rest had experience of up to 36 years. Two thirds of respondents were working in urban areas. The majority described their clinical setting as community working including schools and home visits with just over one third working in hospital inpatient settings.

Respondents indicated that the typical number of dysphagia contacts per month ranged from one to more than 80. Cross tabulation suggested that the larger dysphagia caseloads (i.e. above 40 contacts per month) were held by SLTs working with adults (representing both

acquired and learning disability caseloads); paediatric caseloads varied between one and 30 contacts per month. Seven percent of respondents described working in settings where only SLTs at 'specialist' level C (Boaden *et al.* 2006) were responsible for dysphagia (in some cases, this was a single specialist clinician) and NQSLTs were not able to develop in this field. One response indicated that the dysphagia caseload was 'mainly managed' by nurses rather than SLTs.

The survey went on to explore interests and attitudes towards using a framework approach to structure and record dysphagia competency development. Responses showed variation but it must be noted that this survey predated the official launch of the RCSLT framework (RCSLT, 2014). Regular use of a portfolio or log to record dysphagia experience was reported by 65% of respondents although comments suggested considerable variation in attitudes to maintaining a written record of experience. Comments showed that postgraduate formal training course systems were also considered an appropriate means of recording or logging progress.

*Competency development solutions.* Throughout the surveys, we explored differences perceived between acquisition of theory/knowledge and developing practical skills. In this first survey respondents suggested that in-house methods were currently the most popular for acquiring knowledge both through teaching sessions (74%) and also by self-directed learning (78%). Attendance at a recognised postgraduate dysphagia training course was also common (57%) but other forms of learning (for example role-play, simulation, video, e-learning) were less favoured. From this survey it became clear that SLTs welcomed professional support groups, including local peer groups and regional CENs offering an accessible solution to competency development. The formal taught courses were felt to be more useful after a period of consolidation (between 6 and 12 months post qualification) although there were many concerns regarding cost and accessibility of these.

Current practice for gaining and consolidating practical 'hands on' skills was described in this survey showing multiple options. Comments indicated a generally accepted progression for NQSLT practical skills development moving from observation and discussion with expert SLTs towards direct supervised work, but opinions then varied as to the next stage. Practice development included working with peers, unaccompanied visits, presentation of case study and reflective activities.

Respondent SLTs indicated that formal and informal supervision was highly variable in terms of frequency. Most (76%) indicated that support from dysphagia specialist(s) was available at least weekly.

Types of supervision were also explored: face-to-face supervision was by far the most popular (90%) followed by joint visits (83%). Other forms of supervision included phone discussions, expert-led discussions and peer group discussions. Tele-solutions such as video-conferencing were used rarely.

*Signing off competency.* Most (72%) respondents chose '*supervisor direct observation of practice*' to assess competency. '*NQSLT demonstrates reflective skills as assessed by supervisor*' was also frequently chosen (61%). There was support for accredited formal post basic qualification training (57%) and comments showed that this offered a complete and trusted solution for some teams. Other options included one or more written case studies (41%), review of log or portfolio (48%); and a review of case notes (29%). Less favoured solutions included a written supervisor report, peer SLT review, multi-disciplinary team comments and self-rating by the NQSLT.

The perceptions of time needed to achieve dysphagia competency for NQSLTs varied: 48% responses suggested that it was not appropriate to count hours while 29% selected 'more than 60 hours'. Many strongly worded comments were added to this section with a common theme

of variability according to need, for example: *“depends on individual ability/competence/confidence” (1.17.13).*

The comments did also include expressions of interest in the idea of a standard timescale to inform planning and investment (but acknowledged the need for flexibility):

*“...it would help in these times of limited resources if there were some guidelines [around recommended number of hours] that we could use with organisations to support staff...” (1.21.3)*

*General concerns around dysphagia competency.* To conclude this survey, respondents were asked to reflect on their experience of dysphagia competency development overall. In answer to how they viewed their own experience 65% agreed or strongly agreed that the process is working well (14% neither agreed nor disagreed; 11% disagreed or strongly disagreed). Further comments were added by 26% reporting concerns including time constraints, access to formal training and managerial support. These topics were then explored further (within the first survey and then through the Delphi surveys). The respondents indicated that although they were able to find a supervisor (only 9% had difficulties), over half had difficulty finding time to complete the supervision (54%), to carry out joint visits (51%) and for reflection (32%).

