



Collaborative working between speech and language therapists and rehabilitation assistants: An exploratory qualitative study in an interprofessional Community Stroke Team in Northern Ireland/United Kingdom

Zusammenarbeit von Logopäd:innen und Rehabilitationsassistent*innen: Eine explorativ-qualitative Studie in einem interprofessionellen Community Stroke Team in Nordirland/Vereinigtes Königreich

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Abstract

Background: A demographic shift in the UK population has significantly changed the burden of disease. Coupled with staff shortages in allied health professions within the National Health Service, the introduction of assistant roles aimed at freeing up qualified therapists has modernised the professions and challenged traditional practices.

Methods: To understand the lived experiences of speech and language therapists in a Community Stroke Team in Northern Ireland who work with rehabilitation assistants, an exploratory qualitative study design was chosen, conducting semi-structured interviews with three participants. **Results:** Participants valued the role of rehabilitation assistants as it allows for a higher frequency of therapy for stroke patients, appreciating their holistic approach to home rehabilitation. However, they described the planning process for assistant-led therapy sessions as time-consuming and challenging due to the diverse needs of clients, as well as logistical and geographical considerations. Interviewees supported the expansion of support staff roles and endeavored to assist rehabilitation assistants in improving retention, recognizing the importance of these roles for both service users and the interprofessional team.

Conclusion: The study's findings relate to home rehabilitation, addressing a complex clientele and questions regarding the provision of sufficient speech and language therapy input. These insights can enhance stroke care services in the UK, uncover new research avenues, and highlight opportunities for workforce modernisation in other European healthcare systems.

Abstract

Hintergrund: Der demografische Wandel in der britischen Bevölkerung sowie ein Fachkräftemangel in Therapieberufen im «Nationalen Gesundheitssystem» hatte die Einführung von therapeutischen und pflegerischen Assistenzrollen zur Folge. Dies führte zu einer Modernisierung der Gesundheitsberufe und stellte traditionelle Arbeitsstrukturen im therapeutischen Alltag in Frage.

Methode: Ziel dieses Forschungsprojektes war es, die wahrgenommenen Eindrücke von berufserfahrenen Logopäd:innen in einem Community Stroke Team in Nordirland, die mit Rehabilitationsassistent:innen im häuslichen Umfeld der betroffenen Personen arbeiten, zu analysieren. Es wurde ein explorativ-qualitatives Studiendesign gewählt und drei Teilnehmer:innen konnten für halbstrukturierte Leitfadeninterviews rekrutiert werden, um ein tieferes Verständnis für ihre praktischen Erfahrungen zu erlangen.

Ergebnisse: Die Teilnehmer:innen empfinden die Rolle des/der Rehabilitationsassistent:in als unverzichtbar, da sie es ihnen ermöglicht, Schlaganfallpatient:innen einen hochfrequenten Therapieinput anzubieten. Sie schätzen ihre ganzheitliche Vorgehensweise in der häuslichen Rehabilitation, empfinden allerdings den Planungsprozess als zeitaufwendig und herausfordernd. Gründe hierfür sind eine heterogene Klientel, aber auch logistische und geografische Herausforderungen. Die befragten Personen befürworten eine mögliche Zunahme von Assistenzkräften und bemühen sich, diese zu unterstützen, da sie die Bedeutung der Rolle für Patienten:innen und das interprofessionelle Team gleichermaßen erkennen.

Fazit: Die Ergebnisse dieser Studie beziehen sich auf das Umfeld der häuslichen Rehabilitation, einer komplexen und vielfältigen Klientel sowie offene Fragen über einen angemessenen logopädischen Input. Diese Erkenntnisse können dazu beitragen, die Schlaganfallversorgung in Nordirland zu verbessern und mögliche neue Forschungsfelder zu identifizieren sowie Möglichkeiten zur Modernisierung der Arbeitsstrukturen und Rollenverteilungen für andere europäische Gesundheitssysteme aufzuzeigen.

Keywords

speech and language therapy – rehabilitation assistant – Community Stroke Rehabilitation – interprofessional collaboration – experiences

Keywords

Logopädie – Rehabilitationsassistent:innen – Schlaganfallrehabilitation – interprofessionelle Zusammenarbeit – Erfahrungen



INTRODUCTION

Due to workforce shortages in the rehabilitation of stroke patients, combined with significant population growth in the UK, the introduction of “assistant practitioners” is one of the initiatives that emerged out of policies that encouraged modernisation of the professions and challenged traditional working practices (Lizarondo et al., 2010, p. 144). Support workers, including therapy assistants, healthcare assistants, and therapy aides, represent rapidly growing areas of the healthcare workforce in the UK (see *ibid.*, p.2).

Current challenges

The NHS England (NHS England, 2023), as well as the Department of Health Northern Ireland (Department of Health, 2017), have acknowledged several significant challenges that affect those who use services, but also those working in the sector:

1. The main concern lies in rising pressures on the healthcare workforce. Although the number of NHS staff has grown substantially in the past decade, healthcare needs have also increased significantly, outpacing the growth in the workforce (Morgan, 2022, p. 8). Short-term solutions, such as recruiting locums and agency staff, have made the NHS increasingly reliant on external staff providers (Addicott et al., 2015, p. 19). Alternatively, international recruitment creates additional expenses with negative implications for the quality of care (see *ibid.*, p. 26).
2. A major factor contributing to the increasing demand for NHS services is the rising demographic pressures, as well as a changing burden of disease (Fahy et al., 2011, p. 1). In Northern Ireland, estimates indicate that by 2026, for the first time, there will be more over 65s than under 14s.
3. This shift in population means that patients’ needs are changing, with increasing levels of multimorbidity and frailty, leading to an increasing complexity of service delivery (Soley-Bori, 2021, p. 39). Patients’ expectations have also changed, with them becoming active participants rather than passive recipients of care (Lizarondo et al., 2010, pp. 143-144).
4. Lastly, among all healthcare professions, a limited supply growth is projected due to the education and training pipeline not keeping pace with expected demand (Wilkinson, 2023, p.1). Among the “allied health professions” (AHPs), the greatest shortfalls are expected to be seen for speech and language therapists (SLTs), among others (NHS England, 2023, p. 17).

The NHS Long Term Workforce Plan projects that the current NHS staffing shortfall of 112,000 will increase to 360,000 by 2037 (see *ibid.*). Among the allied health

professions, shortfalls are expected to increase the most for paramedics, occupational therapists, diagnostic radiographers, podiatrists, and speech and language therapists (NHS England, 2023, p. 17).

