Care pathways

Introduction

Care pathways describe the expected sequence of care, designed to lead to positive outcomes for individuals in various care groups and where appropriate within commissioned service provision. Implementation should align with HCPC standards of proficiency, ensuring appropriate assessment, treatment, and management.

Care pathways aim to:

- minimise inconsistencies in local care and outcomes
- provide respectful, culturally responsive, and inclusive support
- encourage collaborative care planning and empower individuals in decision-making

Effective, local-level care pathways must reflect and anticipate the needs of both preventative care and people who have been referred to a service. This includes recognising the vital role of speech and language therapists working with non-referred individuals to support effective communication to safeguard long-term wellbeing. Many service users, whether referred or supported preventatively, have enduring, complex and multiple health and social needs.

From a public health perspective, care pathways should also focus on reducing health inequalities, promoting early identification and embedding communication support across community and universal services. SLTs contribute to public health by working at a universal level. For example, raising awareness of communication and swallowing difficulties, supporting health literacy, and enabling equitable access to services. In this way, SLTs strengthen prevention, promote resilience, and reduce demand on specialist services in the longer term.

These pathways must align with the HCPC standards of proficiency for speech and language therapists, ensuring that all individuals receive evidence-based, person-centred care.

Developing care pathways

Each local area should have clear pathways for each care group supported by speech and language therapy. These pathways must be inclusive and responsive to diverse and complex needs.

Where services are not available locally, pathways should provide access to external specialist provision. Local speech and language therapy pathways should be aligned with existing national or local multidisciplinary guidelines. In the absence of formal guidance, best practice principles and adaptations from related pathways should be applied. Speech and language therapy care pathways should reflect the broader context of collaborative, interdisciplinary care while identifying elements specific to speech and language therapy. Pathways should be adaptable to individual differences such as risk levels, developmental stages, health status, personal preferences and life changes. Regular review and updates are essential to ensure care pathways reflect current research, technologies, and inclusive practices. They must account for all individuals, including those who experience barriers to access or inclusion.

Pathways should be guided by HCPC standards and ethical codes, highlighting the importance of identifying and addressing exclusion risks.

For information about specific client groups, settings or conditions, see the **RCSLT's clinical guidance** pages.

Key elements of a care pathway

A sequence of events occurs on the speech and language therapy care pathway for people who are referred to a service:

1. Referral and triage where required
2. Diagnostic assessment and baseline recording
3. Goal setting and shared planning
4. Episodes of therapy and ongoing monitoring
5. Outcome evaluation and periodic reassessment
6. Transition to self-management/other form of care
7. Onward and sideways referrals with clear criteria
8. Planned measurable discharge

While some aspects may follow a linear sequence, other elements will depend on individual needs and professional judgement.

Screening and referrals

Access to speech and language therapy services requires early identification, clear referral pathways and effective triage

SLTs must use criteria effectively and communicate decisions clearly, with triage supporting clinical decision making and equitable prioritisation.

Referral agents may include individuals themselves, carers, educators, healthcare providers, or multi-agency teams. Information and guidance should be shared across these groups to support access and reduce delays.

Early identification

SLTs should work with local referral agents to ensure:

- effective screening
- a clear referral process into the service

Referral agents may include:

- self-referral
- carers/parents
- general practitioners
- health visitors
- teachers
- hospital medics
- specialist services – such as ENT, neurosciences
- members of multi-disciplinary teams

Ideally there should be a single point of access into the service. Shared referral forms for multiple agency services can help avoid delays caused by professionals having to complete multiple referral forms for different services. Leaflets and guidance documents highlighting the speech and language therapy service should be provided to potential referrers.

Screening services can offer early screening and support resources whilst waiting for full assessment or intervention. This may include proportionate assessment based on need. They can

help streamline services by aiding effective triage onto specific parts of the service pathway (e.g. groups) and aid timely referral on to other relevant services.

Appropriate and timely access

Speech and language therapists should enable appropriate and timely access to their service. Access to speech and language therapy services is equitable, non discriminatory and based on clinical need. The RCSLT recognises the right of every individual to have equal access to the services provided by speech and language therapists however they are aware that not all services are commissioned equally at a local level.