Workforce concerns were cited as a cause of lack of investment in NQSLTs with several respondents highlighting movement between posts at this stage: *“once the time has been invested then it adds to the team. So long as they don’t leave and take their skills elsewhere!” (1.19.12).* It became apparent during the survey that for some departments the investment in NQSLTs to become dysphagia competent was a contentious issue with insufficient staffing and restructuring mentioned as barriers for competency development.

The results of this survey informed the subsequent Delphi process which asked for an evaluation of options.



## Delphi results

Voting stages were completed in the two rounds of Delphi surveys with a level of 75% chosen to indicate consensus as recommended (Linstone and Turoff, 2011). Other outlier options were included as illustrations of how smaller SLT teams can implement competency development and these are listed in the recommendations summary published on the Allied Health Professionals North West website, (AHPNW, 2016). Respondents included NHS and non NHS SLTs with experience of dysphagia competency development. The global themes are presented below.

### Global theme 1: Challenges for competency development

#### ***Figure 2 Global theme 1 Challenges (insert here)***

Figure 2 indicates the first global and associated organising themes. Knowledge and practical skills development were key concerns. Limitations in time and capacity of specialist SLTs for supervision, knowledge and practical development were central to the difficulties experienced.

#### *1.1 Challenges for Supervision*

During the surveys, it became apparent that the role of supervision had different meanings for individual therapists and varied interpretations for different clinical settings and team structures. The term 'mentor' was not welcomed by the initial interviewees and pre-Delphi survey respondents, so in the Delphi process the term 'supervisor' was adopted. Respondents agreed that supervisors should have a clinical role teaching, demonstrating, and acting as an assessor for signing off competency. There was also an expectation of a supportive and informal counselling role. In addition, some supervisors were acting as a line manager, monitoring professional skills, governance and safeguarding.

*Challenges in providing learning opportunities:* Comments showed that challenges included access to dysphagia competency development and timing constraints:

*“We would normally not offer any postgraduate training until the therapist had been working for 6-12 months and had got to grips with basic caseload handling and clinical decision making” (3.16.10)*

Consensus (85%) was that dysphagia supervision should be at least weekly in the first 3 months for NQSLTs (although 5% disagreed) and protecting time for competency development was an issue for some more than others. Limitations to access were also discussed with regards to staffing levels and SLTs commented that access by more remote methods might be considered:

*“As services are limited at the moment, telephone and email clinical supervision is sometimes the only option.” (3.11.17)*

There was concern expressed that supervisory opportunities are even more limited for non NHS SLTs.

*Challenges in knowledge development:* The surveys reflected the changing situation in the university syllabus for dysphagia knowledge teaching. Some SLTs responded by calling for more dysphagia training as part of undergraduate training. Since this survey was completed, the RCSLT has issued standardised curriculum guidelines for dysphagia pre-registration (RCSLT, 2014). There was 100% agreement that any formal teaching for new graduates should refresh and update knowledge covered as an undergraduate. There was strong support for learning in the work setting to support implementation of theory. Difficulties in accessing post-graduate courses were described by some respondents, including delays due to funding and waiting lists for places.

*Challenges for practical skills development:* Developing practical skills in dysphagia presented further illustration of competency development challenges. Respondents commented on lack of variety in patients, which limits dysphagia experience:

*“even if a person is competent with one person they may not be with someone else and giving people a range and breadth of experience can be hard” (3.13.14)*

Surveys showed varying commitment to sharing supervisory resources (staffing) and practical training across organisational boundaries. Some respondents were concerned about how this could be implemented.

### *1.2 Challenges for assessment*

This theme was evident in many comments throughout the Delphi surveys. There were concerns around trust, methods of evaluation and use of frameworks.

*Trust:* Several comments suggested misgivings around aspects of trust between supervisor and NQSLT. Challenges were perceived in decision making around readiness for autonomous practice.