Long-term workforce plan

With these challenges, healthcare services are increasingly faced with the need to ensure an adequate number of health professionals who can provide the most appropriate and timely services to patients (Lizarondo et al., 2010, p. 144). As part of the NHS modernisation agenda, flexible workforce approaches have been encouraged to enhance patient-centered care and help address the effects of staff shortages (Nancarrow et al., 2005, p.2). This plan commits to developing healthcare support workers, providing opportunities to build specialist knowledge and skills that will enable them to advance in their careers while supporting the NHS in addressing specific workforce shortfalls.

The role of rehabilitation assistants

Rehabilitation assistants (RAs) work as members of interprofessional teams assisting with the rehabilitation of patients in various settings. The concept of introducing RAs was first proposed in England as a method of addressing the need for increased rehabilitation activity despite staff recruitment problems (Stanmore & Waterman, 2007, p. 752). It was identified that potential gains include an increase in rehabilitation activity, which may result in possible earlier discharge from care for patients in the community and on hospital wards (see *ibid.*). The use of RAs could also facilitate a more effective use of therapists as they can concentrate more on assessments and complex treatment by allocating prescribed treatment plans to the assistants (see *ibid.*).

The described role falls under the umbrella term of allied health assistants (AHAs), who are defined as support staff that complete clinical and non-clinical tasks under the supervision and delegation of an allied health professional (Stute et al., 2013, p. 4).

The term ‘allied health’ describes health professionals other than nursing and medical professionals (see *ibid.*, p.29). In the UK, the title speech and language therapist is protected. To practise as a speech and language therapist, a registered, accredited degree-level course must be completed. University-based degree-level courses can be completed at either the undergraduate (BSc Honors) level or the postgraduate (PGDip or MSc) level (RSCLT University degrees: About speech and language therapy degrees, n.d.). AHA roles are commonly developed to complement the work of the allied health professionals and assist in the delivery of health services across a broad range of clinical settings (Turnbull et al., 2009, p.28).



Unlike allied health professionals, AHAs are not university-trained, and their qualifications can vary from informal ‘on the job’ training to certificate-level qualifications (Stute et al., 2014, p. 2). They often work within interprofessional teams, carrying out treatment plans under the supervision of registered AHP staff (Griffin, 2021, p. 7), and cannot perform clinical tasks that involve evaluation, diagnosis, or assessment of patient health conditions (Lizarondo, 2010, p. 151).

Interprofessional community stroke rehabilitation

This research project examined the role of a rehabilitation assistant within a Community Stroke Team (CST), which means, in this case, RAs assist with the rehabilitation of stroke patients within their own home as well as within residential and nursing home settings. They carry out therapy programmes as directed by professional staff from the interprofessional team. This may include physiotherapists, occupational therapists, and speech and language therapists. They also assist with general departmental and administration duties to support service delivery.

Stroke is one of the main causes of adult disability, and there is strong research evidence that the provision of stroke specialist rehabilitation enhances recovery (Langhorne et al., 2011, p. 1639). Survival after stroke initially depends on specialist hospital care in the acute phase (Walker et al., 2013, S. 293). However, as most patients with stroke will survive the initial illness, the greatest health effect is usually caused by the long-term consequences for patients and their families (Langhorne et al., 2011, p. 1639). These can include impairments of bodily functions, activities, and participation; however, environmental and personal factors must also be taken into consideration (Walker et al., 2013, p. 293). Therefore, interventions tend to be complex and comprise several interrelated components (Craig et al., 2008, p. 1). Treatments may target several different problems, ranging from relieving specific impairments to enhancing activity and participation. Optimal recovery can be facilitated through coordinated specialist rehabilitation in the early stages of returning home, as well as in the expected months following the event (Walker et al., 2013, p. 293). Substantial evidence supports multidisciplinary team care as the basis for the delivery of stroke rehabilitation (Stroke Unit Trialists’ Collaboration, 2007, p.2).

In the UK, rehabilitative stroke care following hospital discharge is often provided in the patient’s home. This is primarily related to the challenge facing the national healthcare system to reduce costs and shift care away from expensive hospitals (Walker et al., 2013, p. 293). Described care is usually provided by a “Community Stroke Team”.

This is a specialised, interprofessional team of staff (physiotherapy (PT), speech and language therapy (SLT), occupational therapy (OT), nursing, social work and psychology) who provide stroke rehabilitation in the community and the patient’s home (HSC: South Eastern Health and Social Care Trust, n.d.).

Research has shown that specialised Community Stroke Rehabilitation (CSR) leads to improved regaining of independence and thus advances recovery (Walter et al., 2013, p. 296). It was also reported that significant improvements occurred after six weeks and three to six months post-stroke, likely due to the direct transfer of skills to the living environment (Hillier & Inglis-Jassiem, 2010, p. 178). A meta-analysis of randomised controlled trials comparing home-based and centre-based stroke rehabilitation found that home-based services were associated with greater client satisfaction, reduced caregiver strain, and lower hospital readmission rates (Winkel et al., 2008, p. 168). In addition to the numerous positive clinical outcomes associated with home-based rehabilitation, it has been proven that these services are also cost-effective. This was demonstrated in a systematic review, which showed that home-based rehabilitation reduced hospital stays by 13 days (Anderson et al., 2000, p. 1032).

Research gap

In the literature, the use of therapy assistants has been widely examined. However, most studies have focused on exercise interventions delegated by the physiotherapy profession, with other forms of therapy largely overlooked. A recent systematic review and meta-analysis (Snowdon et al., 2020) identified 22 studies that examined the effect of delegation of therapy to assistants. Three of the selected studies investigated the substitution of speech and language therapy with assistant-led therapy. Two of these (Boyle et al., 2007; Dickson et al., 2009) were set within a language therapy setting for children. Merely one cohort study (Wenke et al., 2014) focused on the feasibility of aphasia therapy delivered through different models in a subacute setting. It was reported that assistant-led therapy led to overall higher costs as SLTs required additional time preparing the sessions. Furthermore, SLTs achieved lower satisfaction ratings due to the increased preparation time (see *ibid.*, p. 8). Those findings contrast with the literature, which suggests that the use of support workers allows health professionals more “free time” (Lizarondo et al., 2010, p. 143; Nancarrow et al., 2005, p. 2). Wenke et al. (2014) also reported that a careful selection of suitable clients, who should receive assistant-led SLT therapy, is required. As outlined, literature focusing on SLTs collaborating with assistants is sparse, and RAs working in CSR is an overlooked topic, although the community setting is of particular importance as demand for community care increases (Duckett et al., 2014, p. 3).



