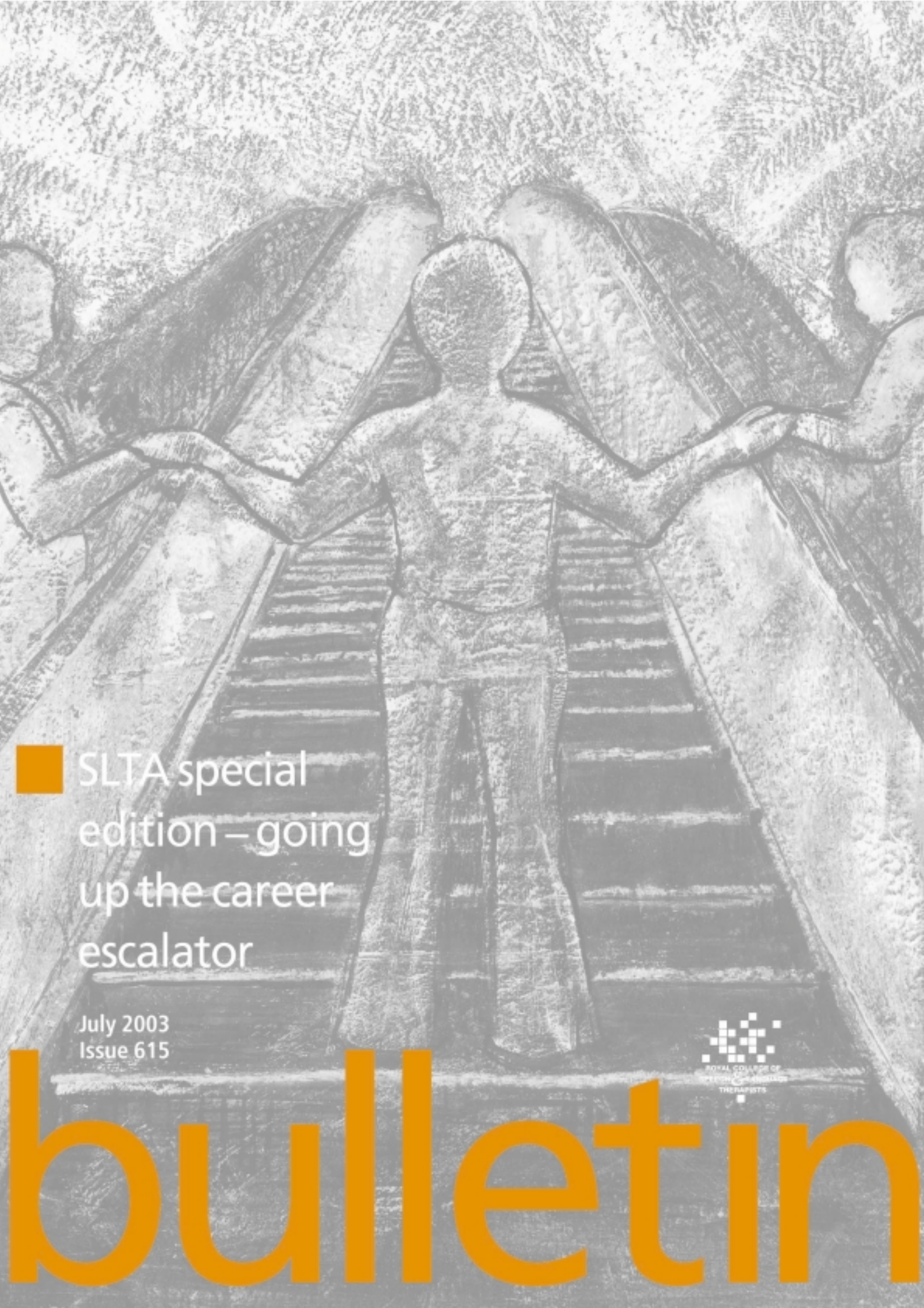

SLTA special edition – going up the career escalator

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Contents

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COVER ILLUSTRATION: HILARY TRANTER

The *Bulletin* is the monthly magazine of the Royal College of Speech and Language Therapists.

College supports campaign to write off student loans

RCSLT is supporting a campaign to get the loans of allied health profession (AHP) students written off. The campaign aims to tackle student debt, improve future recruitment and retention of AHPs in the NHS and support wider access to AHP-qualifying courses from groups currently under represented in the professions.

A scheme is being proposed for newly qualified AHPs to have their student loans paid off by the government in return for working in the NHS for five years. The loan would be written off at a set percentage each year. Campaign plans include raising awareness, lobbying the departments of health across the UK and an AHP-wide petition. We will be calling on SLT students and managers to support the campaign.

So far, professional bodies supporting the campaign include the Chartered Society of Physiotherapy, the College of Occupational Therapists, the British Orthoptic Society, the British Association of Art Therapists, the British Dietetic Society and RCSLT.

Stammer Trust offers small grants to help therapists

The Stammer Trust has £1,000 in small grants of up to £250 to help with research or treatment in the UK. Individuals or SLT departments may apply for the grants, which can be used, for example, for training, or to attend a conference.

Apply in writing on one side of A4, explaining how the grant would contribute to your work. If applying for part funding, explain where you would obtain the remainder.

Successful candidates will be notified before 31 December, and they will be expected to write a short report on how the grant has benefited their work.

Apply to the secretary: Geoff Forward, The Stammer Trust, c/o 17 Larks Rise, Chesham, Buckinghamshire HP5 1RG.

New guidelines on cochlear implants aid deaf children

The RNID has published comprehensive new guidance for parents, teachers and health professionals working with deaf children with cochlear implants. The aim is to improve support for the children, who need time to learn how best to use the implants after they have been fitted and tuned.

The guidelines were developed with the leading organisations in the field, including the Cochlear Implanted Children's Support Group. Speech and language therapist Maria Cameron of the group said that it takes time and patience to learn how best to use the implant. "Children will achieve their full potential only if they receive consistent support. These guidelines with really help."

Around 2 000 children have cochlear implants, and the number is growing by 200 a year. The guidelines are available on the RNID website: www.rnid.org.uk

Alex Kemp, 14, pictured here with his mother, had an implant at the age of two-and-a-half. His mother, Tricia, says that the implant and the support he has received have transformed his life.

"He can join in conversations with family and friends and, more recently, use the telephone," she said.

Picture:The Ear Foundation

Alex Kemp (right) with his mother, Tricia: an implant has transformed his life

Minister to champion children's rights

PICTURE: PA PHOTOS

The government has established a new post of Minister for Children to integrate all services for children under a single Whitehall department. The aim is to organise all services around the needs of children, and to break down long-standing professional rivalries between education, social services and other agencies.

The new post is part of the government's response to the recommendations of the inquiry into the death of eight-year-old Victoria Climbie (pictured above), who was abused and murdered by her carers - her great-aunt, and her aunt's boyfriend.

A green paper is due this month, and it is expected to encourage local authorities to set up children's trusts to bring together schools, social services, health visitors, youth justice teams and other agencies. It is also expected to acknowledge that poor co-ordination of child protection services contributed to Victoria's death.

Education secretary Charles Clarke has hinted that the green paper will also back the Climbie inquiry's proposal for a children's commissioner in England to act as a champion of children's rights. Similar posts exist in Wales and Scotland.

The new ministerial post removes the prime responsibility for children's policy from the Department of Health to the Department for Education and Skills (DfES). The new children's minister is Margaret Hodge, formerly, minister of higher education, and civil servants from other Whitehall departments, previously involved with children's issues, have already been transferred to the DfES.

In another response to the Climbie inquiry, the government has published guidance for those working with children and families on what they should do if they are concerned a child is being abused. The aim is to unify and streamline frontline practice.

The main booklet is accompanied by a summary giving step-by-step action points that all staff can follow. It sets out what to do if you have concerns, explains what will happen once you have informed someone about your concerns and describes what further contribution you may be asked to make. The booklet also provides basic information about the children's welfare legislative framework.

Launching the guidance, former health minister Jacqui Smith said: "The booklet will be supported by a comprehensive training resource, details of which will be announced later this year."

