NHS Governance – Clinical Governance
Royal College of Speech & Language Therapists

The Royal College of Speech and Language Therapists (RCSLT) represents approximately 1,400 Speech and Language Therapists (SLTs) and SLT Support Workers in Scotland. Around sixty percent of the SLT workforce work for children and young people from early years to teenagers with parents at home, in nurseries and schools. Forty percent work with adults at home, in care homes and acute care settings.

As the professional body for SLTs we work to promote excellence in SLT practice and service provision for the estimated 250,000 Scots with speech, language and communication needs (SLCN) and the many thousands with eating, drinking and swallowing difficulties.

In responding to the Committee’s inquiry we contacted speech and language therapy services in each health board area with the six questions. In total six services were able to respond, their respective health board areas serve a total population of over 3.3 million people.

1. Are services safe, effective, and evidence-based?

The responses we have collected from RCSLT members working in Speech & Language Therapy (SLT) services around Scotland indicate that SLT services are safe, effective and evidence-based.

There is a view however that maintaining these standards is now more challenging due to:

- the increasing level of input required for some service users
- requirements to respond urgently to keep people at home and prevent hospital admission
- restrictions in service capacity including frozen budgets, efficiency savings, staffing numbers and skill mix.

One example of this challenge is in children’s services. SLTs are being directed to increase their input at a universal (population) level of service where before work was primarily at a specialist (individual) level. The evidence base supporting effectiveness of universal provision is not well developed.

Another example of challenge is the impact on Continuing Professional Development (CPD) required to meet registration standards across services. Many SLT services are being creative with limited budgets to access more ‘general’ CPD and training.
opportunities rather than the specific professional opportunities they used to access to improve clinical practice.

There is a strong opinion across SLT services that as roles become more universal and population focused, and as resources for professional development remain static or are reduced; supporting the evidence based practice expected of therapists is becoming more challenging.

SLT services identified a number of steps they routinely take to maintain safe, effective and evidence based practice:

- Health Care Professions Council registration routinely checked
- As part of HCPC registration SLTs are required to complete and confirm they have completed CPD requirements
- All practitioners get clinical supervision, CPD support and learning opportunities
- Care and care quality is reviewed through caseload management
- Clinical leads and professional managers responsible for governance of evidence based practice
- Audits of case records
- Use NHS Knowledge and Skills Framework
- Team leaders are Health & Safety Control Book Holders, risk assessments regularly carried out
- Use incident reporting systems such as DATIX, Safeguard
- Mandatory training on H&S is provided and monitored through performance management
- Use of outcomes frameworks such as ‘TOMS’ to assess effectiveness and ‘Care Aims’ to support clinical decision making
- Access professional body resources including evidence based clinical guidelines and service standards
- Health Boards apply Patient Safety and Quality programmes
- Care Assurance and Accreditation Systems
- Communicate with other professionals using SBAR (Situation Background, Assessment, Recommendation)
- Team review of evidence, national strategies and guidelines

2. Are patient and service users’ perspectives taken into account in the planning and delivery of services?

SLT services are regularly incorporating patient and service users’ perspectives into planning and delivery of services, particularly for those who have SLCN (Speech, Language & Communication Needs). A range of approaches are being taken but they may not be applied consistently across the country or even within the same Health Board area due to the way in which guidance is interpreted and the variations in Board policy, priorities and approach.

At the level of individual care planning:
Therapists focus on ‘patient story’ at first appointment and seek to establish patient / carer perspective
Focus clinical assessment on what matters to the patient
Care planning is collaborative and person centred goals are formed
Make use of Augmentative and Alternative Communication (AAC) methods, for example Talking Mats, to gain views (at the end of this response we have included a case study from NHS Lanarkshire on how they used ‘Talking Mats’ to evaluate a service from a user’s perspective).

At the level of service planning:

- Complaints and comments leaflet, patient satisfaction questionnaires are used and monitored
- Service planning events organised when changes happen
- Connect with civic organisations on strategic planning issues
- Lay representation on review boards
- ‘You said, we did’ boards used in hospital settings
- Varied patterns of focus groups
- Patients can usually ‘self refer’ to an SLT service, this empowers individuals to access support when they need it.