Research question and objective of this study

It is therefore the goal of this exploratory qualitative research project to analyse the lived experiences of SLTs in CSR to gain a deeper understanding of their impressions and personal challenges when working with assistants. This can facilitate a better understanding of unmet needs, which can help improve policies and training, while also highlighting possible benefits that offer new possibilities to healthcare systems where the use of RAs is not yet commonly accepted. The research question for this study is therefore phrased as follows:

„How do speech and language therapists in Northern Ireland perceive working with the support of rehabilitation assistants?“

METHODS

Research design

An explorative qualitative study design was chosen for this research project due to the open-ended nature of the research question. To assess the subjective perceptions and experiences of the participants, a semi-structured online interview method was employed. That way, questions are pre-planned, which provides a structure for comparability; however, the interviewer gives the participant the chance to elaborate and explain particular issues through the use of open-ended questions (Alsaawi, 2014, p. 151).

Participants

All participants were recruited from the Community Stroke Team of the South Eastern Trust in Northern Ireland/United Kingdom. The first author is currently employed as a rehabilitation assistant within the team, and therefore, a rapport had already been built. Developing rapport with participants is critical as a form of partnership must be achieved to generate meaningful data (Aburn et al., 2021, p.5). Having a pre-existing relationship with a participant can mean that rapport is established more quickly, providing an opportunity to generate rich data in a short period of time (McConnell-Henry et al., 2010, p. 4). Initial contact with participants was made verbally to assess whether a general interest in participation existed before details of the planned study were shared and interest was officially registered.

One month prior to the planned interviews, participants who registered interest in participating received specific information about the study, the planned interview process (required length of time, technical requirements,

etc.), as well as consent forms and the socio-demographic questionnaire for participants to fill in, sign, and return.

Three SLTs who work in the CST fulfilled the inclusion criteria (see Table 1) and agreed to take part in this research project. Two participants hold Specialist SLT positions (Band 6), and one participant is employed as an SLT team lead (Band 7). As part of a national framework known as “Agenda of Change”, the majority of HSC posts are banded depending on the tasks required and level of responsibility (HSC Jobs, 2024). SLTs who have qualified in the United Kingdom typically hold at least a relevant undergraduate degree and usually start their careers at Band 5 level. After 2 years of working experience, progression into Band 6 as a Specialist SLT is common, whereas Band 7 positions are usually team lead/managerial roles.

Interviews

During the conducted literature review in medical databases “PubMed” and “Cochrane Library,” a comprehensive and adequate understanding of the research subject was gained. Based on previous knowledge, but mainly through the acquisition of complementary empirical knowledge, a semi-structured interview guide was developed to investigate the experiences and perceptions of research subjects. The interview guide (see Table 2 in the [supplementary material](#)) consisted of main questions, follow-ups, and probes (Rubin & Rubin, 2011, p. 131). The prepared questionnaire was pilot-tested with a qualified SLT team lead who fulfilled all the inclusion criteria of this study. Thereafter, the guide was revised to optimise the questions. The finalised questionnaire was not sent to the participants in advance to avoid preparation prior to the interview, which could result in answers that are perceived as socially desirable. Due to Trust insurance policies, all interviews were held digitally.

There is evidence that suggests that digital interviews make participants feel at ease as they regard the setting as more flexible. This, in turn, can make them feel more comfortable disclosing their experiences (Weller, 2017, p. 613). To ease participants, interviews began with a settling-in phase. The dialogue then commenced with the semi-structured interview along the prepared questionnaire. The interviews lasted between 30-55 minutes.

Data evaluation and analysis

The conducted interviews were transcribed in accordance with the guidelines for content-related semantic transcription (Dresing & Pehl, 2018) with the help of the



Table 1: Inclusion and exclusion criteria of research participants (source: author's own)

Inclusion criteria	Exclusion criteria
at least undergraduate degree in Speech and Language Therapy (B.Sc.)	students, any type of health care support staff (pay band 3 and 4 *), AHP of other professions
at least 5 years of professional experience as a qualified speech and language therapist (pay band 6 and over *)	less than 5 years of professional experience as a qualified speech and language therapist (pay band 5 *)
at least 3 years of professional experience as a qualified speech and language therapist working in Community Stroke Rehabilitation	less than 3 years of professional experience as a qualified speech and language therapist working in Community Stroke Rehabilitation
currently working in Community Stroke Rehabilitation	currently not working in Community Stroke Rehabilitation
currently working with the support of one or more rehabilitation assistants	currently working without the support of rehabilitation assistants
legal adult	Minor/not legal adult
English is native or primarily used language	not fluent in the English language

AHP = Allied health professionals, SLT = Speech and language therapist
 * The majority of HSC posts are banded ("Agenda of Change"), depending on the tasks required and level of responsibility (HSC Jobs: Pay Bands in Health and Social Care, 2024). Support worker roles are typically Band 3 or 4 positions. Qualified SLTs start their career at Band 5 level and progress with experience.

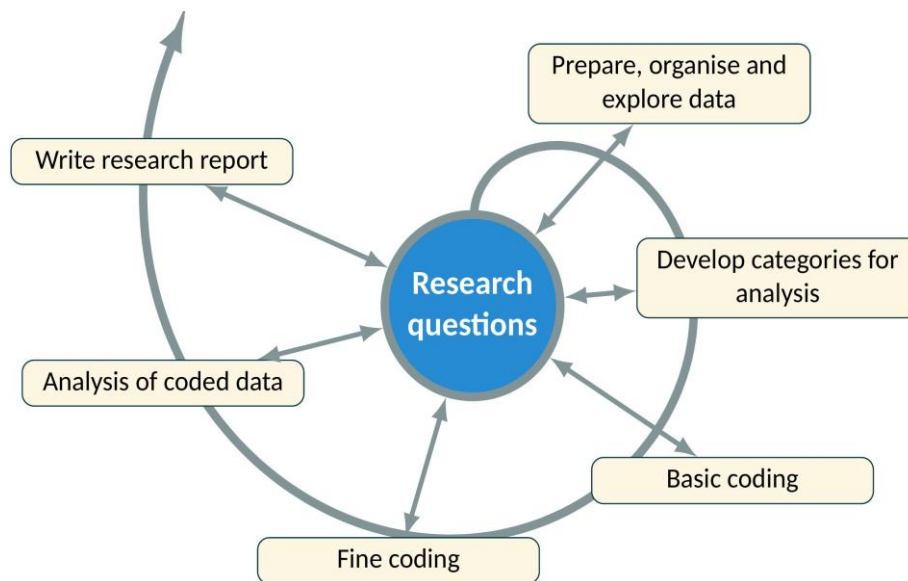


Figure 1: Focused analysis of interviews in six steps (source: author's own based on Rädiker & Kuckartz, 2020, p.17)