'*What To Do If You're Worried A Child Is Being Abused*' can be found at: www.doh.gov.uk/safeguardingchildren/index.htm

RCSLT fights for members' pay rights

RCSLT has been working jointly with the union Amicus-MSF to influence Agenda for Change to ensure that SLTs maintain the same career structure and earning potential of the current pay bands. "We are waiting formal notification from Amicus on the outcome of the job profile workshop held at RCSLT, but meanwhile SLT union representatives have identified a significant and negative impact on SLTs' pay bands," said chief executive Kamini Gadhok.

"RCSLT is aware of the government agenda to bring everyone 'in line' in terms of pay and conditions, and we hoped that we could minimise its impact on SLT, even though as the professional body we are not recognised as official negotiators.

"RCSLT has not given up the fight. We have already organised a meeting with Amicus, the managers of the early implementer sites and some of the SLTs involved in the job profiles to identify further joint work (16 July).
RCSLT policy officers will also look at other ways to lobby on the profession's behalf, and we hope that members can work to support their union representatives locally," Ms Gadhok said.

The National Advisory Committee for Amicus urgently needs representation from the West and East Midlands and would welcome contact. This committee will make recommendations as to whether these profiles should be accepted or rejected.

AHP self-assessment tool for primary care trusts

The new Allied Health Professions' (AHP) self-assessment tool for PCTs has now been published on the National Primary and Care Trust (NatPaCT) webpage - http://www.natpact.nhs.uk/newcf/index.php?show=y&d=A

A number of RCSLT members officers contributed to its development and the aim is to raise the profile of AHPs within PCTs. We are keen to collect any feedback on the tool and particularly any examples of it making a positive difference. Please contact Anne Whateley on tel: 020 7378 3007. or email: anne.whateley@rcslt.org

SLT assistants

The role of assistants in speech and language therapy has evolved considerably since the post was first introduced in the late 1970s. Changes in the scope of speech and language therapy practice have resulted in opportunities to devolve tasks traditionally undertaken by qualified staff to assistants. The profession has seen the therapist moving to a more consultative role which involves overall responsibility for the differential diagnosis of the communication disorder and assessment of need for intervention, the development of long-term aims and objectives within a strategic therapy plan, and the management of a client's therapy care in a variety of ways – one of which is increasingly through the use of speech and language therapy assistants (SLTAs).

The assistant workforce across the health and social care sectors is growing in size and developing in relation to scope of activity. This growth looks set to be sustained by a number of drivers, including an increasing emphasis on client-centred models of service delivery; the redesign of jobs around the needs of the client; the demand for accessible and flexible services; difficulties with the recruitment and retention of qualified staff; and a greater use of standards/protocols in service delivery.

The government has acknowledged that the allied health professions have been at the forefront of developing support staff and ensuring high levels of competence (DH, 2000). Within speech and language therapy services, there is a wide variation in the recruitment of SLTAs, bilingual co-workers and technical instructors (TIs) and in the roles they are expected to fulfil. RCSLT is encouraging an emphasis on defining support practitioner roles, documenting the competencies they require and ensuring that clear policies are in place relating to their training and employment.

We hope that the examples of practice shared in this special edition of *Bulletin* will inspire therapists and assistants alike.

Jenny Pigram
RCSLT Policy Lead, Assistants/Support practitioners

Reference: Department of Health. *Meeting the Challenge: A Strategy for the Allied Health Professionals*. DH, 2000.

One sm

One trust found that emp was a positive experience

In line with the principles of the Government white paper *Valuing People* (DH, 2001), our speech and language therapy team in Leicester recognises the need to include people with learning disabilities in developing more accessible information. Jones (2000) also states that "People with learning disability need to be more involved in the development of a common language of signs and symbols."

Employing Helen Jesson, a communication support worker who has Down's syndrome, is one of the ways we are trying to put these principles into practice.

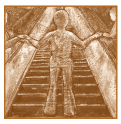
Helen's job

For the past year, Helen has worked for up to half a day a week on the Leicester Symbols Project (LSP). This is one part of our communication strategy. It is a book and computer CD resource of easy words, signs and symbols and covers the vocabulary areas of things people do, and places they go to.

Helen's job includes:

- demonstrating the signs for photographs to go in the resource
- helping to write and check information about the LSP using easy words and pictures
- talking to people about the LSP and her work
- showing the signs to service users and their communicative partners.

We have identified ways in which Helen needs supporting in her work and, for example, a member of the SLT team



all step for equality

loying a communication support worker with Down's syndrome for all concerned. **Sue Lyons** and **Helen Jesson** explain

works with her. Helen asks for all written information to contain short sentences, easy words, with clear pictures down the left side (Mencap, 2000).

Sue's views

Working together:
Things that are good

"I have gained a lot professionally and personally working with Helen. She has had a big impact on the project. She is very professional in the photo shoots: the photos are excellent. Helen has found it easy to learn the signs.

"Helen has been clear and confident when telling other people about the project. People listen to her. The quality of the resource, and our ability to tell people about it is better because Helen is working with us."

Things that are difficult

"Our trust employs Helen on a 'bank' contract. She is on a high rate of income support and she is only allowed to earn £20 a week as 'permitted work' before it affects her benefits. This means she can only work for us for up to three hours a week. Helen has needed an independent person to advise on this.

"Helen also has other voluntary work commitments. Sometimes it has been hard for her to organise her working week.

"We have sometimes found it difficult to build in sufficient time for planning and supporting Helen's work properly. There were also a few times early on when Helen didn't understand me, and didn't feel able to say. We have identified the best ways to support Helen's understanding as we have worked together. These have included using easy words and short sentences, providing back up written information, and giving information on more than one occasion. Helen then checks out that she understands by talking through each task."

Highly valued

Helen is a highly valued member of our team. She adds to our skill mix, and is able to give her views as someone with a learning disability. We feel that this has been a positive experience as Helen is "being involved in something which has real purpose, feels personally meaningful and is valued" (Hewitt and Byng, in press).

This project is one small step towards working as equal partners with people who have learning disabilities.

Sue Lyons
SLT team leader
Helen Jesson
Communication support worker
Leicester SLT Adult Learning Disabilities Team

Helen's views

Things that are good

"I never thought I could do this but it shows that I can. I like having my photo taken. It will help people look at the book and know what the signs are. I like sharing the signs because I am keen to show people my skills. You are helping other people to use the signs.

"I like saying things are easy to understand. It makes it easier for other people to read. I enjoy talking to other staff.

"I enjoy working with you and Ann [another communication support worker]. I really enjoy meeting all the team. I enjoyed going out to work Christmas lunch with them."

Things that are difficult

"Getting to Leicester on the train can be hard. You don't know whether the train will be cancelled. The money worries me a bit. I would like to work more hours but I can't because of my benefits. Filling in the forms is hard."

References: DH. *Valuing People: a new strategy for learning disability in the 21st century*. The Stationery Office, March 2001, Cm 5086.

Hewitt A, Byng S. From doing to being – from participation to engagement. In: Parr S, Duchan J, Pound C. (Ed). *Aphasia Inside Out: Reflections on communication disability*. In press.

Jones J. A Total Communication Approach Towards Meeting the Communication Needs of People with Learning Disability. Tizard *Learning Disability Review* 2000; 5, 1: 20-26.

Mencap. *Am I Making Myself Clear?* Mencap, 2000.

PHOTO: JOHN BIRDSALL

Dysphagia

support

Linda Sharpe

We've all been complaining about the same issues for years. Too few staff, too much dysphagia, no time for dysphagia therapy, no time for communication, too many inappropriate referrals

But when we complained to our chief executive (trying to get more staff!), he responded, "Why don't you use support workers in dysphagia?" We wanted to say "Because…", but then could not think of a good enough reason. All other professional groups in our trust are facing similar problems and have had to consider skill mix and the use of unqualified staff. Indeed, widespread recruitment and retention difficulties in the NHS have made this a national issue.

Hot debate

In the past, SLTs have hotly debated whether dysphagia should be managed by speech and language therapy or nursing. Our SLT department believed that dysphagia management generally was best done by SLTs, but we wanted to find some middle ground. We felt that nurses should have a greater role in identifying appropriate referrals, and in line with many other departments, have developed a nurse screening programme. There also appeared to be a number of routine tasks which, potentially, someone else could do. We considered whether nurses or nursing assistants should carry out these tasks, but felt they could be neglected because of the many competing new responsibilities nurses are being given.