*“NQ SLTs do bear responsibility for their own professional competency but this should not be relied on too much as some individuals may not have good self-awareness.”*

*(2.7.2)*

*“Important not to get tempted to sign off on anything unless you can stand behind the decision as the supervisor” (3.13.2)*

*Methods of assessment:* The methods of evaluating competency were described as having many challenges. Respondents were both for and against exams: *“Exams do show whether knowledge have been assimilated” (2.3.10)* in contrast to *“Exams only test what you know on*

*the day*” (2.3.9) and many respondents reiterated the need for observation by a supervisor for example:

*“The supervising clinician can easily spot poor knowledge and understanding which can be missed by a written piece of work” (2.3.11)*

*Frameworks:* RCSLT launched the Dysphagia Framework (RCSLT, 2014) whilst the Delphi process was being conducted. Respondents made reference to existing competency frameworks but were varied in their use and attitudes towards these:

*“The IDF [Interprofessional Dysphagia Framework (Boaden et al. (2006))] supported a case I made to (non-SLT) management about the need for supervision from a dysphagia consultant. More of this type of documentation which can be used to support bids to management would be welcomed” (3.11.1)*

*“At present there is an over reliance on the Post Basic Dysphagia Course ..... SLTs are anxious about not having a recognised qualification.” (3.16.7)*

Unsurprisingly, these comments showed that SLTs varied in their opinions on how to evaluate competency.

### *1.3 Organisational barriers.*

*Time allocation:* Respondents showed concern around preserving adequate time allocation for competency development in comments regarding Continuing Professional Development (CPD). Nearly half (45%) agreed with the statement *“In my situation difficulties with funding and/or time restrict my access to this learning and impacts on my CPD”* but almost equally 40% disagreed. One comment stated *“Time for CPD must be protected - however harsh the economic climate!”* (2.5.9).

*Policies and procedures:* The Delphi surveys flagged up risks around supervision arrangements including issues such as formal contracts, accountability, complaints, confidentiality. The survey responses raised concerns around cross-organisational supervision for individual NQSLTs working in isolated settings. The implications for governance and safeguarding structures to ensure adherence to RCSLT guidelines and HCPC standards were discussed by respondents with concerns such as:

*“There would need to be clear lines of accountability .... with clear expectations as to the quantity and quality of practice and of supervision.” (3.5.3)*

Across the interviews and surveys, it appeared that generic posts combining multiple clinical specialisms are becoming increasingly rare. Surveys showed that NQSLTs typically now work with a smaller range of ages and/or populations than historically. This has led to smaller staff teams with a smaller pool of expertise.

*“The service is spread very thinly and there is no funding or interest from trust/management level in developing the service further despite the obvious need.”*  
(3.16.3)

*Patient availability:* Smaller departments with fewer dysphagia cases also commented that it would take longer to offer an adequate number and breadth of dysphagia experiences. Comments suggested that NQSLTs usually focus initially on less complex patients. The RCSLT framework (2014) describes the meaning of complexity including various factors such as “illness and stage of illness; multiple co-morbidities; emotional and psychological issues; social effects; and personal circumstances” (RCSLT, 2014 p11).

Global theme 2: Solutions in competency development

**Figure 3 Global Theme 2 Solutions offered to develop dysphagia competence (insert here)**

The Delphi process led to a consensus on solutions from respondents creating global theme 2 (figure 3). This theme comprised organising and basic themes compiled from detailed comments by respondents.

*2.1 Knowledge development solutions*

The surveys offered consensus on knowledge development in NQSLTs using resources available. Solutions were offered reflecting the different situations across the region and for varied clinical settings.

*Opportunities for sharing:* The surveys explored the potential for sharing between SLT teams either within a team or across organisational boundaries. Most respondents (96%) were in favour of such options (none disagreed):

*“We are a small team and utilise neighbouring Trusts for support when needed. We also try to share resources and training events” (2.13.23)*

Comments suggested that a majority of existing arrangements were informal. As expected, surveys showed that larger departments with large dysphagia caseloads tended to have a larger pool of experts to draw on allowing them to spread the supervision workload between specialist staff and fast track NQSLTs’ experience and learning.

Comments showed a strong interest (93%, none disagreed) in covering NQSLTs’ need by running ‘in house’ training which may be income generating for the host department.

Successful examples were described involving 2-3 days of classroom teaching relevant to the clinical setting and led by local SLTs drawing on multidisciplinary and SLT experts. Comments indicated that in-house training is more feasible where a group of SLTs with similar training needs can be collected as a cohort, this may include NQSLTs and others. Costs for local

participants and speakers are reduced to a minimum and offering paid places to neighbouring SLTs can help to defray costs further.