3. Do services treat people with dignity and respect?

People with communication disability and / or eating, drinking and swallowing (EDS) difficulties present particular and fundamental challenges to health and social care services given so much of that care is mediated through communication between patient and provider and can involve oral consumption of food, fluids and medication.

SLTs are aware that the appropriate communication supports and the skills and resources to support individuals with EDS difficulties are not always readily available to individuals and their families. For this reason patients may not experience being treated with the dignity and respect they should expect.

Treating people with dignity and respect is very much at the core of Speech & Language Therapy. The first section of the HCPC’s Standards refers to the promotion and protection of the interests of service users and carers and defines this in terms of respect, confidentiality, person centred care and challenging discrimination.

SLT practitioners are expected to proactively seek patient feedback and services plan their development based on feedback. Vulnerable patients, families and communities are supported to access services using a range of methods, including use of interpreters and bilingual support workers to engage with Black & Minority Ethnic (BME) families.
Practitioners and all staff in services are aware of their wider duties under the Patients Rights Act, Charter of Rights and other responsibilities. Children’s services are also aware of the UN Convention on the Rights of the Child and its implications. In addition Health Boards promote their own values statements that they are expected to apply.

Access is available to equality and diversity training though this may not be compulsory in all areas.

4. Are staff and the public confident about the safety and quality of NHS services?

SLT staff are confident about both safety and quality of their services but recognise there may be a wider public reaction to ‘bad news’ stories in the media about the NHS generally.

Use is made of confidential staff surveys and regular case capacity meetings that explicitly ask about workload issues that may affect safety and quality.

SLT services support an open culture for their staff to raise any issues and regularly seek feedback from the public who uses their service, including the use of different communication methods (AAC) to get feedback from client groups.

RCSLT stress that the capacity to maintain safety and quality is dependent on the financial budget and subsequent workforce available to deliver that service. As indicated above capacity is coming under significant and increasing pressure.

5. Do quality of care, effectiveness and efficiency drive decision making in the NHS?

From the perspective of Speech & Language Therapy services, clinical focus is firmly on person centred care planning, patient centred outcome setting and efficient timescales for the delivery of services.

The challenge of working efficiently and within resources has become greater. Health Boards are now making greater use of locality profiling to identify need and at same time undergoing efficiency programmes. There is a strong feeling that services are now at or are reaching a point where efficiencies will affect the quality of care delivered.

SLT services are being challenged to work differently, for example to increase universal activity and targeted levels of care, and to continue using resources that are the same or reducing.

In the long-term service redesign activity should be beneficial to all individuals with SLCN but SLT services are currently stressed by a lack of resource to meet their current commitments, efficiency savings and new methods of delivery.
Integrated Joint Boards (IJBs) are also beginning to set the direction for services and this is likely to increase for adult services in particular. There is an increasing challenge as SLT services are adapting to new structures and are increasingly managed by non SLT leads which is changing the way in which services develop.

6. Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?

The view from SLT services is that the correct systems are in place to both identify and address problems.

As mentioned previously case management meetings and planned clinical supervision are used to identify or raise concerns around poor quality care, along with auditing of case notes. This is evidenced in care gaps, a lack of care planning, non collaborative practice, inappropriate clinical approaches and ‘caseload drift’.

Both Informal and formal processes are led by the leadership teams who have a specific remit for quality care, including the use of audit. Health Boards have a governance framework in place which all services are required to report on and are accountable for the delivery of governance.

For when things do go wrong, mechanisms are in place for learning and also dealing with competency. Practitioners are also aware of the Duty of Candour.

RCSLT and the other Allied health Profession (AHP) bodies have in the past highlighted to the committee that AHPs are not directly represented on NHS Boards or Integrated Joint Boards and can be poorly integrated into multidisciplinary teams. Informed clinical governance at a strategic level, which is at the heart of safe and effective practice, is needed at an organisational level for AHP services and their service users.

Recommendations

Based on our consultation responses RCSLT Scotland would make the following recommendations for improving clinical governance for the Committee’s consideration.