So where did we start? The first step involved process mapping. We mapped the patient journey from hospital admission to discharge, tracing the speech and language therapy steps involved. This highlighted two areas for action:

- we decided to concentrate our dysphagia nurse screening programme in admissions areas, rather than spread throughout the general wards
- we compiled a list of routine tasks which could potentially be carried out by support workers.

The second step involved identifiying competencies. Armed with our process map of how a dysphagia referral is dealt with, we met with the practice and professional development team. We produced a list of competencies that we felt underpinned the routine tasks. This list has already changed several times and will probably continue to do so while the role develops. It may also need to be adapted in the light of the current RCSLT competency project. Table one shows a sample of our framework.

Step three involved the recruitment process. From the routine tasks and competency framework, we produced a job description, person specification and a training programme with methodology and timescale.

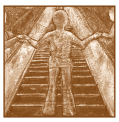
Step four involved appointing staff. The whole process from conception to appointment took nearly a year. This was because it was completely new for us, quite complex and required extensive consultation.

We were fortunate to recruit a trained nurse and a health care assistant (HCA) with a National Vocational Qualification (NVQ) 2 in care. This has accelerated the training programme considerably and has avoided some of the problems that we might have met if we had recruited staff with no experience of the environment or the client group.

Having had our assistants in post for six months, we have seen a number of benefits and potential problems (table two).

Table one: a sample of the competencies framework

competence	method of evaluation	target date	date achieved	SLT signature	dysphagia assistant signature
ability to identify own learning needs and progress	appraisal in conjunction with SLT manager/supervisor	as agreed			
able to comply with casenote standard	audit of casenotes	as agreed			
ability to demonstrate oral exercises to patients	therapist observation	as agreed			



assistants – why now?

and **Sarah Waddell** explain how they trained workers in the new role of dysphagia assistant

Table two: showing the benefits and potential problems

benefits	pitfalls
• part-time assistants working in the middle of the day has helped mealtime assessments	• role boundaries can be confusing if the staff member has already worked in the NHS as a nurse/carer; different levels of initiative and clear guidelines are needed
• routine tasks such as some administration activities and liaison with ward staff has freed up therapists' time	• team disagreements about what the assistants can and can not do
• identifying patients who are too ill for assessment (and who subsequently die before recovering sufficiently to be assessed) has reduced the number of inappropriate contacts made by trained SLTs	• large commitment to training
	• time needed to 'switch roles' and adjust from working in a ward environment (one of the assistants was a HCA on the ward and used to a very different environment)
• patients who need small amounts of food regularly throughout the day can have this from the same person, without other priorities taking over	• SLTs and assistants need to learn to work together appropriately in their new roles
	• confusion on the wards about their role – what should their title be?
• the amount of regular dysphagia exercises being undertaken has increased	• potential boredom

Evaluation

Our staff have been in post for six months and we have not yet evaluated the success (or otherwise) of their appointment. This is partly because we are unsure how to do so. Their appointment coincided with improved staffing levels in the department. Therefore it does not seem appropriate to audit number of contacts, waiting times etc, as we could not attribute this solely to the assistants' work. Our impression is that the quality of our service has improved. However, quality is always harder to measure than quantity – if anyone has any ideas of how to measure this, we would welcome comments.

Speech and language therapy assistants Shelly Maybury and Susan Hamilton give their views.

"We feel that the role is progressing well. The fact that it was a completely new role meant that it was daunting, but this also made it challenging and exciting. The development of the role has been a partnership between us and the rest of the team. It seemed that, on a daily basis, we were questioning aspects of the role, competencies required and, particularly, boundaries.

"We would sometimes have liked a quick response to new issues, but these took time to consider. This could be a little frustrating for us.

"We felt that the most significant benefit appears to be that the increased liaison with the wards which has improved nursing staff's awareness of our clients' needs."

Benefits and challenges

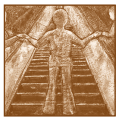
The staff member who had nursing experience has found that her background has brought benefits and challenges. We had to constantly remind ourselves that she was not functioning as a nurse but a qualified support worker. This meant that there were tasks that she would be deemed competent to perform when functioning as a nurse, but would not be allowed to do as a speech and language therapy assistant.

It is inappropriate to consider expanding the role, either in duties or numbers of staff, until we have evaluated its current impact. However, potential areas for expansion are – training in the dysphagia screening test, combining the roles of support workers in dietetics and speech and language therapy and, of course, the possibility for inclusion of the more traditional role of assistants with communication patients.

Linda Sharpe
SLT dysphagia specialist

Marie Waddell
SLT head of service
Birmingham Heartlands and Solihull Hospital NHS Trust (teaching)

For more information on the RCSLT competency project, see *www.rcslt.org/comp.shtml*



Competent

Rehabilitation support workers have the chance to work in various therapy settings while developing both professionally and personally. **Erika Ottley** and **Ruth Williams** report

The importance of competencies in developing the skills of health care professionals is recognised nationally. Sandwell Healthcare Trust in the West Midlands developed a generic assistant – the rehabilitation support worker (RSW) – as a part of its community rehabilitation team. These assistants support all the qualified staff by working with clients in an holistic way, rather than the team employing individual assistants for each discipline. Rehabilitation support workers join the primary care rehabilitation team (PCRT) bringing with them a range of previous life and work experiences, including social services, retail and school.

The PCRT is an interdisciplinary rehabilitation team with a remit to see all adults in Sandwell with any rehabilitation needs. The team benefits from having the resources of speech and language therapy, occupational therapy, physiotherapy, specialist nursing, dietetics, social workers, podiatry, counsellors, clinical psychology assistants, rehabilitation support workers and admin staff. The RSW is the vital link for clients, delivering delegated treatment programmes from the range of disciplines.

We developed a competencies programme that responds to the PCRT's changing needs, as well as to the trust's continuing commitment to staff development (see table one). All RSWs in the PCRT are required to complete the programme. To be deemed competent in a particular skill, the individual must show sound underpinning knowledge as well as the practical ability to carry it out.

The programme approaches team working and development cohesively, and improves each client's quality of care. During induction, the RSWs are expected to meet their mentors to introduce the RSW development programme (RSWDP) and to clarify how they will proceed with its completion.

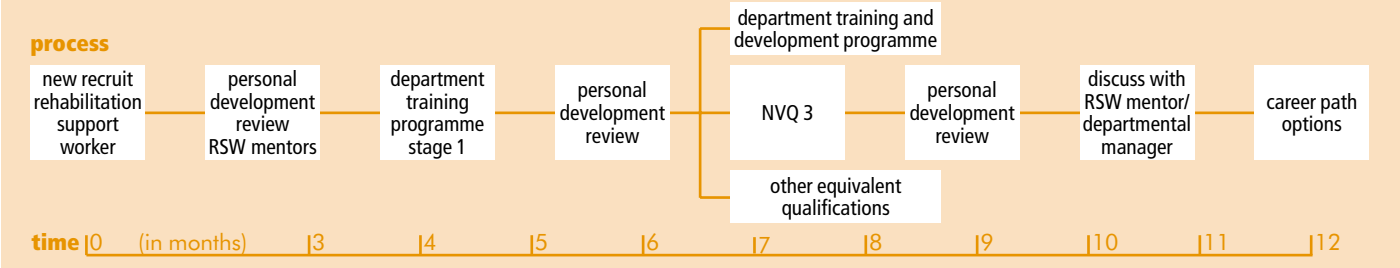
The programme consists of core and clinical competencies. The core competencies cover a range of broad skills. These include: confidentiality, presentations, awareness of other agencies, documentation. The clinical competencies cover specific areas of rehabilitation which may be incorporated into a client-centred management programme. As rehabilitation is goal focused, the RSWDP is based on functional activities rather than activities within a single discipline.

There are obviously cross boundary contributions for some disciplines and for others it is much more discrete. In order to reinforce interdisciplinary working, the competencies are arranged to reflect the range of tasks that a client is likely to fulfil in a day rather than being arranged by professional group. They start with transfers, personal activities of daily living, feeding, swallowing and diet, outdoor mobility, communication etc. The senior clinicians in the team have contributed to the RSWDP by writing competencies within their own clinical area.