The RCSLT acknowledges the challenges some services are operating within. If your service is facing difficulties meeting the needs of the community it supports or is facing increased risk that cannot be mitigated where a risk assessment and/or quality impact assessment has been completed please refer to the service planning (ADD LINK) and responding to proposed changes to your service (ADD LINK) guidance.

The RCSLT acknowledges the dedication of services working within challenging circumstances, where resources may not always meet the level of demand. We support the principle of focusing resources where they will have the greatest positive impact, enabling services to deliver effective, evidence-based care that leads to meaningful outcomes.

Responding to referrals

The terminology used for referrals to services within the UK may vary depending on the region or service level. They may be referred to as a referral, a request for assistance, or a request for help. Likewise, local guidance on how to respond to these referrals can differ to reflect service-specific procedures. Consult your local policies for service specific detailed guidance and support.

Referral processes should be inclusive, transparent, and supported by clear information. Standard response times must be defined, and services should be prepared to discuss if the service users needs are best met by that service with potential referrers. Open referral systems, where appropriate, allow access from multiple sources. Consent and information-sharing policies must be followed.

This may include transfer from specialist regional units and out-of-area referrals.

An open referral system will operate in many parts of a speech and language therapy service. Where this is the case, referrals will be accepted from any source, including self-referral.

Written information outlining the scope of tertiary services for a specific client group is provided to potential referrers, including other agencies and relevant groups within the general public. This information includes details about the referral process, as well as guidance on re-referring individuals who have previously been discharged from the service.

Standard local response times to referrals will be specified.

SLTs may discuss the suitability of a referral to speech and language therapy with individuals considering self-referral, as well as with professionals who are considering referring someone for assessment.

Speech and language therapy services will need to use a range of methods to help individuals engage with services and provide for timely access and information should be available in a range of formats to address service user and carer's needs. Specialist services for particular client groups may apply locally agreed referral criteria or referral procedures.

Triage/screening assessments

The RCSLT recommends that where triage arrangements are available or required due to the service need, triage assessment enables service users' needs to be reviewed to ensure the appropriateness of the referral and enable initial screening of identified support needs. This grants service users ready access to speech and language therapy services and other appropriate facilities without a lengthy wait. Triage assessment also allows each service to profile the unmet need within any waiting list for therapeutic care. This information can then be used to put forward a case for service development.

Triage enables swift access and efficient service allocation. It helps services understand unmet need and make informed planning decisions.

Triage aims to:

- determine referral suitability
- identify needs and expectations
- share information about service scope
- prioritise according to risk and benefit
- redirect to appropriate services if needed.

Principles of triage

- Triage does not replace the initial assessment stage but complements it. By using triage as a caseload management strategy, therapists can retain an overview of the needs of the caseload as a whole to plan the most effective use of limited resources.
- Experienced clinicians should conduct triage due to its complexity. Any appointments should be timely and accessible. Referral agents should be informed that a triage system is in use so that they can inform individuals/carers at the time of initial discussion with the individual. Triage should be undertaken as soon as possible after the receipt of referral, within local standard response times.

Duty of care

Service-providers hold a duty of care to:

- provide comprehensive services
- demonstrate that the appropriate priorities are chosen within the limits of available resources.
- ensure that individuals on waiting lists are supported to "wait well", with access to information, strategies and signposting that promote wellbeing, reduce risks, and maintain progress while they await specialist input.

Duty of care to service users exists from the moment of referral. More information on **duty of care** is available on the RCSLT website.

Waiting well support may include providing service users, families, carers and professionals with practical resources, advice on communication-friendly environments, and wellbeing strategies that reduce anxiety and safeguard participation. This proactive approach helps to mitigate the negative impact of delays in access, while reinforcing the service's commitment to safe, person-centred care.

Speech and language therapy services must be aware of other facilities within their locality that can support, enhance and assist with the management of those with communication and swallowing disorders. Knowledge of these local facilities should be considered when drawing up local policies related to triage assessment.

Prioritisation

Prioritisation should be consistent, evidence-based, and sensitive to risk, timing and interagency dependencies. Services should avoid group-based prioritisation, instead focusing on individual needs within wider population demands.