1. Within the rapidly changing landscape of health and social care provision, there is clear strategic leadership identified for clinical leadership of the Allied Health Professionals group in Health Boards and Integrated Joint Boards / Health & Social Care Partnerships.

2. An appropriate balance is struck between general and profession specific CPD and training, with the value of profession specific development being recognised as continuing to be of importance to standards of clinical practice.
Case Study – using Talking Mats to evaluate AAC services in Lanarkshire

BACKGROUND
Talking Mats devised a set of 10 key quality indicators\(^1\), in consultation with people who use AAC (Augmentative and Alternative Communication). These were subdivided into 3 categories:

A. People who work with me:
   1. Training
   2. Values
   3. Being put in touch with other AAC users

B. How information is provided:
   4. Information about the AAC team
   5. Information about timescales, the assessment and funding process
   6. How information is shared
   7. How information is presented

C. The process (how AAC services work):
   8. Equal access to funding and services
   9. Access to equipment and expertise
   10. Ongoing support

They then devised a set of symbols and a supporting script to use to interview people who use AAC in order to mark our service on the above 10 indicators\(^2\).

THE INTERVIEW
Mr G is a 25 year old man with cerebral palsy. He uses speech to communicate with his family face to face, however he has severe dysarthria (motor speech impairment) so cannot be understood by others. He was assessed in 2015 and was provided with a Gridpad 11” tablet\(^3\), the Grid 3 software\(^4\) and a switch, so that he can operate his device with his knee or foot. He previously did not use any form of AAC and relied on family members to ‘translate’ for him.

A Service Review interview was carried out in June 2017 using the ‘Talking Mats AAC Feedback’ resource\(^2\). Mr G was asked to indicate if he thought things were ‘going well’, ‘not going well’ or if he was ‘unsure’. Mr G, his mother and father all participated in the interview.

RESULTS

People who work with me:
Mr G indicated that he felt most things were going well. He was unsure about the level of training provided to his family and felt that training for people in his local environment (e.g. shop keepers, taxi drivers) was not going well. Mr G’s mother felt

\(^2\) [http://www.talkingmats.com/right-to-speak-scotland-legacy/](http://www.talkingmats.com/right-to-speak-scotland-legacy/)
\(^3\) [www.thinksmartbox.com/products/grid-pad/](http://www.thinksmartbox.com/products/grid-pad/)
that they would like more regular contact with SLT and the rep/technician from Smartbox. She felt that her son gets frustrated when things change (in relation to new developments/updates of the software), and his father agreed that Mr G is often left with a problem, rather than a solution.

**Information and how AAC services work:**
Mr G agreed that most aspects were going well. He stated that the assessment process was “amazing” but that he would like “more” ongoing support. He was unsure about ongoing support, what to do if his equipment was to break down, or what would happen if his equipment needed replaced.

**Other information:**
Mr G felt that an acceptable length of time to wait from assessment to provision of AAC equipment was six weeks. He felt that, if the process was to take longer, weekly updates on the status of the order would be appreciated, so that he could be fully informed.

**DISCUSSION**
Overall, Mr G was very happy with the service he received. The areas he identified as not going well – Training for the wider community, ongoing support – had previously been identified by the AAC Steering Group in Lanarkshire, and work is being carried out to address these issues.

An AAC pathway for Lanarkshire was developed to give clear information about timescales for equipment provision, ongoing support and review. This document is currently being reviewed and Mr G’s comments will be taken into consideration.

Using the Talking Mats tool was simple and straightforward. The provision of a script aided the interviewer in asking the right questions for valuable feedback. Mr G has a high level of cognitive ability and was therefore able to participate in the interview with minimal support. Individuals with lower cognitive levels may require additional support in understanding the questions asked.

**RECOMMENDATIONS**
Review the AAC Pathway document and include a version for people who use AAC to be discussed at the time of assessment. This should ensure they are aware of targets for provision of equipment and the level of support they should get.

Continue to raise awareness of AAC at a local level with the wider public

Provide training in key local areas to relevant individuals (e.g. libraries, shops)

Improve the level of training and support provided to individuals and their families/carers