The competencies are set out as in the thermal stimulation example below, with an explanation in brackets.

skill (area of competence to be achieved)	**brief description** (aim/reason why that skill is required)	**knowledge** (underpinning knowledge that shows awareness of the complexities of those skills)
thermal stimulation	to improve the trigger of the swallow	• how to carry out thermal stimulation • contraindications

Table one: rehabilitation support worker development structure



skills

Assessment sheets correspond with the core and clinical competencies and reflect the RSW's learning process as it evolves. The assessment is led by the RSW who signs the assessment sheet relating to a particular skill when they think they are sufficiently competent.

This then leads to a formal assessment meeting with any of the qualified staff who will assess the rehabilitation support worker and discuss cases or scenarios which test the RSW's knowledge in a range of situations. The assessment is graded 1-3: 1 = not fully competent in skill; 2 = partially competent in skill; 3 = fully competent in skill.

If there are areas that still need improvement this is detailed on the assessment sheet and a reassessment date is set. The assessment is completed by the assessor's signature.

Role play

The assessor does not need to observe the completion of all the competencies before they sign the sheet. Assessment may involve some observation, but also role play, worksheets, questioning and training. Role play may involve a group of RSWs carrying out proprioceptive neuromuscular facilitation or dysarthria exercises on each other while being monitored by the therapist. Clinical supervision, discussion and written case studies are also used to establish underpinning knowledge.

When the RSW completes the development programme and NVQ 3, or equivalent, they may be upgraded to a technical instructor (TI) III level. The RSW will always work under supervision, but a technical instructor has more responsibility, for example fitting equipment, or carrying out the initial screen. A TI is expected to request supervision rather than the therapist, closely monitoring the delegated intervention programme and they receive more money. This is reflected in a change to the job description and salary scale.

We are interested to hear from other services using support workers so that we may continue to develop this growing workforce.

Erika Ottley, Ruth Williams
Specialist SLTs
Sandwell Healthcare Trust
West Midlands

Acknowledgment: We would like to thank RSWs in the PCRT, particularly the contributions from Deborah Wyatt, Amanda Howe and Helen Taylor.

Two rehabilitation support workers give their personal perspectives

Example 1: an established RSW who works as a technical instructor

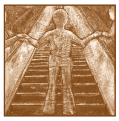
I started as a physio assistant in a large teaching hospital before working in the rehab team as a RSW. I've been with the team for three-and-a-half years and my job role is continually expanding. For example when I started I was an assistant to SLT, PT and OT. Now I also support nursing, podiatry, dietetics and social work. Initially the competencies were limited to the three main therapies but now they include the other professionals with whom I work. The competencies track what I can do and monitor my learning of new skills.

I am able to co-ordinate care of clients due to the training and support given by professional staff based on the competencies. An example of this is Mrs M. Mrs M had a stroke and her goal was to do the cooking. As I was aware of how the individual therapies work and their aims I was able to co-ordinate the therapy programmes. I worked on weight transference, hip stability, balance, shoulder stability, fine finger movement, control of upper limb, confidence, gait education, posture, reinforcement of safe swallowing and supplements. All this while encouraging clear speech and good communication strategies without being in a traditional therapy-based environment.

I have recently completed my NVQ 3 (diagnostic and therapeutic support), a case study and the competencies, and have been upgraded to a technical instructor grade 3. This now means my role is acknowledged financially. I can now take more responsibility for delivering therapy, under supervision, as well as departmental objectives. I also support less experienced RSWs. Being more multi-skilled takes some of the pressure off the professional staff: they rely on me to report back on the treatment programme, as they don't have to monitor my work so closely.

Example 2: RSWs working in intermediate care, currently working towards technical instructor grade

A shortage of therapists can result in difficulties completing the development programme as quickly as we would like. Coming from backgrounds in social services and retail, the programme is a good foundation to work from as it helps you understand what you are doing in each environment of therapy. The programme offers you a direction to follow in a learning process



Redefining roles

Becky Blagdon and **Lucy Hardy** outline the training and evaluation of support staff in Northampton

In September 2001 the number of assistants in Northampton primary care trust speech and language therapy department increased from five – three speech and language therapy assistants (SLTAs) and two technical instructors (TIs) – to nine. Before this, work with the SLTAs and TIs had focused around career structure and re-grading from assistant to technical instructor level. This career development is available to SLTAs who have successfully completed a BTEC professional development certificate in caring – speech and language therapy support or NVQ level three in speech and language therapy support (Bell, 2001; Hillery, 2001). Any SLTA can apply for these courses once they have worked in the department for at least one year.

Following the arrival of these new assistants, SLTA/TI meetings were introduced. They provide an opportunity for the SLTAs and TIs to meet and support each other, share information and provide a forum to feed back ideas on service improvement to the therapists. Latterly, a therapist has been available at the end of the meeting to answer any immediate questions or concerns, particularly those relating to non-clinical issues, such as working practices. These meetings initially ran every six to eight weeks are are ongoing but less frequent.

A number of issues highlighted by the SLTAs and TIs prompted the professional lead of the SLT service to assign two therapists to work on related service improvements. One therapist took the lead for SLTAs/TIs and one for SLTs. This work has so far included:

- developing a set of guidelines to outline the roles of SLTAs and TIs
- formalising a package of training for assistants
- introduction of 'therapists working with SLTAs/TIs meetings'.

Roles and guidelines

Through the SLTA/TI meetings, it became obvious that there were differences in the roles SLTA/TIs were expected to undertake within the service and that this was causing some concern among the support staff. Therefore, we decided that defining the role of a SLTA and a TI and guidelines regarding their responsibilities and a SLT's responsibilities were needed. The lead SLT helped the SLTAs/TIs to develop a definition of their roles and guidelines for practice and to identify the difference between a SLTA and a TI.

Late in 2001, the first draft of their role definition and guidelines was produced and this was then revised via discussions with all parties. The roles identified were in relation to assisting with therapy, developing materials, group work, training others, liaison, administration, supervision and attending relevant meetings/courses. The roles for the SLTAs and TIs were the same but the guidelines on the amount of supervision and the level of independence varied between them (table one). In September 2002, the final roles and guidelines were launched and are due to be reviewed in the light of the new RCSLT Competencies Framework for Support Practitioners (RCSLT, 2002).

Table one: example of role definition and guidles for SLTA / TI

role definition	SLTA guidelines	TI guidelines
assist the SLT in the preparation and maintenance of speech and language therapy materials	SLT needs to check that the SLTA knows where the resources are kept, what is available and give specific instructions on where to find resource job sheet needs to be comprehensively completed, with all details needed to complete task concrete tasks are given	a broad remit can be given and a TI is expected to obtain resource using initiative, develop resource according to client need and evaluate if further resources are needed

Training package

TIs and SLTAs in the service have always been encouraged to attend relevant internal and external training but most of the knowledge and skills were learned 'on the job' before September 2001. In order to formalise the training, SLTAs and TIs were supported to compile a list of their core training requirements and identify important areas of further training for each part of the service.

Each training course was developed from various existing resources in the department (see table two). The training for the four new assistants was delivered by two therapists and two

TIs. The TIs were already involved in leading signing, early language and communication aids awareness sessions for the service and were able to provide this training for the SLTAs. The TIs were also asked to develop general housekeeping, administration and computer software awareness packages.

The training sessions were spaced over five months in order to avoid overload and problems with releasing SLTAs from their work. The sessions were evaluated through verbal feedback from SLTAs, trainers and SLTs, as well as an anonymous evaluation form. The general feedback was very positive, although some comments were made about the timing and relevance of some of the training sessions – some SLTAs had not yet had contact with clients since they were setting up a new Sure Start scheme and felt they would have benefited more if they had worked with clients first.

The training courses were run initially with the group of four new starters, which allowed for practical group activities. As more new assistants have entered the department in smaller numbers, we have adapted the format of each training session to cater for individual needs.