*“As a large department we are able to offer formal/theoretical training from our dysphagia lead..... The theoretical aspect is an area which could be traded to support smaller Trusts in helping staff achieve competency” (3.7.4)*

Movement of NQSLTs may be expected across the region and shared training may compensate and accommodate for this.

*Self-development solutions.* Interest in indirect options for learning intensified as the surveys progressed, moving from 8% (pre-Delphi survey) to 95% by the final survey. The potential to develop e-learning and further options for distance learning through resources such as simulation, role-play, video observation, video-conferencing and other media were explored as the surveys progressed. This may take different forms and the surveys suggested that SLTs may lack experience and understanding of the wide potential of options available to support learning.

*“Simulation learning could also be brought in at an earlier stage to develop confidence and the soft skills e.g. at the observation and observed stages.” (2.9.21)*

Surveys showed strong interest in video (90% agreed/strongly agreed) as a means of widening experience supported by discussion with peers and the supervisor. Comments included a need for careful consideration of confidentiality and adequate consent procedures and the need to support this with adequate supervision, monitoring of skills and reflection.

*Accessing training:* Comments showed that opinions on timing of formal theory training were widely variable. No consensus was reached but 65% voted for training at around 12 months post qualification (23% disagreed). Many added comments showing a wide variation in settings

and capacity. For example some SLTs wanted the formal training straight away (comments from a SLT in an acute hospital team with a large caseload and others), others wanted the NQSLT to have general SLT practice to consolidate generic skills before attending specialist training (comments from a SLT working in an adults with learning disabilities team and others).

Interest in e-learning changed as the surveys progressed. Initially unsure, SLTs showed increasing interest in finding out more. The pre-Delphi survey showed 1% interest moving to 95% in the final Delphi round. Recent research has indicated a role for tele-solutions as a cost and time effective solution when geographical barriers limit access (Boaden *et al.* 2014). Surveys suggested only 2% of respondents had some experience of video-conferencing (compared to 41% use of phone supervision) and that this was used for supervision rather than knowledge development. The potential for e-learning for post qualification SLTs needs further consideration.

Further solutions were offered during the Delphi process, with strong interest in accessing study days and CEN training: 100% agreed/strongly agreed on relevance in attending one-day events on dysphagia topics. Respondents suggested that events presented as structured and formally organised were recognised favourably by managers and funders. In contrast, meetings advertised as informal support groups were less likely to be supported.

CENs are now coordinated through the regional RCSLT hub structure. Consensus was that these groups are valued, accessible and offer primarily an opportunity for knowledge exchange, research updates and also support, peer supervision, and networking:

*“We actively encourage attendance at CEN's relevant meetings. Despite the pressure of the job, we have no pressure from commissioners or senior managers not to attend and this really helps.” (3.12.15)*



Formal courses were seen as useful by many (83%) respondents with none disagreeing. The opportunity to learn, refresh, reflect and to consolidate theory away from routine clinical pressures was welcomed.

When asked to consider the format of the training there was some agreement, but responses fell below the consensus level of 75%. Surveys explored options for length of course (ie attendance at teaching days) with a majority (65%) opting for 3 day courses.

### *2.2 Solutions for gaining practical skills.*

Many respondents commented on generic professional craft skills, which transfer across all areas of SLT clinical work and consolidate over the first year of work. Basic themes consisted of hands on experience, access to patients and indirect options.

There was consensus that wider practical experience 'on the job' is fundamentally important:

*“nothing can replace hands on learning and experiences” (2.3.25)*

The survey comments also showed agreement that NQSLT competency develops by moving from observation to joint work to more distant supervised practice. Solutions acknowledged that NQSLTs' development was dependent on caseload number and complexity.

As for the formal training above, the use of video was seen to be a way to extend skills development and widen the range of experience in practical aspects. Comments recommended *“flexibility within the department to enable therapists to gain experience of lower incidence difficulties, possibly through group observations or video links, provided families agreed to this” (3.13.11)*

Unsurprisingly, this was an area where there continued to be more questions than answers.

### *2.3 Assessment solutions*

*Direct observation:* Respondents agreed that the most appropriate measurement of skills was direct observation by a specialist SLT. Ninety five percent agreed/strongly agreed that assessment requires direct observation of practice (5% neither agreed nor disagreed). Throughout the survey process there was consensus on the need for direct supervised work experience to develop competency. Currently 94% of SLTs offer joint visits for observation with a NQSLT initially leading onto 87% offering subsequent supervised practice.