Response times will vary according to context, but will normally include a review of the level of risk which may necessitate an **assessment of risk** and as appropriate:

- the need to ensure access to other services
- timescales of other agencies

In these ways, service prioritisation policies will take account of the whole population requiring access to speech and language therapy and will not discriminate against any one group or individual. The RCSLT recommends that services develop proactive policies and reviews of service, in conjunction with their employing authority and commissioners.

It is inappropriate to make relative judgements on the effects of experiencing or potentially experiencing a communication or swallowing between any groups of individuals. The policy of prioritising one individual group above another is therefore not supported. Within any group of individuals, there will exist a continuum of need and an optimum time to deliver therapy. The prioritisation of an identified group of individuals for assessment by (for example) age, disorder or location, does not allow an efficient assessment or profiling of need to be made.

For more information see RCSLT guidance on **service planning and responding to proposed changes to your service** guidance.

Referral response times

Services must set response times that ensure safety and effectiveness, reflecting clinical urgency and available guidance such as NICE recommendations. These response times will need to take into account regulations, local risk management policies and protocols, and include consideration of a multidisciplinary approach.

RCSLT advocates a needs-led service and expects that response times and prioritisation strategies reflect the evidence for optimum effectiveness and consider any specific risk factors that need to be managed for individual service users.

To support this, services should implement a transparent prioritisation framework that considers risk, potential impact, and appropriate signposting into care pathways. These pathways should be outcome-focused and respond within specified timeframes, as outlined in local policy guidance related to the level of presenting risk.

Sharing information

Secondary referrals or sharing of referral information should include clear information, with appropriate consent for sharing, and must follow guidance regarding information governance. SLTs must ensure that service users or their carers understand what to expect and how to access further support. Information must be accessible and appropriate to the service user or carer's communication needs.

Service users or their carer must consent to the sharing of information. This consent must be clearly documented. Where it is not possible to obtain consent, information may be shared in the 'best interests' of the service user. In cases where the service user is under 16, SLTs must consider the principles of Gillick competence, assessing whether the young person has sufficient understanding and maturity to make informed decisions about their own care and any information provided to an individual must also include the policy regarding failure to attend appointments and its implications.

Safeguarding

Safeguarding remains a fundamental responsibility within all care pathways. SLTs must be alert to safeguarding concerns, ensure they follow local and national safeguarding procedures, and report any concerns promptly to the appropriate safeguarding lead or authority. Where safeguarding issues arise, the duty to protect the service user may override the requirement for consent, and decisions must be documented clearly with a rationale based on the best interests and safety of the individual.

Assessment

- Assessments are guided by the best available evidence and take place with the informed consent of the service user and/or their family or carers.
- Assessment approaches should be flexible, respectful, and responsive to the service user's cultural background, language, identity, and individual needs.
- Collaboration with the service user and those who know them well is essential to build a full picture of strengths, needs, and priorities.

This section offers guidance on:

- The purpose of assessment and the values that shape it
- Partnering with families, carers, professionals, and other key people in the service user's life
- Considering the right time, format, and setting for assessment
- Sharing and using assessment information in clear, meaningful, and respectful ways

Purpose

An initial assessment allows the therapist to understand the service user's presenting skills/needs and explore their goals and what is important to them. This informs appropriate future support and guidance.

An initial assessment may use formal or informal methods to gather relevant information. It may involve significant others, parents or carers, as well as the service user. Bilingual service users should be appropriately supported, via interpreter services; bilingual colleagues; friends or family. See **Bilingualism** and **Interpreters**.

An initial assessment may:

- establish if there is a clinical risk for speech and language therapy (especially where triage has not been used)
- inform the need for referral to other professionals for advice

An initial assessment should:

- identify the immediate impact of the referred need including the impact on the service user's daily life
- identify capacity for change, for both the service user and within the environment

- enable a clinical judgement about the need for speech and language therapy service involvement
- enable clinical prioritisation judgements regarding the service user's needs
- assess and provide recommendations on the timing, setting, and type of speech and language therapy input required to support differential diagnosis
- provide a baseline of skills, together with current and projected needs against which the effects of intervention can be measured.

Assessments may include discussions, observations, standardised tools, and informal measures. They should consider the individual's environment and be inclusive of carers and other professionals as needed.

Reporting and documentation must be comprehensive, accessible, and shared with consent. Where language or capacity is a barrier, support should be provided.