Table two: outline of training for assistants

core training for all assistants	paediatric and learning disability only	adult service only
general administration and house keeping	normal language development	course for assistants run by Connect
communication and communication disorders	awareness of Derbyshire language scheme concepts	communication aids workshop
observation skills	speech sounds phonology	
dealing with difficult situations	total communication	
Widgit programme – gridmaker and writing with symbols	introduction to signing	
resource familiarisation	introduction to the picture exchange communication system (PECS)	
general approaches to therapy (specific to area of work)	social skills and challenging behaviour	
basic IT training (if required)		

In order to achieve equity of implementation of the guidelines and policies across the service, a SLT support group was set up. The aims of the group were developed and meetings took place every three months, and are ongoing. The group is open to all SLTs in the department, however, all SLTs working with SLTAs/TIs are expected to attend. During the first year, the group has concentrated on finalising the role and guidelines for SLTAs/TIs; identifying training needs for SLTs working with SLTAs/TIs; identifying the SLT's responsibilities; the role of the SLTA/TI in assessments; writing clear treatment plans; NVQ training; and developing an induction framework for SLTAs/TIs. Other aims of the group include:

- to give opportunities to discuss how we work / share ideas / support one another
- to identify training needs of SLTA/TI from a SLT's perspective
- to raise and discuss concerns/issues.

Continuing developments

We are currently developing and piloting an induction package for new SLTAs entering the service – identifying a mentor who is a SLTA or a TI and outlining a timetable of core activities and training required in the first month. An evaluation of this will take place following the induction period in order to identify its success, and any areas for improvement.

The service as a whole is formalising its clinical supervision sessions. The SLTAs and TIs have recently started group supervision sessions with a SLT supervisor. This format will be reviewed in a year's time.

SLTs have been able to suggest gaps in the core training and have been keen to find out more about the content. New sessions have been added and each clinic and hospital base has now been provided with a copy of the full training package (containing course outlines and handouts). Each new SLTA joining the service is also provided with their own training and continuing professional development file, which enables them to keep a record of their own learning and reading.

Having reviewed our guidelines in the light of RCSLT's competencies for support practitioners and the continuing development of our SLTAs' skills, we will be considering incorporating an additional grade of practitioner for established SLTAs, recognising the level of experience and independence they have gained in their clinical areas.

As with any service developments, on-going evaluation has been required to keep these initiatives up-to-date. We have been fortunate that so many of our SLTs, SLTAs and TIs have committed their time and energy into reviewing and developing our local systems. It is a tribute to them that we have been able to provide a supportive environment for all our new and established staff.

Becky Blagdon
Lucy Hardy
Speech and language therapists
Northampton Primary Care Trust

References: Bell A. Back to the nursery. RCSLT *Bulletin* September 2001; 593: 20.
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See. www.rcslt.org/comp/shtml

Assistants in Uganda

Speech and language therapy assistants face a challenging task in Uganda, as **Heather Robinson** explains

Uganda is a country with a mixed reputation in the West. Winston Churchill called it the 'Pearl of Africa' because of its stunning scenery. But, following independence in 1962, and under the dictatorship of Idi Amin and Milton Obote, Uganda suffered a number of tragedies. However, for the past 16 years under the leadership of President Museveri, most of the country has been stable. Uganda now has the fastest growing economy in Africa with developing health, education and community services, including growth in services for people with disabilities.

The international development charity Voluntary Service Overseas (VSO) has provided a speech and language therapy service in Uganda since 1986, based centrally in the capital city Kampala. When I started my working here for two years in 2001, I found I was the only SLT in the country with a small team of two 'speech and language therapy (SLT) assistants' – as their job title describes them. I soon realised that this is an inadequate title for their role in providing for Uganda.

Adult communication disability

Our SLT department is based in the ear, nose and throat ward of Mulago Hospital, the main government teaching hospital in the country. Clemence Aryanyijuka and Enid Mugume have been working as SLT assistants since April 1999. They did one-and-a-half-years' informal training in paediatric speech and languages disorders with Ailsa Gillet, the previous VSO speech and language therapist. I am currently training them in adult communication disability.

They have previous medical experience as Ms Aryanyijuka is a clinical officer – which involves studying for a three-year medical diploma – and Ms Mugume is a registered nurse. Both are committed workers dedicated to 'serving' people (as they refer to it) with a communication disability in Uganda. Without them the SLT service would not be possible.

We are a small service of three people. How do we best serve those people who could benefit from speech and language therapy input? It is a tough challenge and we have responded by providing three aspects to our service: clinical, teaching and developing sustainable Ugandan-led services. It is only possible to work effectively in each of these areas because Ms Aryanyijuka and Ms Mugume have the confidence and motivation to take on a broad range of responsibilities, especially in the clinical field.

Paediatric clinics run four mornings a week, an adult clinic once a week, and we see between 700-800 clients a year. Ms Aryanyijuka and Ms Mugume directly manage the paediatric clinics, while I assist them twice a week so that we can share skills through joint assessments and case discussion. Their clinical work is varied: they see disorders as varied as speech and language delay and disorder, dysarthria and dysphagia. The main medical diagnoses of children coming into our clinic are infectious diseases (measles, malaria and meningitis), neurological and hearing impairment (Robinson, Tumweheire, 2002).

Assessment and advice

Ms Aryanyijuka and Ms Mugume's work is mainly assessment and advice. They also try to develop simple home activity programmes for the families to work with, which are based around daily home routines. Most children are looked after by several family members and other siblings may also take a leading role, so therapeutic activities need to be planned so that others, often as young as 12 years old, can carry them out. If the literacy levels allow, they give written information, but if not drawings can act as prompts.

Ms Aryanyijuka and Ms Mugume demonstrate most programmes in the clinic, discuss them at length with the carers and then review when the family can next travel back to Kampala. This generally means reviews every two to three months. They also provide therapy, both for individuals and groups, but this is for a minority of people partly due to the difficulties people have paying for travel to the clinic (Robinson,Tumweheire, 2002).

We also try to bring people together for support and both Ms Aryanyijuka and Ms Mugume have taken over the management of a support group for parents with autistic children. They have also assisted with a support group for adult stammerers.

The clinical work would be impossible without them. In Uganda there are more than 33 languages spoken (Nzita, 1983), although regional languages are closely related. English is widely spoken and is the medium of instruction for much of primary education, but many children who do not attend school are not exposed to English. Children with a disability often fit into this latter category. Research in South Africa suggests that children who do not have English as their mother tongue are "essentially untreatable by the English-speaking therapist… (and this) makes the provision of effective diagnosis and intervention virtually impossible" (Bortz, Jardine, Tshule,

Meeting needs:(left to right) Enid Mugume, Clemence Aryanyijuka and Heather Robinson

1996). Having Ms Aryanyijuka and Ms Mugume in the department, who are fluent in many of the vernacular languages, is vital in managing communication disability.

Another aspect of the department's work is training other people. This is an important way to ensure that we try to meet the needs of most of the people with a communication disability in Uganda. Most Ugandans live in rural areas and are often unable to access services (Human Development Report, 2002). Over half (57%) of the population never comes into contact with government trained health care professionals in their lives.

Media publicity

Services for people with a disability who live in rural areas are limited. There are community development workers in some of the districts, teachers and a small number of health workers (OTs, physiotherapists, clinical officers, nurses) who can be accessed. It is these community, education and health workers who see families who cannot afford to travel to Kampala to access our clinic, and whom we will never see. We run regular training programmes to complement other services, for example The Ugandan National Institute of Special Education, which trains teachers. It has a course component focusing on communication disability which has been developed by a SLT and community based rehabilitation association (COMBRA) which trains community workers to work with families who have a child with a disability and, again, it includes a communication disability component.

We also, as a department, try to sensitise the wider population to communication disability and give information about how to help. National newspapers and local radio stations are the most effective way of reaching the majority. We have all written articles for one of the national newspapers The New Vision and have appeared on live radio chat shows discussing communication disability and answering questions from the public. The most common question was: "My child can't speak. We have had his tongue cut but he still can't talk shall we cut it again?" And one of the most memorable was: "My child can't speak because he was born after twins and so was cursed at birth, can you do anything?"

It is only since 1999 that Ugandan nationals have been trained to provide specific SLT services from Mulago Hospital. However, the assistants do not get recognition from the Ugandan government, as their training is informal. This means they are paid according to their recognised qualifications (that of a clinical officer and registered nurse). So Ms Aryanyijuka and Ms Mugume receive different salaries for doing the same job. Both salaries are low so they need to do extra work as well as their full-time job at Mulago to bring in enough money to cover school fees and daily living costs. Ms Mugume, for example, runs a small shop.