*Reflective practice:* Reference to reflection occurred in comments throughout the surveys, and the importance of this aspect was indicated by 90% agree/strongly agree with the statement that *“After unaccompanied visits NQSLTs must discuss/debrief within 24 hours with specialist level SLT”* (2.6.4)

*Written assessment:* In addition to observation of practice other assessment approaches were considered and adopted across the region. Strategies included use of case studies, written assignments/exams, audit of case notes. This topic received no consensus during the surveys: written exams were thought to be valuable by 45% (31% disagreed), others (65%) voted for (at least) two assessed case studies but 21% disagreed.

Opinions varied on audit of written records (such as case studies, portfolio or casenotes): *“ensuring entries are verified is essential for quality control”* (2.13.22) in contrast to *“I do not believe they should be checked as they are quite personal”* (2.13.6) and there were many comments showing mistrust of written assessments suggesting that they are a poor measure:

*“I think the written exam and case studies are ineffective at measuring knowledge and definitely does not tap competencies”* (2 .3.1)

Further comments and solutions included appraisal of articles and exploring the evidence base around a topic. Some respondents were keen to involve other members of the multidisciplinary

team to contribute to development and some for input with assessment of a NQSLT's skills but others felt this was not valid or helpful.

#### *2.4 Organisational solutions*

Organisational solutions were seen to be essential, underpinning the other approaches to competence development.

*Management support and governance:* Some comments suggested a possible lack of consideration of governance and accountability structures e.g. *"I meet with a colleague from a neighbouring trust for peer dysphagia supervision as we are both working in isolation geographically"* (3.5.9) and some worrying complacency e.g. *"Experienced supervisors don't also require supervision"* (2.7.4)

Many respondents, however, reiterated the importance of embedding competency development within existing management structures. Solutions were offered advising the importance of management understanding the value of investing in competency development and CPD generally:

*"if this was documented as regional required competencies for development, this would have more influence on reluctant employers/managers."* (3.12.6)

*Timescales:* Consensus was not reached regarding protected time for learning, however 58% agreed that 3.5 hours (pro rata) per week should be protected for an initial period, between 3 and 6 months was suggested (10% disagreed). The comments indicated that flexibility was needed to accommodate different caseloads and clinical settings spreading the protected time across a month rather than a week. Throughout the project there was resistance to prescriptive timescales, instead there was consensus that individualised programmes of supervision and knowledge training were desirable.

*RCSLT Framework:* There was consensus that the new RCSLT (2014) framework, was key to structuring competency development and would be used to support discussions between a NQSLT and supervisor. There was unanimity (100%) that the framework should be used to structure and monitor progress but comments emphasised that this would be more robust when combined with discussion (i.e. monitored by the supervisor). The surveys suggested that SLTs are planning to use the new RCSLT framework to inform both the structure for competency development process and to log evidence of learning.

*Novel approaches:* During the surveys interest increased up to 95% in alternative and innovative methods of learning for both theoretical and practical skills. Currently there is a lack of experience and availability but comments suggested a change in attitude: *“there could be an optional north-west multiple choice test question pool that could be available to assess NQSLTs” (3.13.12)*. For other indirect methods (such as use of simulated patients), comments showed increasing interest:

*“Simulation and roleplay would be useful to NQSLTs .... Maybe resources could be available at a central place in the region which NQSLTs could access.” (2.7.22)*

## Discussion

The project was initiated following widespread concern regarding competency development in dysphagia. Local concerns centred on lack of time and capacity to support new graduates and there was an interest in finding effective solutions.

In the Inter-professional Dysphagia Framework (Boaden *et al.* 2006), autonomous dysphagia practice is considered to be achieved at level C. This has been found to be a challenge to accomplish by graduation from university (Stewart and Hall, 2014; Husak, 2016). Dysphagia placements are in short supply. Lack of generalisation of experience across different patient groups has also been described for those undergraduates who have been successful in gaining

direct dysphagia experience through placement (Cocks *et al.* 2013). On graduation, further supervised practical experience is commonly necessary to consolidate dysphagia competency (Boaden *et al.* 2006).