Principles of assessment

Assessments serve to:

- identify strengths, challenges and desired outcomes
- inform future care and service planning
- establish baselines for measuring progress
- support appropriate referrals.

Assessments must be based on the best available evidence and carried out with the informed consent of the service user. Involving carers in both assessment and intervention enhances outcomes.

SLTs should:

- have access to relevant medical/educational notes (with documented consent)
- use up-to-date standardised assessment tools
- consider and address any linguistic, cultural, or communication barriers, ensuring culturally competent practice

Where relevant, initial assessments should be designed to allow for future re-assessment.

If a service user lacks capacity and no advocate is present, assessment may proceed in their best interests, with clear documentation of the rationale.

Commissioned assessment-only services:

Where assessment-only input is commissioned, services must consider:

- risks to the child, young person or adult
- implications for the SLT's role and responsibility
- impact on future funding and commissioning decisions

Format of the assessment

Recommended assessment practices should include:

- taking a comprehensive history covering background, current presentation and functional communication/swallowing needs in daily life, gathered from the service user, carers, care records, and other professionals
- environmental evaluation, including observation in natural settings, to identify barriers to functioning where appropriate
- establishing clear baselines to measure change
- the use of a range of tools including standardised tests, informal assessments, observations, and discussions as appropriate
- cultural, linguistic and age-appropriate materials, including assessments in service user's primary language

Assessments should reflect the service user's usual and potential future contexts.

Reporting

Assessment records will be stored according to the context and may be:

- held in the SLT case notes
- included in SLT notes with a summary in multidisciplinary, educational, or medical records
- documented solely within a multidisciplinary care pathway (e.g. stroke pathway), where separate SLT notes are not required
- stored as part of the patient's electronic health record

A written report or summary outlining findings, recommendations, and agreed actions will be shared with the referrer and relevant professionals.

Where only MDT notes are kept, they must include sufficient detail to meet SLT documentation standards while remaining appropriate for the wider team. For more on record keeping, storage, electronic records, and handling sensitive information, refer to the **Information Governance guidance**.

Consent is required from adult service users for disclosure of information to third parties (including next of kin). A best-interest decision, in discussion with other professionals, should be made if the service user lacks capacity to provide consent. For more information see**consent**,**confidentiality**,**mental capacity**.

Reporting and sharing information

Reports and letters should be provided in a format that is appropriate, accessible, and aligned with the preferences of the individual. This may include:

- using aphasia-friendly formatting (see the Stroke Association's **Accessible Information Guidelines**)
- verbal summaries for bilingual families who cannot read English, particularly where the language has no written form (e.g. Mirpuri)

Where appropriate, individuals and carers should also be given:

- key evidence-based resources and websites related to their needs
- information about relevant national or local support organisations

- clear guidance on how to contact the speech and language therapy service for follow-up or concerns.

For complex needs or beyond the SLT's scope of practice, seek advice from a specialist SLT or alternative provision with appropriate expertise.

For more information, see:

- **Information governance**
- **Writing professional advice on children with SLCN**
- **Writing reports on referred individuals**

Management and intervention

The purpose of management and intervention is to offer the right support at the right time in a way that involves the individual, their family or carers and other professionals.

Interventions should be functional, evidence-based, and collaborative. They should be guided by:

- the person's needs, culture, language, and life circumstances
- evidence based approaches
- professional judgement and team agreement.

The aim of an intervention is to provide timely, coordinated support that is both person-centred and context sensitive. Planning should reflect an individual's unique background and priorities, drawing on evidence, professional expertise, and collaborative decision-making.

SLTs should be aware of any national service pathways that apply to their care group, and how this might impact on an individual's care plan.

Key principles of speech and language therapy intervention

Communication and safe eating and drinking are basic human rights. Speech and language therapy ensures that challenges experienced do not limit a service user's ability to make choices, engage in life, or feel fulfilled.

Intervention should be guided by the best available evidence and shaped by clinical reasoning. Interventions should focus on reducing risks to health, education, and wellbeing, while promoting access to and participation in everyday activities. They should always be delivered with the **informed consent** of the service user and/or their carer.

Therapy should aim to support service users to self-manage their differences and to advocate for their own goals. The aim of all interventions should be to make communication and eating/drinking safe, meaningful and positive experiences.