artificial intelligence-powered service “speechtext.ai” as well as through manual revision to correct possible errors. The transcribed data was then imported into the qualitative data analysis software MAXQDA (2022) and analysed by the authors without the use of artificial intelligence. Before the coding process, suitable coding guidelines (see Table 3 in [supplementary material](#)) for the analysis were defined to ensure interview statements were assigned to the adequate category (see *ibid.*, p. 62). Individual text segments were first assigned to the categories of the guideline. The text segments in each category were then summarised and provided with evidence and explanations.

Finally, the material was systematically organised by the first author and provided with anchor examples. The steps of the content analysis are summarised in Figure 1. Table 3 in the [supplementary material](#) provides an overview of the main and subcategories, including anchor examples.

RESULTS

The results of this research project will be presented in a descriptive and interpretive form, organised according to the category system (see Figure 2).

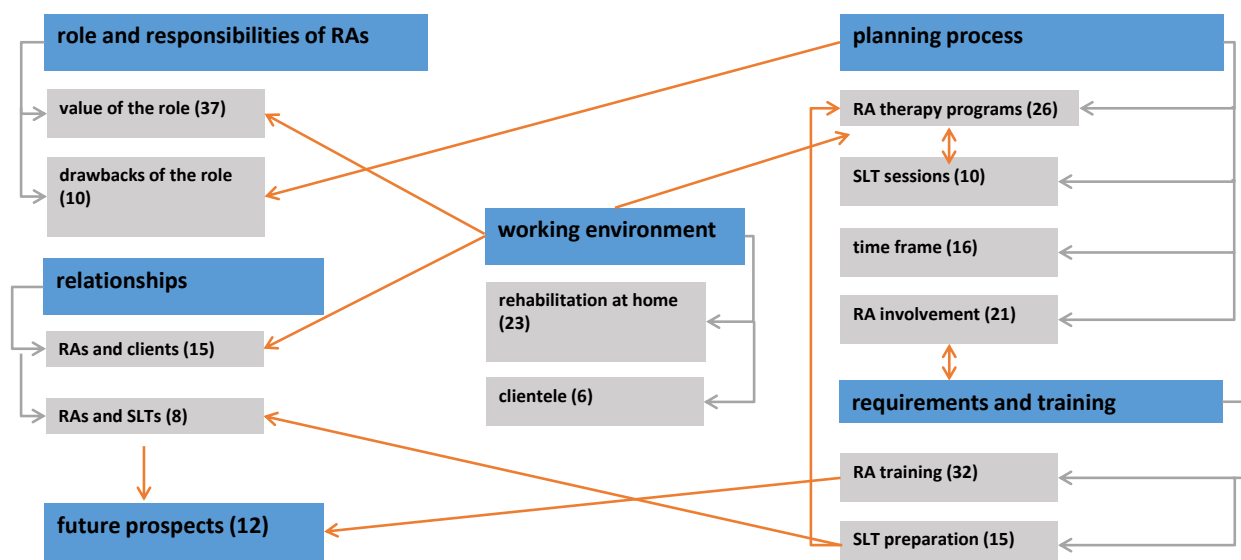


Figure 2: Concept Map of main and subcategories (source: author's own)

Role and responsibilities of rehabilitation assistants

SLTs in CSR believe the main benefit of the RA role is to offer stroke patients a higher frequency of speech and language therapy per week (P1, pos. 17).

“So, if we can use rehab assistants, it means the patients are getting more intensive therapy. Still not up to the standards, but we’re able to provide more than we otherwise would. And then I think it helps them with patient’s outcomes, that they progress quicker as well, and they’re on their best time with us and our team.” (P1, pos. 17)

Participants also felt that the use of RAs enhances patient outcomes as additional therapy time enables them to progress quicker and therefore results in earlier discharges from the CST (P2, pos. 48). Participants furthermore appreciate the fact that due to the RA role, therapists are being “freed up” which allows them to complete new assessments and offer therapy input to patients with a more complex stroke outcome (P1, pos. 17). SLTs regard RA as a profession with a unique, holistic viewpoint who has a varied skill set across three different professions (PT, OT, SLT) (P2, pos. 50). They appreciate their highly flexible expertise and acknowledge the opportunity for RAs to work on functional goals with patients through a unique integrated approach (P1, pos. 51).

According to the perceptions and experiences of interviewed SLTs, the role of RA is particularly useful when performing low skill, repetitive tasks with patients,

as for example in the treatment of Dysarthria (P1, pos. 17). SLTs select patients suitable for RA treatment according to their complexity (P2, pos. 10) and instruct them to motivate and support clients as well as to provide adequate feedback during SLT input (P3, pos. 26). The delegation of low skill tasks to RAs ties in with insecurities of questioned therapists regarding suitability to perform SLT specific tasks. Participants perceive it as challenging at times to choose RAs who are confident in carrying out cognitive and/or language-based therapy tasks (P1, pos. 49).

“So, some might be more suited to doing physical therapy or maybe wouldn’t have the skills, natural skills in delivering cognitive or language therapies. So, we do tend to try and place rehab assistants into the roles where we think their strengths are, then that often means that some therapies are limited, you know.” (P1, pos. 49)

Another mentioned drawback is the difficulty in retaining AHP support staff. SLTs feel that the process of training assistants to a high level is lengthy and oftentimes time consuming and expressed their frustration of staff then deciding to move on or pursue further education (P1, pos. 47). As a solution questioned SLTs advocated for an increased effort to be approachable and supportive of RAs as they recognise the importance of the role for stroke patients and the interprofessional team alike (P2, pos. 52).



Planning process

The overall process of planning SLT sessions for RAs is perceived as lengthy and taxing. Frequent necessary adjustments were described as time-consuming, and participants feel it is at times a challenge to “plan for two” (P1, pos. 4). Allocated planning time is perceived as inadequate. It is their impression that planning RA therapy programs can add additional pressure (P1, pos. 6).