The interviews and surveys illustrated the aspects that most frequently caused concern amongst SLTs. In particular, there were comments about accountability, risk and safeguarding. Competency development requires consideration of risk management and the skills, self-reflection and confidence of both the NQSLT and the supervisor. In addition, the local resources available (including time and finance) impact on dysphagia competency development. Consideration of the wider context, within which dysphagia competency training takes place, is also recommended by Miller and Krawczyk (2001).

*Attitudes:* Responses to the surveys showed wide variation in SLT's opinions. Discussing NQSLT confidence levels the comments showed contrasting attitudes, many indicated that NQSLTs lack confidence although a small proportion indicated that NQSLTs can be overconfident. Opinion also varied on supervisors' confidence in new graduates, with some suggesting that supervisors can lack confidence in NQSLTs and be too risk-averse.

Risks around potential for harm, and the potential life-threatening aspects of dysphagia were presented through the surveys for consideration. Here consensus was not reached, and responses included strong opinions, some insisting that dysphagia be considered a special case while others suggesting that dysphagia should be regarded just as any other clinical area.

*Staffing risks:* Comments acknowledged the impact of lack of funding and staff capacity to invest in NQSLTs. Some responses linked this to difficulties in retaining staff, however the final Delphi phase suggests this is only relevant to a few areas. While a small minority stated that their SLT departments did not invest in NQSLTs due to concerns about retention, the majority did not agree with this approach, possibly suggesting that new graduates should seek the

many supportive employers who do exist. Generally, comments showed commitment to working across the SLT profession with development of new graduates seen as a benefit for the profession across the region.

*Supervision:* Five major areas were identified with solutions for the issues the project had been devised to address, these being: protected formal learning time, individualised approaches to facilitate development of practical skills, novel approaches to supervision and practical skills development, an expansion of the Clinical Excellence Networks to support the entire profession and workforce planning. The importance of supervision was apparent throughout all of these areas. Generally, respondents suggested that the most competent NQSLTs would be able to identify when they should request support and supervision, but the less competent may not have this self-awareness or initiative. Additional comments acknowledged the difference between complex and routine dysphagia with more complex cases requiring greater support for NQSLTs. This is reiterated in the RCSLT framework (2014).

Respondents showed a commitment to finding ways to support and develop NQSLTs describing a variety of methods to provide supervision. Throughout there was consensus that this must be individually focussed and that time scales and supervision need to be flexible responding to need. Respondents were strongly in favour of structures protecting CPD and supervision even when practical issues gave many causes for concern. Eclectic and individualised approaches to dysphagia competency development have also been suggested in previous studies (Duivesteyn & Gerlach, 2011; Miller and Krawczyk, 2001).

A consensus model for competency development in dysphagia was constructed from the themes generated by the Delphi surveys' responses, which reflects the opinions of SLTs within the North West region (see Figure 4). The RCSLT has published a dysphagia competency framework (RCSLT, 2014) that details dysphagia competencies for SLTs to work towards at

different stages of their career. The North West consensus model presented here complements the RCSLT dysphagia competency framework (RCSLT, 2014) by presenting how services can support SLTs to meet the dysphagia competencies included within the framework.

The consensus model is detailed in Figure 4 and summarised here. When an SLT student graduates from a university in UK they will have been taught dysphagia knowledge in a curriculum recommended by the RCSLT (RCSLT, 2014) and may have additional knowledge or competencies depending on their clinical placement experiences. During the first year of dysphagia work the North West model recommends the NQSLT will be working through the RCSLT dysphagia competency framework (RCSLT, 2014) supported by weekly supervision. NQSLTs may attend additional formal dysphagia competency training 6-12 months after qualification, which may be externally or internally provided, to revise the theoretical knowledge of dysphagia. There was a consensus that for most settings it was better not to do this training immediately after graduation to allow NQSLTs to develop other general clinical skills first. The NQSLT should have protected continuing professional development time (CPD) equivalent to one session per week pro rata for competency development. During the second year of dysphagia work the individual would usually continue to work through the competency levels of the RCSLT dysphagia competency framework (RCSLT, 2014), receive regular supervision every two to four weeks (RCSLT, 2012) and have a minimum of 30 hours of CPD per year pro rata (RCSLT, 2006). Development of dysphagia competencies continues throughout an individual's career (RCSLT, 2014) and the model recommends ongoing supervision at least 3 times a year, an appraisal process (RCSLT, 2012) and attendance of appropriate clinical excellence networks for more experienced dysphagia clinicians.