Person-centred care is based on a holistic view of the service user, taking into account their life, values, culture, language, and environment.

Care must be designed to be both effective and efficient. Continuity and consistency are key to good outcomes.

Therapy plans may focus on improving or maintaining function, as well as managing how their specific needs impact on daily life and community participation. Therapy should be provided in the most supportive setting – whether in the community, at home, or in a clinical environment, and ideally as part of a coordinated, multi-agency team. All forms of communication (spoken, signed, written, or aided) are valued and should be included in therapy planning.

Types of Intervention

Intervention should be designed around the service user's goals and delivered in the most appropriate format. This may include a combination of direct therapy, either in person or via appropriate virtual means, support for others, and environmental modifications to promote access and participation.

Intervention may include:

- one-to-one or group therapy
- training for family, carers, or staff
- adapting the environment
- using assistive technology(AT) including augmentative and alternative communication (AAC) systems
- sharing information and strategies with others involved

Setting goals & managing intervention

Goal setting underpins effective intervention. Goals must reflect the service user and their carers or families' priorities and functional needs, while being measurable and adaptable over time to support meaningful outcomes.

Goals should be:

- clear, realistic, and meaningful
- focused on participation and wellbeing
- set in partnership with the service user and their support network
- time-bound and reviewed regularly
- appropriate in terms of cultural or individual context, including values, beliefs, and communication preferences.

The timing of intervention should be guided by the individual's capacity for engagement and change. A considered approach ensures interventions are appropriately paced and more likely to be effective

. More information on**goal setting** can be found on the RCSLT website.

It's essential to clearly and swiftly share details of intervention plans. Informed consent must be obtained and documented, and steps should be taken to ensure all information is accessible, especially where language barriers exist.

Interdisciplinary collaboration is key to delivering integrated care. SLTs should ensure communication with other professionals is clear and consistent, with the service user's consent and preferences respected at all times. See the **collaborative working pages**.

Outcomes & review

The SLT will decide how**outcomes** for the service user will be determined in conjunction with the service user and/or their carer, and the SLT should make sure baseline measures are detailed.

Outcome measurement supports accountability and continuous improvement. Regular review of progress ensures that intervention remains aligned with the person's evolving needs and that all parties remain informed and engaged.

Reviews should aim to:

- evaluate intervention effectiveness
- inform next steps and adjustments
- identify new needs or priorities
- facilitate collaborative decision-making
- provide updated support or second opinions
- determine if discharge from the service is appropriate.

Ongoing monitoring refers to the continuous observation and documentation of an individual's progress throughout intervention. It is integrated into everyday therapy sessions and helps guide day-to-day clinical decisions. In contrast, a formal review is a structured event with a defined objective, often involving reassessment and collaboration with the individual and their support network to evaluate outcomes and determine next steps. While ongoing monitoring supports immediate therapeutic planning, formal reviews focus on broader evaluation and future planning.

As part of promoting autonomy and self-management, SLTs may also use Patient Initiated Follow-Up (PIFU) pathways. PIFU allows service users and their carers to take greater responsibility for their own health and care by contacting the service for review when they feel it is needed, rather than waiting for a scheduled appointment. This approach supports person-centred care, empowers

individuals to recognise changes in their own needs, and can reduce unnecessary appointments while ensuring timely intervention when required.

Continuity of management

As appropriate, and with the consent of the service user and/or their carer, the SLT should ensure that any other agency involved with the individual is kept informed of speech and language therapy involvement, management and progress made, with consent from the service user/carer. Wherever possible, care should continue until it has been established that optimal recovery or function has been achieved.

Care is often episodic in nature. Where there are several episodes in a care pathway, particular attention should be paid to ensure that the service user and/or carers feel clear about the process.

Discharge

Discharge plans should be service user focused, not caseload management focused.

Planning for discharge should be collaborative, transparent, and clearly communicated with the service user/carer and clear advice on re-referral routes should be provided.

Reasons for discharge

Discharge will be at the discretion of the SLT after full consultation and agreement with the service user/carer.