“Yeah, the appreciation that creating programs isn’t just: “Well, there you’re done.” And, you know, particularly with speech therapy, you know, there’s an awful lot of thinking through, figuring out what’s going on. “What’s actually helpful for this person?” “How can I make this functional?” You know, there’s so many elements of it to think over.” (P2, pos. 16)

According to participants, SLT led therapy content often mirrors the rehabilitation program carried out by a RA, though usually includes some assessment and more challenging tasks (P3, pos. 20). Research participants expressed their desire to have more overall planning time, for RA and SLT led sessions alike (P2, pos. 16). Especially during a high influx of new referrals, planning time can be sparse which results in some instances in reduced therapy input for patients conducted by SLTs (P2, pos. 12). It is the therapist’s impression however that time invested for drawing up therapy plans for assistants is nevertheless valuable, as patients receive a higher frequency of therapy input in the long term (see *ibid.*). Participants reported that it is expected of them to plan as part of their administrative duties. They feel that their workload in this matter is often not appreciated (P1, pos. 6). Allocated planning time for their sessions but also to create rehabilitation programs, is a wish all three participants expressed (P1, pos.8; P2, pos. 16; P3, pos. 8). It was also mentioned that patients, especially within the first few weeks after the stroke event, at times recover quickly. Therapy plans require frequent reviews and updates (P2, pos. 12). This can add additional pressure on planning time and raises the question of whether the involvement of an assistant is a viable option in this case. It is also perceived as problematic to meet assistants face to face for a formal handover of therapy programs caused by inconsistent work schedules and logistical challenges (P2, pos. 14). SLTs reported to be appreciative of RA feedback regarding the patient’s progression, new observed medical issues or other social or family matters (P3, pos. 22).

“They can be our eyes and ears when they’re out there you know if they’re reporting back things that are very helpful.” (P3, pos. 52)

This impression highlights a complementary collaboration between therapists and assistants, with a focus on patient well-being and progress. However, organisational challenges and time constraints can negatively impact these experiences.

Requirements, training, and preparation

In the interviewed SLTs experience, RAs often come from a diverse professional background (P3, pos. 42). It was reported that candidates require previous experience in a patient-facing role (see *ibid.*) before attending a standardised training format through educational videos as well as observing AHP led therapy sessions (see *ibid.*). Full training days for all RAs, where profession-specific input is being offered (P1, pos. 37), are also being perceived as beneficial, and SLTs expressed that they would like to be able to offer these development opportunities more frequently (P1, pos. 41).

„So that happens every so often, where we provide training in a certain area in order to meet those competencies. It is the rehab assistants, you know, their responsibility really to take ownership for those competencies and to be coming to the therapist asking for opportunities to shadow or to get them signed off if they’ve been, you know, doing those things. So, it is quite hard to monitor or, you know, you’re relying on the rehab assistants to keep those updated. So that’s what we’re finding challenging.“ (P1, pos. 37)

In due course, it is the RAs’ responsibility to work through competencies within all three professions (P1, pos. 37). SLTs reported that they rely on assistants to work through the competencies and training independently, which, in their opinion, is hard to monitor and can therefore lack transparency (see *ibid.*). It was also noted that a shift to more practical input through “shadowing” therapists or acquiring coaching skills through training might be more useful than paper based or video education (P3, pos.34). Participants expressed that they felt unprepared when starting out in their current roles to work with the support of RAs as no or sparse training was offered during their professional education that could have prepared them for this collaboration (P1, pos. 33; P2, pos. 54).

„I don’t think, I was prepared at all for supporting RAs because not all speech therapy posts would use assistants. I don’t think it was covered at our university degree, but it wasn’t until I started in the post. I just developed the skills then and delegating to rehab assistants, handing over programs that can be quite difficult when you start out working.” (P1, pos. 31)



Some participants entered their current role coming from a post where assistant roles were not common and it was their impression that preparation during induction was not sufficient (P2, pos.38). Participants expressed that a generic template for therapy plans as well as information regarding common practices for the use of RAs within the team would be helpful when starting out and would support them in a positive and effective collaboration with assistants (see *ibid.*).

Unique working environment

As the setting of the research project at hand is in a Community Stroke Team, it was, among other things, essential to examine SLTs' impressions and experiences that refer to this unique environment and the role of rehabilitation assistants who work in it.

SLTs identified several benefits and drawbacks of offering therapy in the patient's home environment. It was regarded as positive for patients to be in their familiar environment which allows for more natural conversation and privacy often with family present who can support them if necessary (P3, pos.30). Participants also observed that patients gain back independence quicker and appear more relaxed in their home (P2, pos. 28).

SLTs also pointed out that all members of the CST carry out therapy sessions mostly on their own which can bear risks and eliminates the backup of other professionals as it is the case for example in a hospital or outpatient centres (P3, pos. 32). This is particularly challenging for inexperienced staff members of all professions (see *ibid.*).

"It can be challenging because you don't have the backup of like other professionals. There's no doctors or nurses around if something happens... Like if people have had a stroke, they're at risk of having another stroke, especially in the first month or two...and you've nobody to ask: "Is this okay? Should I call somebody?" You know, especially in some of the places we go to where the signal even on your phone might not be very good, you know, you're totally on your own." (P3, pos. 32)

It is the impression of SLTs that all points mentioned above need to be taken into consideration when allocating an assistant to carry out rehabilitation programs. Participants stated that geography (keypads, distance between visits) and logistics (therapy resources, devices) need to be carefully considered during the planning process, and the safety of staff must always be a priority (P2, pos. 30).

It was reported that the client demographic is diverse, with patients ranging from 30 years old to 90 years or older (P2, pos. 24).

"We've had quite a wide range. In recent months, we've had from 30, young 30s right up to late 90s. So, our demographic is quite huge. And obviously this brings different challenges because a 30-year-old has very different goals to a 90 year old." (P2, pos. 24)

This means that goal setting can be very diverse and needs to be tailored individually to the patient's personal circumstances. Interviewees furthermore described that the team's clientele presents itself not only with varied needs and cognitive presentations but also has very different backgrounds, often with several other underlying medical diagnoses (see *ibid.*). It could be interpreted that this clientele especially benefits from additional therapy input offered through RAs, as presentations are often severe and require intense and frequent rehabilitative intervention. From a SLTs point of view it requires mindful planning and intensive assessment as stroke complexity and impairment severity has been described as one of the main factors when considering RA allocation (P2, pos. 10). In particular inexperienced staff members could be overwhelmed which can lead to dissatisfaction of service users and have a negative effect on the patient's rehabilitation process.