Unfortunately funds are not available to train them formally abroad. So how do we ensure that with their specialist skills they are able to keep working in communication disability in Uganda? And how can we ensure that there is a growing service, which will appropriately meet the needs of this group of people?

I asked Ms Aryanyijuka and Ms Mugume these questions. They replied: "It is a great challenge for Uganda. We require further training so that we can handle the complicated cases in the clinic, but this can only be got abroad at the moment. We are planning to develop a SLT curriculum in our own country, but this will take time. The SLTs who have come have shown us that there is a tremendous need in Uganda and that we can make a change in patients' lives to help them realise that they can live a meaningful life."

An essential service

Assistants? It is hard to define Ms Aryanyijuka's and Ms Mugume's role but certainly speech and language therapy assistant does not seem to describe their job fully. They manage

the service and ensure continuity even when there is no SLT there. They are without doubt doing a very broad role and providing an essential service for people with a communication disability. Without them Uganda would be much poorer.

Heather Robinson
SLT, Voluntary Service Overseas
Enid Mugume
SLT assistant
Clemence Aryanyijuka
SLT assistant, Speech and Language Therapy Department
Mulago Hospital, Kampala

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Mobile

The skills approach –

Recent government initiatives addressing the workforce for the NHS clearly identify a national workforce agenda for the future (DH, 2000, 2001, 2002), designed to enable the NHS to deliver more flexible and accessible services focused around the needs of the client. The human resource (HR) strategy within the NHS plan (DH, 2002) outlines five key objectives. These are modernisation of: pay; learning and personal development; professional regulation; jobs; and increasing staff numbers and modernising workforce planning. Central to this strategy is the concept of the 'skills escalator':

"Staff are encouraged and assisted to constantly renew and extend their skills and knowledge, enabling them to move up the escalator. Meanwhile roles and workload are delegated down the escalator, generating efficiencies and skill mix benefits. The skill escalator is also about attracting a wider range of people to work within the NHS by offering a much greater variety of step-on and step-off points." (*HR in the NHS Plan*, 2002).

The idea of the enhancement and creative use of a variety of skills is also described in *A Health Service for All the Talents* (DH, 2000). This document defines four categories of new ways of working:

- skill mix – moving a task up or down a traditional uni-disciplinary ladder, to ensure that available skills and training are used most effectively to deliver quality care
- expanding the breadth of a job – enabling staff to give more care to individual patients
- increasing the depth of a job – giving staff greater in-depth knowledge of their respective area and more responsibility in order to maximise their skills and their contribution to effective patient care
- developing new roles or combinations of tasks/skills needed for particular patient groups.

Meeting the Challenge (DH, 2000) reports that support staff should have better opportunity to access further training and development, and that those taking on new roles and responsibilities will see the potential of improved career progression in the new pay system.

So what does this mean in practice for SLT services? The development of a clinical governance strategy and the recognition of the importance of continuing professional development (CPD) will enable all SLT and assistant practitioners working in the speech and language therapy service to adapt and

skills

is it an escalator or a ladder?

ask **Linda Bromwich** and **Ranjit Rana**

develop while maintaining and ensuring high quality care for clients. This needs to go hand in hand with an extended and appropriately funded career structure for assistants. If this is not in place they may be seen as the cheap option when providing services, and will be open to exploitation and misuse.

The professional perspective

Communicating Quality 2 (RCSLT, 1996) states that the SLT assistant is an integral member of the speech and language therapy team, employed to act in a supporting role and under the direction of a qualified speech and language therapist. RCSLT has also identified the following provision as necessary to enhance the quality of care offered by assistants (in response to the *Care and Support Worker National Inquiry Call for Evidence,* King's Fund Publications, 2000):

- support workers having their skills and experience recognised through a defined career structure
- accredited training with financial recognition of the skills and knowledge gained
- the provision of agreed minimum standards of care
- increased resources to enable appropriate supervision
- formal appraisal systems which incorporate personal and professional development plans
- appropriate external monitoring systems to ensure that the above are in place and maintained.

The profession has already begun to develop the roles of assistants and to address some of the training and development issues outlined overleaf (see table one), much of which we have incorporated into our own skill mix model in Walsall.

Local implementation

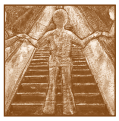
Walsall speech and language therapy service has employed SLTAs since 1989, initially as a result of severe difficulties in recruiting and retaining qualified SLTs at the time. As we started to implement this skill mix model we found it was essential to review the whole team's roles and responsibilities. It needed to be underpinned by a clear and detailed service development plan with agreed departmental aims, objectives and core purpose, and a robust programme of continuing professional development. We had to consider carefully the ratio of staff able to give support versus those requiring extensive supervision. This is not simply reviewing the ratio of qualified to non-qualified staff as for skill mix to be effective there needs to be an appropriate distribution of skills and knowledge across all team members.

Over time, the roles of the SLTAs working in the team have become extremely varied. For example, assistants now:

- run communication groups for clients with dysphasia
- lead a support group for laryngectomy clients, previously run by a speech and language therapist
- provide assessment and treatment to children who speak English as a second language
- provide intensive, school based therapy to children with severe phonological difficulties
- support children with communication aids
- deliver staff training including the co-ordination of cross agency Makaton training
- plan and deliver Sure Start services in conjunction with teaching colleagues.

Review of grading system

Initially we employed the assistants on Whitley terms on the nursing pay scale as this was marginally more than the existing assistant salary scale, reflecting the fact that we were employing staff who had already qualified as nursery nurses. In 1995 the trust board transferred this staff group to trust pay and conditions in recognition that SLTAs needed a defined career structure to take into account the additional skills, knowledge and responsibilities acquired during their employment within the service.



In January 2002, in response to the new initiatives, we reviewed this system and identified the following issues:

- continuing inequities in pay and conditions
- the current system restricted the service in developing and rewarding team members based on ability and skill
- the recruitment and retention of experienced, qualified SLTs continued to be a major difficult - the need for experienced assistants was crucial in redressing the balance of skills in the team
- we needed to put in place a system for succession planning, to maintain appropriate skill mix if and when assistants were enabled to start the undergraduate SLT course
- new assistants joining the team needed a transparent career structure
- the new grading system needed to reflect and complement the structure already in place for qualified SLTs
- appropriate pay scales were needed to reflect the skills overlap between recently qualified therapists and very experienced assistants.

Following discussions with the personnel department, the trust management board agreed to extend the existing pay structure by a further two bands (that is six points) to overlap with the speech and language therapy pay scales, up to point 25. All the SLTAs are now on this pay scale, including those not intending to go on and train as an SLT, and have the potential to move up according to skills, experience and qualifications. This was implemented in April this year.

Benefits to the organisation

What have been the benefits to the service in Walsall? The focus on developing the skill mix model supported by the improved career structure within the trust has, undoubtedly, improved retention of a skilled and effective SLT and SLTA workforce. We have a greater pool of skills available and as a consequence can maintain a wider range of support for clients with communication difficulties. The model is cost effective, for example a SLTA running a group with a SLT rather than using two SLTs. We have more staff who can provide greater flexibility of service provision and increased access with, for example, more intensive input to the schools' service. There has been greater opportunity to employ people from the local community who reflect the cultural and social mix of the population. Succession planning is now possible and we are more able to provide a fluid service while maintaining continuity, for example, re-employing SLTAs once they qualify as SLTs. Finally, there has been a positive effect on the recruitment and retention of newly qualified SLTs, in particular, who are staying in the service longer because they are better supported by SLTAs.

The way forward

The NHS plan provides a clear opportunity for the profession to develop effective working practices across the whole workforce. In order to achieve this the following must be in place:

Table one: training and development opportunities

- the BTEC professional development certificate for SLT assistants
- level 3 N/SVQ in diagnostic and therapeutic support
- associate membership of the RCSLT for support workers
- part-time speech and language therapy degree course at the University of Central England (UCE)
- access to undergraduate modules at UCE
- special interest groups for assistants

- increased access to appropriate training courses for assistants with appropriate funding to support this
- a clearly defined competencies framework for all speech and language therapists and assistant practitioners
- increased access to BTEC and NVQ training for assistants
- a pay structure that recognises the diversity of roles and responsibilities as well as qualifications
- increased access to part-time undergraduate training to become a speech and language therapist
- the further development of a comprehensive clinical governance strategy to include appropriate systems of clinical supervision.