The manner of applying this model will vary across the different contexts in the region and a challenge remains to establish robust dysphagia CEN provision for all SLT caseloads, however the fact that consensus was achieved is seen as a major step forward for dysphagia competency development.

***Figure 4 North West Model for implementing dysphagia competency about here***

The RCSLT Dysphagia framework (2014) is welcomed as a means of formalising and unifying the competency development of NQSLTs across the region. Several recommendations from the interviews and Delphi process for dysphagia competency development within the North West can be made. Locally CENs are available for some but not all clinical caseloads so additional CENs to fill the gaps would support competency development. Services running in-house training could consider advertising it to other services to share expertise within the region and this may be effective at generating income for the host service. An evaluation of the e-learning resources currently available and development of distance learning resources would increase CPD opportunities for when physical access to training is difficult. Additional training in supervision for both SLTs new to the role and more experienced SLTs would be beneficial for supervisors. If external supervision is provided then contractual, governance and accountability issues should be considered carefully. The potential role of higher educational institutions to extend provision of CPD for clinicians was highlighted.

## Limitations

While the survey approach was used to offer the opportunity for as many SLTs as possible across the region to respond, the total number of potential respondents was not known due to the cascade approach and anonymous returns. However, the responses reflected a wide regional spread of environments, caseloads and SLT experience.



The survey software experienced difficulties with NHS firewalls in some IT systems and there were reports of frustration by users. Efforts were made to support users and to facilitate responses. Two Delphi rounds were completed (one fewer than originally planned), due to reaching stability of opinions, which complies with recommended Delphi process (Linstone & Turoff, 2011). Consensus was achieved at the required level for core themes, with outlier solutions reflecting smaller SLT teams and less common clinical specialisms. These variations (resulting in lower consensus levels for some items) were helpful as the process was able to reflect different settings in caseloads and working environment.

## Conclusion

This project has illustrated current SLT working practice across the North West region of England, focussing on dysphagia competency development. The barriers and solutions for development were elicited from respondents in answer to reported difficulties in supporting NQSLTs to develop knowledge and practical skills. The surveys indicated that actually finding a supervisor was difficult for only a few, the main concern was finding the time to complete the supervision and competency development process. The overwhelming consensus was for sharing resources via improvements to the CEN structures both electronically and at venues across the North West. This was seen as instrumental in improving wider supervision opportunities, sharing of training events, addressing concerns regarding risks and helping to improve consistency in developing and supporting the profession.

There are many practical ways of developing dysphagia competency. The final word is left to one of the respondents, *“there isn't just one way to skin a dysphagia cat!”*

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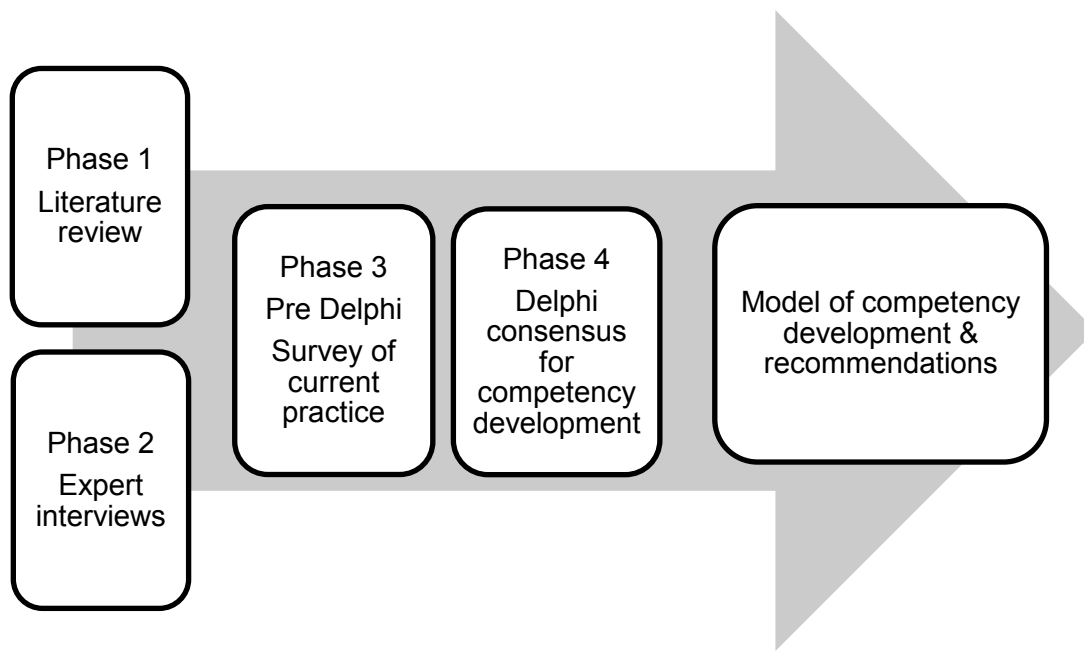
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**Figure 1. The four phases of the project**