Relationships

As described, RAs usually encounter patients more often than SLTs, and it is the participants' impression that this leads to an overall better rapport with clients (P1, pos. 27; P2, pos. 32).

"I think rehab assistants tend to develop better rapport with patients because they're often seeing the patient more than the therapist. They have that opportunity to develop a better relationship and especially if the rehab assistant is providing other therapies, you know, OT, physio and speech therapy. They could be in the house quite regularly during the week, so I think they're able to develop a good rapport with patients." (P1, pos. 27)

They feel that patients are more relaxed with assistants as they know they are not being tested or assessed (P3, pos. 36).

The interviewed therapists also reported about positive feedback from clients themselves who mostly appreciate the "extra input" and perceive assistants as personable (P2, pos. 26 & pos. 32). Though it was also described that some patients do not recognise the difference between a trained AHP and support staff which can lead to confusion as clients might have higher expectations of assistants that they cannot fulfil (P1, pos. 29). It was furthermore



mentioned that in their experience at times stroke patients feel that they receive inferior treatment if a trained SLT is not seeing them (see *ibid.*).

Participants feel that they have good, open and supportive relationships with the RAs of their team (P1, pos. 57). During the analysis, it stood out that all SLTs expressed their dependence on assistants (P1, pos. 55; P2, pos. 48; P3, pos. 52) which ties in with the described shortage of AHP staff and the pressure this shortfall puts on trained therapists who are currently unable to offer stroke patients adequate therapy frequency without the support of RAs.

"I think I'd be lost without them. Yeah, like it's, they're definitely invaluable to us as therapists, to the patients. They can provide a really good service." (P3, pos. 52)

"I depend on RAs. I couldn't manage without rehab assistants. So, I think they're very valuable." (P1, pos. 55)

"I would say that if I did not have rehab assistants, patients and their families would be complaining about me a lot." (P2, pos. 48.)

Participants feel that it can be challenging and time consuming to train assistants (P1, pos.55). However, they reported during interviews that they wish for more time to delegate, train and supervise RAs adequately (P2, pos. 16). They feel that assistants are invaluable for the success of the team as a whole and for the therapy outcome of stroke patients under their care (P1, pos. 55). As an outlook they perceive that it is imperative to be approachable and open for questions but also to offer frequent and current training in order to be able to retain qualified support staff (P2, pos. 52).

Future prospects

It was described that it is the long-term goal of the NHS to employ more trained AHP staff, whether this is through traditional university degrees or through alternative apprenticeship routes. Given the drastic demographic changes in the coming years, it is also unavoidable that more support staff in various roles, as RAs, are needed to cover the needs of the services.

"From a therapist perspective, ideally, we would love, you know, a therapist who is able to assess and do swallow therapies and manage swallow patients. So that would be the preference. But also, I think a band four can develop the skills to a high level. And often, I've seen band fours who have been at a better level really than a band five therapist (laughing). So,

I think they're bringing in apprenticeships more into speech therapy and I think that's a good thing because there's a lot of rehab assistants that are highly skilled that, you know, they could be developed more." (P1, pos. 59).

Research participants are supportive of this future prospect (P2, pos.52; P3, pos.54). They ideally would prefer to have more trained SLTs on their team who can support them in assessments and carry out more complex therapy content (P1, pos. 59). However, they are aware of this not being feasible with the current pressure on the health service (P2, pos. 52). SLTs reported that the NHS pay scale is supposed to be pyramid shaped which means more support staff is being employed than registered staff with higher pay bands. They recognise the economic benefits (P3, pos. 54). Interviewees feel that more alternative routes to reach higher pay bands should be explored in the future (P1, pos. 59).

Participants have experienced highly skilled assistants and expressed that there should be opportunities in place for them to progress further without having to attain a university degree (see *ibid.*).

DISCUSSION

Role and responsibilities of rehabilitation assistants and future prospects

Participants perceive the value of the RA role as very high, as it enables them to offer stroke patients in Community Rehabilitation a higher frequency of speech and language therapy per week. The treatment frequency is a crucial factor, particularly in the treatment of aphasia (Brady et al., 2010), as intensive treatment is reported to be more effective for recovery compared to a less intensive treatment schedule (Kelly et al., 2010). Research participants believe that more frequent rehabilitation input leads to a quicker progression of clients and, consequently, an earlier discharge from the CST. The described dependence of participants on support staff correlates with the earlier described AHP staff shortage across the NHS. Demographic changes in the UK population, along with a shifting burden of disease, are likely to put further pressure on health services in the coming years (Fahy et al., 2011, p. 1). This may potentially increase the importance of support roles, such as RAs, in the future (Lizarondo et al., 2010, p. 144). The SLTs expressed sympathy towards this future prospect, as they recognise the economic advantages and the importance of support staff roles for service users. The opinions of SLTs who are supportive and appreciative of the RA role can offer valuable insights for countries facing similar challenges within their healthcare



systems but have not yet introduced assistant roles. It was furthermore established that SLTs regard RAs as a profession with a unique, holistic approach that can offer integrated, patient-focused therapy with functional goals in mind. This observation was confirmed by Knight et al. (2004), who described that RAs have a good overview of the rehabilitation process and their role can serve as a link among all disciplines within the multidisciplinary team. In this case, participants were primarily engaged in caring responsibilities and physical therapy, and reportedly had limited contact with speech and language therapy (Knight et al., 2004, p. 311). Notably, studies in the current literature have examined either multidisciplinary roles with a focus on physical therapy and/or caring responsibilities (Knight et al., 2004) or SLT-specific assistant roles (Wenke et al., 2014). In the context of this research project, RAs conduct therapy programs for three different professions (PT, OT, SLT), which require a varied skill set and a flexible work approach. These abilities, unique to RAs, are highly valued by participants but also raise questions about the adequacy of SLT therapy input.

In the questioned therapist's experience, the use of RAs is reasonable when carrying out high-frequency, repetitive tasks, as it has been proven to be effective, for example, in the treatment of dysarthria (Mahler & Ramig, 2012, p. 685). Exercises carried out in physical therapy after a stroke are also often geared towards frequent repetition (de Sousa et al., 2018, p. 210), which is why it appears sensible to work with the support of assistants. Participants in this study believe that conducting SLT therapy programs, particularly for the treatment of language disorders, requires a distinct skill set and professional experience. This was confirmed by Wenke et al. (2014), who stress that merely treating lower-level aphasia, where categorical or hierarchical tasks are carried out, is recommended for assistant-led sessions. This limits SLTs in their choice of suitable clients for RA-led sessions and raises the question of whether assistants should be trained in one specific AHP field according to their natural skill set and interests, rather than having to be proficient in three professions with very different requirements.