The NHS HR strategy can now effectively support the profession's further development of the assistant's role, giving access to a professional development programme underpinned by an appropriate career structure and system of remuneration. This can only serve to enhance the quality of the team and the client care given.

Linda Bromwich
Head of speech and language therapy
Walsall Primary Care Trust
Ranjit Rana
Assistant speech and language therapist
Walsall Community Trust

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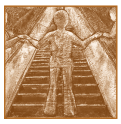


"You can always have a laugh"

Jenny Sheridan talks to **Angela Taylor**, a speech and language therapy assistant who loves her work – and has a taste for audits

Angela Taylor considers herself a lucky woman. After five years as an SLT assistant (SLTA), there is nothing she dislikes about the job. Based at Northwick Park Hospital in Harrow, north-west London, she covers a community clinic, a special school and has four pre-school sessions in her three-day week. She works alongside speech and language therapists and also carries her own phonology caseload. "These are not the really difficult cases," she says. "It's mainly stopping, fronting or backing. I decide whether to treat them individually or if there are enough children with similar problems to run a group. If I come unstuck I can ask a therapist. If a child has met their targets I decide whether to discharge them, or to keep them on and work on another sound. I write up the notes but they are countersigned by a SLT, usually within a few days."

Pre-school settings

In pre-school settings, Ms Taylor often works with a therapist. She may take notes or a language sample during a group session or lead the group while the SLT observes. "The children may have autism, complex needs, acquired brain injury or Down's or other syndromes. We have seen some with global delay and feeding difficulties as young as ten months."

Thanks to an HSA grant, Ms Taylor attended a training course for the National Autistic Society's Early Bird programme, together with an SLT colleague. "Early Bird is a parents' group, similar to Hanen in some ways, using video and feedback and with a strong emphasis on parents' mutual support and on the group's dynamics," explains Ms Taylor.

They will start their first three-month programme in the autumn and will work on an inter-agency basis with portage workers, employed by the education authority. In the special school, where there is a large caseload, Ms Taylor is currently supporting a locum SLT while the regular therapist is on maternity leave.

Ms Taylor and the other assistants also carry out general duties such as library searches and making resources and they find time for a multidisciplinary assistants' support group, which runs every six weeks. There are two SLTAs, an occupational therapist (OT) assistant who also does one day a week for SLT and a physiotherapy assistant. Ms Taylor feels that she has excellent support and training. She has regular appraisals and monthly, documented support meetings with her line manager, Celia Harding. A monthly training programme for all the assistants covers topics such as feeding, Makaton or autistic spectrum disorders. When they start work, the assistants follow the same two-week induction programme as the therapists.

Ms Taylor feels fully included in the therapy team and attends unidisciplinary and multidisciplinary meetings. She took part in a neonatal audit, looking at the effectiveness of SLT advice to parents on feeding, which she says has given her a taste for audits: "You can see if you really are making a positive change. We may look at the Early Bird groups or at groups in nursery settings."

Does Ms Taylor want to train as an SLT? "It would almost be time to retire by the time I finished training! But the previous assistant is now at university and she says it helps a lot having been an assistant and having some of the prior knowledge," she says.

Within the past year, Ms Taylor has been re-graded to technical instructor level 3 (Amicus-MSF, RCSLT, 2002), a process started by the service manager, Maria Luscombe. This meant less leave entitlement but better pay and more scope for career development. She feels that the main difference between her job and an SLT's is the level of responsibility. Also, she does not take on the more complex cases, does not diagnose and has a very limited discharge role.

Ms Taylor's previous job as a pre-school group leader stood her in good stead, as she was already aware of autism and other special needs and of the contribution of SLTs.

"I really enjoy my job," she says. "I love working with children, and speech and language therapists are a friendly, welcoming bunch. You can always have a laugh. And because there are so many of us we have enough in the children's therapy service to run two multidisciplinary rounders teams – the schools service usually wins!"

Jenny Sheridan
Former editor - *Bulletin*

Reference: Amicus-MSF. RCSLT. *A guide to regrading: Speech and language therapy assistants*, 2002.

AHP research and clinical effectiveness

11 June 2003, Harrogate

This conference on AHP research and clinical effectiveness was organised by the research and development sub-group of the West Yorkshire AHP Forum and supported by its Workforce Development Confederation.

The first speaker was Kim Dent-Brown, representing the research and clinical effectiveness arm of the national Allied Health Professions Forum. He dealt with the aims of developing the consultant role, making the best use of the NHS leadership programme and working with NICE. While talking about the development of profession specific guidelines he referred to a paper written by Kamini Gadhok, RCSLT Chief Executive.

The consultant post theme was taken further by Deirdre Collier, the deputy AHP chair of the northern region, who spoke on the development, aims and objectives of consultant posts. By the end of 2004, AHPs will need to meet a target nationally of 250 consultants in post.

Linda Ward described the role of clinical librarian. This is an established post in the USA, but is new to the UK. Ms Ward attends ward rounds and audit meetings to hear the questions raised by the multidisciplinary team. She gave several examples of how her searches for the evidence had altered the course of individual patients' treatment.

SLT Hilary Gardner related how she had succeeded in getting a PPP Foundation mid-career award. This scheme aims to support therapists beyond normal CPD activities and enrich applicants' professional capacity.

The session's final speaker, Dr Mark Johnson, gave an entertaining account of how to get an article published. He covered what to write about, how to gather data, write a manuscript and make sure it is in the right format for the publication you are sending it to. Write a covering letter and send it off. Six months later you will get a rejection. So, what do you do? Make amendments and try again, he said.

He maintained that it is a myth that a good paper automatically gets published: it needs to attract an audience, and needs to fit the format and the readership of publication. Writing requires time not talent, prioritise some time to write, was his final tip.

The afternoon session was dedicated to discussion groups. Topics included problem-solving in practice, the research conscious workforce project report and the role of the AHP R&D co-ordinator.

The final speaker was Dr Val Blair, who explained the AHP/Quality Improvement Scotland Clinical Effectiveness Project. See www.show.scot.nhs.uk/cesahp.

Get on to the website and have a look.

Caroline Fraser
Chair of RCSLT

Reference: Gadhok, K. Delivering the Research and Clinical Agenda: What the AHPs can offer. *Journal of Clinical Excellence* 2002; 4: 121-124.

For PPP Foundation mid-career awards see http://www.ppp.foundation.org.uk/grant_programmes.html

OBITUARY

Miss Ruth Bennett December 1915 - May 2003

Many SLTs in South Wales will be saddened to hear of the recent death of Miss Ruth Bennett, a pioneer of speech therapy in the principality.

She qualified in 1936, and was working in London in 1944. By 1948 she was working in Monmouthshire hospitals, and was the first SLT to work in St Lawrence Hospital, Chepstow, which opened in 1950 as a burns and plastic surgery unit for the South Wales region.

Though based at St Lawrence, as part of the cleft palate team, she also worked with patients suffering from dysphasia and other neurological conditions in Mount Pleasant Hospital, Chepstow, built for soldier casualties of the first world war. These hospitals have now closed, and the cleft team moved to Swansea. Other speech and language therapists work in the Royal Gwent and St Woolos Hospitals, which Miss Bennett also visited.

Her funeral was held in the Forest of Dean, and only two other former colleagues and I were able to attend at short notice. We had all observed Miss Bennett at work in one of the Newport hospitals when we were high school pupils before going to train as SLTs. We remember a lady whose direct manner was tempered by deep kindness.

After Miss Bennett retired I kept in touch, and although she was reluctant to talk about her own career she was keen to hear all about new trends in the profession. Many of her colleagues have predeceased her, but those who knew her will remember her with respect and affection. Monies in lieu of flowers will be sent to RCSLT at the request of her family.

Sue Brenchley
Senior SLT, Gwent

write to the editor, RCSLT, 2 White Hart Yard, London SE1 1NX, email: bulletin@rcslt.org

Please include your postal address and telephone number if emailing. Letters may be edited for publication.