**Table 1. Themes from the literature review**

<b><i>Global theme</i></b>	<b><i>Organising themes</i></b>	<b><i>Basic themes</i></b>
Dysphagia competence	Acquiring knowledge	University based
		New graduate
		Extended practice and expertise
	Acquiring skills	University based
		New graduate
		Extended practice and expertise
		Profession specific
	Supervision	Direct
		Indirect
		Distant/ virtual
	Competency frameworks	Multi-professional
		Uni-professional
		Assessment

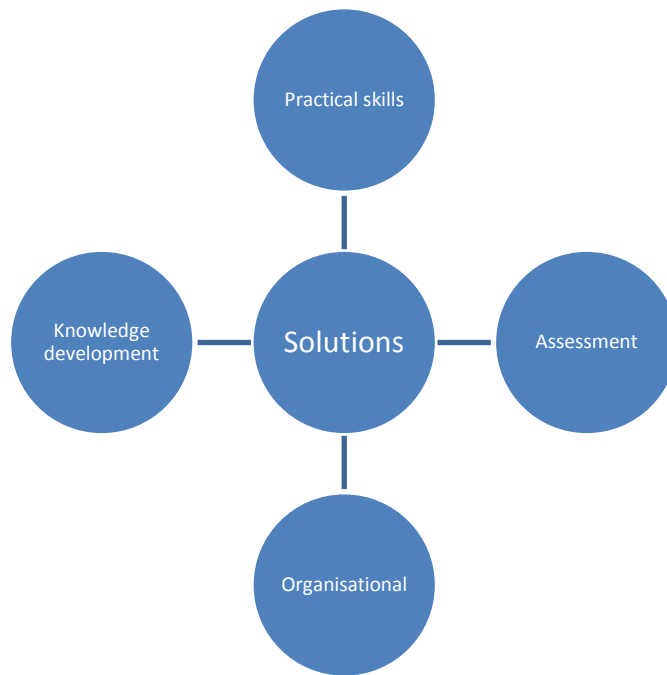
**Table 2. Themes from the experts' interviews**

Global theme	Organizing themes	Basic themes
Dysphagia competence	Nature of new graduates	Variation in university course content
		Variation in placement experience
		Variation in NQSLT skills
		Level of confidence
		New graduates feel threatened
	Development of knowledge	Covered in university course
		Topics relevant to setting
		Cost effective training
		Involving other professions
		Formal courses
		In house if have numbers
		Advanced level also needed
	Development of skills	Similarity with skills for communication therapy/general SLT professional skills
		Joint visits, observation, Supervised practice, experiential learning
		Use of video
	Assessment	Observation/shadowing
		Audit casenotes
		Peer review
		Case study
		Personal log/portfolio
	Supervision	Competency frameworks
		Approaches to supervision
		Responsibility for supervision
Safety	Timing	
	Moving towards autonomy	
Barriers	Risk management	
	Time, resources	

		Balance with work on communication
		Community-distance from mentor
		Culture, mindset
		Commissioners
		Finding expert SLT
		Supervisor reluctant, risk averse
		Funding for courses
		High staff turnover
	Solutions	Strong professional body leadership
		Local commissioners' support
		Managers' support
		Training from local universities
		Clinical Excellence Networks
		Sharing inter-organisation for small services
		In house training (generates funds)
		On line e-learning
		Protected time for gaining experience and supervision



**Figure 2. Global theme 1: Challenges in developing dysphagia competence**



**Figure 3. Global theme 2: Solutions offered to develop dysphagia competence**

**Figure 4. Dysphagia consensus competency model North West**