Planning process

Participants reported that they feel they are being “freed up” by the support of RAs, which allows them to focus on new assessments and offers the opportunity to carry out therapy for stroke patients with more complex needs. These findings align with insights from the conducted literature review (Lizarondo et al., 2010, p. 143; Nancarrow et al., 2005, p. 2), but offer a different perspective on the research, as the qualitative study at hand focuses on Community Rehabilitation rather than

hospital care. Several findings are unique to this working environment and therefore add new insights to current research. According to participants, the safety of support staff, as well as logistical challenges and geography, must be considered by SLTs when planning therapy sessions for RAs. It is crucial to consider the potential drawbacks of home rehabilitation and prepare assistants accordingly. Extra sessions where the AHP accompanies the assistant for visits, but also the careful selection of suitable clients for RA-led SLT sessions according to their complexity and needs, require additional planning time, which is distinctive to the examined Community Stroke Rehabilitation setting. Participants reported that “planning for two” can be challenging, but it also supports the planning process of their own sessions at times. According to SLTs, thorough planning and well-thought-out therapy programs enable patients to receive more frequent therapy input, which, in their opinion, compensates for the increased administrative duties. They perceive the planning process as time-consuming, but also expressed their wishes to have more allocated planning time on hand, particularly to support RAs efficiently and improve communication with support staff. Increased allocated planning time could therefore improve treatment outcomes as SLTs reported to rely on feedback from assistants regarding the patient's development and described RAs as their “eyes and ears”. More planning time might be associated with higher costs, as concluded by Wenke et al. (2014, p. 8), but it may also lead to better patient outcomes and higher job satisfaction among trained AHPs, as well as support staff.

Requirements, training, and preparation

In the eyes of participants, it is currently difficult to retain skilled RAs. It was reported that support staff, once they reach pay band four, currently have no way of further professional development without pursuing a university degree. The described AHP staff shortage and the high turnover of support staff are interrelated with the participants' impression of the necessity for reforming these policies. It is the interviewed SLTs' impression that highly experienced support staff would be suitable for progressing in their careers, for example, through apprenticeships or training programs. Training and requirements for support staff currently vary widely across the UK (Nancarrow et al., 2005, pp. 4-5), and different roles with divergent job responsibilities are found in the current literature (see *ibid.*, p. 1). Variations in the role appeared to be a consequence of the demands of the organisational context and the relationships between assistants and the associated professionals. In this research project, it became apparent that training for RAs is offered similarly across all three professions,



comprising online training, initial “shadowing” of trained AHPs, independent completion of profession-specific competencies, and internal training days. Participants expressed a desire to offer more SLT-specific training days and provide practical support for assistants. It was also reported that the completion of required competencies is hard to monitor and is currently not transparent enough. Specifically, for the SLT field, it appears important to participants to equip assistants with practical and profession-specific skills. This again begs the question of whether a SLT-specific assistant role, which allows staff members to be trained to a higher level in one profession, could be more beneficial for patient outcomes, but also staff satisfaction. This would also eliminate the issue of role confusion and feelings of inadequacy by RAs, due to the multidisciplinary nature of the work, which was concluded by Knight et al. (2004, p.315). The SLTs themselves, for this study, felt unprepared to work with the support of RAs, as no or very little insight into the collaboration with support staff was offered during their university course. They expressed that an introduction to the role and responsibilities of RAs when starting in their current job role, as well as the use of a standardised template for therapy programs, would have been beneficial for them, as not all posts work with RAs. These perceptions can also be found in the reviewed literature, where the lack of clarity among staff in terms of the scope of the assistant’s role was described (Conway & Kearin, 2007, p. 188). Clarifying the assistant’s role and outlining expectations for both professions, but also facilitating adequate preparation during SLTs’ professional education, appears especially important as the number of support staff is likely to increase in the coming years, and more posts will require SLTs to cooperate with assistants on a day-to-day basis.

Unique working environment

This research project examined SLTs’ perceptions of their cooperation with RAs who exclusively work with a specific patient group. Participants reported that stroke clients, who are being referred to their team, come from a varied demographic background, oftentimes with underlying health conditions and complex needs. The vulnerability of clients and complexity of their impairments speak for a more frequent therapy input facilitated through RAs, but can also bring challenges for inexperienced support staff members. The described unique working environment in the patient’s home, but also the often complex needs of stroke survivors, can bear more risks and challenges and therefore require a more extensive preparation for SLTs and RAs alike. These findings stand in strong contrast with research that has been conducted, for example, within an inpatient (Knight

et al., 2004) or a paediatric language therapy setting (Boyle et al., 2007; Dickson et al., 2009).

Relationships

Because of frequent home visits, participants perceive that RAs often have a better rapport with patients. They feel that clients are more relaxed within their familiar home environment, but also experience assistant-led sessions as less formal. This can lead to a more casual therapy environment, but can also result in patients perceiving that they receive inferior treatment when RAs are carrying out sessions. In turn, though, participants also experienced that some patients did not recognise the difference between a trained AHP and an assistant, which led to higher expectations that an assistant cannot fulfil. The described findings can also be found in literature (Conway & Kearin, 2007, p.188; Knight et al., 2004, p.315), where a lack of clarity amongst staff in terms of the scope of the assistant’s role, unrealistic expectations of RAs, and feelings of inadequacy are commonly reported. It is therefore crucial to define the responsibilities of the RA role clearly from the outset, so that SLTs can plan accordingly. This clarity is also essential for patients to avoid disappointment and for support staff to reduce feelings of inadequacy.