Discharge may be initiated by the:

- speech and language therapist
- service user
- the carer (if appropriate)

Discharge occurs when:

- goals are met
- self-management is appropriate
- specialist care is required
- services are no longer needed
- attendance or consent is withdrawn (in line with policy) with due respect to child protection implications. See the RCSLT's **safeguarding** guidance
- Where patients move out of area
- Where patients do not attend (DNA) or were not brought (WNB)

Preparing for discharge

Preparation for discharge involves supporting transitions, providing re-referral routes, and evaluating outcomes. Where necessary, discharge summaries should be shared with other professionals, with consent. Documentation should be comprehensive, timely, and shared in line with information governance standards.

SLTs must ensure users understand follow-up options and available support. For some, regular review or access during life transitions may remain appropriate.

Principles around discharge

The RCSLT recommends the following principles

- Put the service user first. Discharge decisions should be based on the needs of the service user, not related to caseload management.
- Be clear and open. If the SLT initiates the discharge, they must clearly explain the reasons to the service user and their carer.
- Investigate missed appointments. If the service user did not attend (DNA) or was not brought (WNB), the SLT must explore the reasons and consider any risks, including **safeguarding** concerns, before deciding on discharge.
- Explain risks and options. If the service user or their carer chooses to stop therapy, the SLT should explain any potential risks and how to re-refer if support is needed again.
- Work with others. If agreed by the service user or carer, the SLT should consult with other professionals involved before making a discharge decision.
- Keep clear records. The decision to discharge and the reasons for it must be recorded in the service user's notes.
- Support communication after discharge. Carers and staff should be familiar with how to continue supporting the service user's communication in their everyday environment.
- Signpost support. The service user should be given information about local and national organisations that can offer ongoing support.
- Plan for the future**.** For some service users, it's important to understand that re-referral might be needed during major life changes.

It is recommended that service users with:

- rapidly progressing conditions are not discharged from the service
- slowly progressing conditions are given the option of direct review, either in person or by virtual or telephone means, or clear details of self-re-referral routes back into service
- long term conditions are given clear details of re-referral into the service if future support required.

Documentation

Documentation regarding discharge should be comprehensive, timely, and shared in line with information governance standards. This may be a formal report, but in some circumstances, such as inpatient care, the discharge may just be documented in the care-pathway/medical notes.

Discharge details should include:

- the initial referral need
- a summary of intervention, including aims, goals and outcomes
- the reason for discharge
- guidance on re-referral
- recommendations for other services taking over intervention/ providing support
- any other specialist details related to the service users' particular needs or clinical area of need such as medication or diagnosis.

With the consent of the individual or, with the knowledge of the carers (for those unable to consent), copies of the discharge summary should be sent to relevant others including the individual's GP.

Resources

Referrals

- Gov.uk (2025) **Mental Health Bill**
- Gov.uk (2005)**The Mental Capacity Act**
- Gov.uk (2022) **Health and Care Act**
- NHS England: **Data security and information governance**

RCSLT Outcomes and review

- **Delivering quality services**
- **Clinical guidance**
- **Research**
- **Outcome measurement**
- **Service planning** and **Responding to proposed changes to your service**
- **Quality services** and **quality improvement** processes
- **Workforce planning, staffing and improvement**

Other resources

- **The Care Aims Intended Outcomes Framework** helps practitioners managers and commissioners/health boards in health, education and social care achieve better outcomes for their service users, by improving organisational decision making and processes.
- **Improved Clinical Decision Making** The Improved Clinical Decision Making (ICDM) team roles aim to work with Health Boards and Trusts in identifying problem areas where Care Aims training and support to multi-disciplinary teams will form part of a solution to the problem. The Care Aims Intended Outcomes Framework utilises the pillars of Duty of Care (Legal and Ethical Principles) to support professional decision-making. The emphasis for this work is on improving relationships at all levels. It promotes skilled, empowering conversations within and across teams, and with families, carers and leaders.
- **What works database** is an online library of evidenced interventions designed for professionals working with children and young people with SLCN. It is maintained and developed by a moderating group, the RCSLT and Speech and Language UK.
- **SpeechBITE**is a database of intervention studies across the breadth of speech and language therapy.

- **Realistic Medicine Scotland** is supported by a range of professional and patient organisations. It helps professionals and patients to have meaningful conversations that will allow people to share decisions about their treatment and care and make an informed choice.

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