STRENGTHS AND LIMITATIONS

The authors aimed to assess the quality of this research project using criteria unique to a qualitative methodology, as personal experiences and impressions were examined, which aligns with a naturalistic paradigm (Guba, 1990). Among these, the criteria of *credibility*, *transferability*, *dependability*, and *confirmability* (Guba & Lincoln, 1989) are well-known in the pursuit of trustworthy research. Megheirkouni and Moir (2023) updated and simplified these well-established criteria for examining the trustworthiness of this exploratory qualitative study, using their “Simple Quality Criteria for Qualitative Research” (see Table 4 in the [supplementary material](#)). Firstly, the methods used speak in favour of *credible* results, as prolonged engagement, especially through the relationship between the interviewer and participants, as well as through persistent observation and referential appropriateness, was strictly adhered to. Although the already existing relationship between the first author/interviewer and the participants also has to be viewed critically. The power differentials in relationships, as well as the risks of assumed understanding and over-disclosure due to shared experiences, are well-known risks associated with interviewing within one’s community (Aburn et al., 2021, p. 3). The strategy of triangulation had to be neglected due to time constraints, and therefore,



the author was unable to employ a multiplicity of sources, methods, and investigators.

For this small-scale research project, the criteria of confirmability had to be also neglected, although ethical standards and scientific merit had been ensured at all times. The strategy of member checking was nevertheless largely fulfilled, as the second and third authors continuously reviewed the collected data, as well as the research process, to challenge the first author's assumptions.

Data and participant representativeness were ensured, as both represent the phenomenon under investigation and are suited to the author's intention to explore and understand the research question at hand.

Although a sufficient amount and range of data could be collected from the interviews, data saturation cannot be assumed. To increase the possibility of generating new findings, at least two discussion rounds in the form of focus groups with different target groups (e.g. support staff, SLTs, physiotherapists, occupational therapists, patients and their relatives) should be carried out in follow-up studies (Kühn & Koschel, 2018; Vogl, 2019). Due to the small number of research participants, the results of this qualitative study should be regarded as preliminary indications and are subject to further critical examination. In addition, this study only examined the perceptions and impressions of SLTs working in one CST in Northern Ireland and is therefore not generalisable to other settings or countries; however, it can still serve as a possible source of inspiration for these countries. This means that the project carried out is context-specific, involving only one institution and a small number of participants. The limitations mentioned are therefore clearly at the expense of generalisability but may have implications for broader implementation.

Since the coding process was conducted in collaboration among the authors and not independently, no statement can be made regarding intercoder reliability, meaning it is unclear to what extent similar results were obtained. Therefore, the results should be considered subjective, as they are based on the individual interpretations of the authors. The collected data effectively serves the author's goal of exploring and understanding the research question. Thus, it can be concluded that the research question has been satisfactorily addressed, as a diverse range of impressions and personal experiences of SLTs working with RAs in CSR has been thoroughly examined and summarised. The presented findings can encourage further research and offer some insight for international healthcare systems outside of the UK, where support staff roles are not yet the norm.

The results could also provide food for thought, particularly for the German healthcare system, where the authors have extensive clinical experience in inpatient

and outpatient settings. The German healthcare system is also struggling with a shortage of qualified staff. Although the number of academic speech and language therapists (SLTs) has increased over the last 20 years (Schwarzmann et al., 2018, p. 22), demand remains high due to an aging population and growing health awareness (Waltersbacher, 2024, p. 23). Alarmingly, 37% of qualified therapists are considering changing careers, mainly due to inadequate remuneration and limited prospects (Berger et al., 2018). The introduction of assistant roles, such as the rehabilitation assistant position analysed in this study, could expand therapy options and alleviate the pressure on qualified therapists. Overall, the study indicates that policy adjustments are necessary to address staff shortages and enhance job satisfaction, thereby ensuring the quality of SLT services in the future.

CONCLUSIONS

It has been established that current literature rarely focuses on collaboration with assistants from the SLT's perspective. Specifically, the use of RAs as a role with interprofessional responsibilities and the effects of that on SLT therapy are an overlooked topic in research. The findings of this qualitative study suggest a positive impact on stroke patients resulting from an integrated approach by RAs to the rehabilitation process. Due to the specific skill set required to carry out SLT therapy programs, questions arise about whether an intraprofessional role supporting SLTs alone could be more appropriate in this context. Furthermore, improvements regarding SLT-specific training provided for RAs, as well as necessary preparation for SLTs to collaborate with assistants, need to be taken into account. This is necessary to improve staff satisfaction and, therefore, much-needed staff retention, as well as to enhance the service user experience and therapy outcomes. Apprenticeship routes into AHPs should also be considered to offer opportunities to highly skilled assistants and counteract staff shortages within the NHS.

This research project describes new insights into planning processes of SLTs as it explored the unique setting of CSR which comes with a variety of challenges that research conducted in a hospital (Knight et al., 2004) or a paediatric language therapy setting (Boyle et al., 2007; Dickson et al., 2009) cannot offer. It was concluded that, particularly, the safety of staff, logistical and geographical challenges, as well as the complexity and variety of the clientele, are to be considered by SLTs who plan for RAs. These factors can add pressure to already sparse planning time and call for improvements to current workflow expectations. The positive stance of SLTs towards the likely prospect of an increased number of support staff in the future speaks for the importance of



the RA role for the NHS. These insights can also serve as an indicator of change and progress in other countries where AHP assistant roles are not yet a common practice. Three different approaches to future research are being regarded as desirable:

- Home rehabilitation settings should be examined further as demand for community care increases (Duckett et al., 2014, p. 3); however, the role of RAs within this work environment from an SLT perspective has not been sufficiently explored.
- The effects of RA conducted SLT therapy in the context of stroke outcomes should be quantitatively examined to conclude if a decrease in responsibilities of the RA role is necessary to ensure adequate therapy quality.
- Further qualitative insights from the perspective of RAs could be valuable to examine their viewpoint and gain a deeper understanding of how they perceive navigating a multitude of responsibilities and the effects of this on their job satisfaction.

Further research, employing a multi-method approach (triangulation), could yield additional insights through observations or quantitative data (Bans-Akutey & Tiimud, 2021). The inclusion of objective outcomes (e.g., higher treatment frequency, faster achievement of treatment goals, higher patient satisfaction) could significantly improve the results, as these are primarily based on self-reported changes. In addition, it would be beneficial to consider the patient's perspective in research, particularly in terms of the shared decision-making process and orientation towards the International Classification of Functioning, Health, and Disability (ICF) (Hinckley & Jayes, 2023; Feistauer & Lücking, 2025; McCormick et al., 2017).

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Ethical approval, registration

As persons capable of giving consent and not vulnerable people took part in the study, no full application was required for the study project.

The participants were informed both verbally and in writing about the aim, procedure, and benefits of the study, and they provided written confirmation of their consent. The data collected was pseudonymised during transcription and then anonymised.

Conflicts of interest

None.



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