Letters deadlines:
September 2003: 12 August October 2003: 10 September

Working in harmony

Is it possible to improve the relationship and lines of communication between independent therapists and practitioners working for the NHS? We have struggled with this question for some time, but the recent correspondence in *Bulletin* (May, June) shows the levels of frustration experienced on both sides of the debate. Fundamental differences of philosophy and working contexts inevitably create friction across the profession: one practitioner makes decisions based on need, caseload management, NHS requirements and resources, while the other bases decisions on need, patient requirements and the necessity to run a business.

Part of the solution must lie in dialogue and understanding, involving honest discussions and agreement around standards of practice. There may be occasions when we have to agree to differ on the 'best' intervention at a specific time, but we will achieve nothing through reinforcing negative attitudes to fellow professionals. We represent the independent and state sections of the profession and, having had the opportunity to discuss the issues, three main points may add to the debate.

First, we must develop mutual respect, recognising that a culture of criticism among professionals can never be constructive. Independent practitioners need to recognise that the services delivered through the NHS are not routinely failing people with communication difficulties. Equally, those working in the NHS need to recognise that the service provided by independent practitioners can complement the NHS service as well as offering choice for the public. SLTs must remain absolutely professional and avoid opinionated judgements in their relationships with each other and the public.

Second, we are all working to agreed standards as set down by RCSLT. Monitoring the quality of therapy is the responsibility of the managers in the NHS. This provides protection for the public and professionals alike. Such monitoring may not be available for independent practitioners unless they are members of ASLTIP and access recognised support networks and training. Membership of this organisation is essential to ensure that clients receive quality intervention.

Finally, independent practitioners could be in a privileged position with services that are paid for often being regarded as superior to the state provision by the 'customer'. It is sometimes possible to be viewed as a 'patient advocate' particularly when providing professional advice for statements or legal cases. All therapists, wherever they work, when providing reports in such situations should state their experience and post-graduate qualifications clearly so that third parties can weight the advice impartially.

We hope that the newly formed RCSLT education working group may be able to provide additional guidance for all professionals who are aiming to work collaboratively across the public-independent divide. Our starting point, as representatives for the independent and state sections of the profession, is that collaboration by all is not optional but essential.

We know that there are areas in which the RCSLT document Working in Harmony has created excellent liaison between therapists. We hope that by opening this dialogue we can extend this practice throughout the profession.

Karen Davies
Head of SLT, Trafford Healthcare Trust
Jenny Jackson
Chair of ASLTIP

As mentioned above, RCSLT is aware of the issues around joint working between therapists in different sectors, and has convened a working party to address some of these and other concerns. We have received many letters on the topic which we have been unable to print, but they will inform this work.

Correspondence is now closed in the Bulletin*, but, Yvette Johnson, education subcommittee secretary, welcomes your comments and any further feedback on the issues raised, tel: 0207 378 3020; email: yvette.johnson@rcslt.org.*

Cancer dataset

Last year a group to define a core surgical voice restoration dataset was set up and chaired by chief SLT Anne Hurren. The dataset will be used together with a national head and neck cancer dataset by ENT surgeons, SLTs and specialist nurses to collect information about national surgical voice restoration practice. It will be used to establish a baseline of, and to begin to work towards,

evidence-based practice for key areas of SVR.

The next stage will pilot collection of the dataset for a period, and we welcome volunteers to assist us with this stage.

If interested contact Jenny Millman, pilot co-ordinator for NHSIA National Cancer Dataset Project, by 31 July 2003, for an initial discussion without obligation; Email: jenny.millman@nhsia.nhs.uk; tel: 07850 324625.

A draft version of the dataset is available on www.nhsia.nhs..uk/cancer.

Gwen Isaacs
Project manager
Cancer Dataset
NHS Information Authority

AfC vote

It was with horror that I read in *Therapy Weekly* how those members of our profession who could be bothered (42%), voted in favour of AfC. How did this happen? The information provided from SLT reps made very clear what a disaster this system would be for us as a profession. I can only think that this information was not circulated widely enough, hence people making uninformed decisions.

I know my colleagues voted against AfC, as it clearly negates what we have gained via regrading. Even without information from national SLT reps, documents that I read some time ago made clear how catastrophic this agenda would be for us — longer working hours, less flexibility and poorer pay. In light of these factors, I can only express my abject disappointment that a 'yes' vote has gone through from speech and language therapy assistants.

Christine McCormick
Specialist SLT
Royal Group of Hospitals Trust, Belfast

Voice your concerns

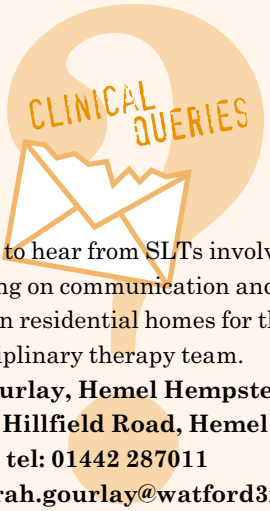
I am responding to 'Voice your concerns' in the May *Bulletin*.

How appalling that a newly qualified therapists (NQT) should have to question how she will receive effective clinical supervision in an over-demanding post. The difficulty in my speech and language therapy department is that NQTs do not seem to want the posts we are offering, where they would be eased gently into their careers, with excellent support, mentoring and supervision.

It seems many would rather sink or swim in posts which are over-demanding for NQTs.

I commend the good sense of the writer to make sure she has the appropriate structures in place, and hope she has not been put off joining our profession.

Heather Saunders
High Wycombe



RCSLT holds a database of clinical advisers who may be able to help with many queries. Contact the information department 020 7378 3012.

Q Interested to hear from SLTs involved in planning and training on communication and swallowing for care staff in residential homes for the elderly within a multi-disciplinary therapy team.
Sarah Gourlay, Hemel Hempstead General Hospital, Hillfield Road, Hemel Hempstead HP2 4AD tel: 01442 287011
email: sarah.gourlay@watford3r-pct.nhs.uk

Q Interested to hear from anyone working in community brain injury teams, specifically what outcome measures do your teams use?
Lisa Chess, Traumatic Brain Injury Service, Morriston Hospital, Swansea SA6 6NL
email: Lisa.Chess@swansea-tr.wales.nhs.uk

Q My final year dissertation is 'Investigation into the tools used for functional communication assessment of adults following TBI, with a view to proposing the development of a single assessment tool.' I amsending questionnaires to as many SLTs specialising in TBI rehab as possible. If interested, let me know asap, and indicate preference - email or post.
Lisa Thorne tel: 029 20576801
email: L.A.Thorne@BTOpenworld.com

Q Are any SLTs employed directly by social services? If so, please contact me to discuss the pros and cons and whether it is working out.
Caroline Darby tel: 01332 293474
email: darbycaroline@hotmail.com

Q Are there any SLTs in Gwent interested in setting up a SIG for paediatric special needs?
Jayne Smith, Trethomas Health Centre, William Street, Trethomas, Caerphilly
e-mail:jayne.smith@gwent.wales.nhs.uk

Q We have developed a colourful semantics resource kit - anyone interested, please contact us.
Kate Brophy, Natasha Everitt, Glebefield Health Centre, St Mark's Road, Tipton, Dudley DY4 0UB tel: 0121 530 8035
email: natashaeveritt@yahoo.co.uk

COLLEGE

College advises on independent therapists

RCSLT's information team receives many calls from parents and clients wishing to contact independent SLTs. We would like to remind members that the Association of Speech and Language Therapists in Independent Practice (ASLTIP) now deals with this.

ASLTIP is administered by a secretarial agency, Woodside Secretarial Services (WSS), and Jude Awdry is the administration manager. When putting members of the public in touch with ASLTIP, please advise them as follows:

- there is searchable database of independent therapists on the internet at www.helpwithtalking.com
- there is an answerphone service on 0870 241 3357. Please stress that this is an answerphone service and callers should be prepared to give some details about the type of therapy required, eg client's age, area in which they live and the problem if possible. They will also have to give a name and address as the information is sent by post only. Clients should receive a response in about five days.
- make contact by fax on 01494 488590 or email: asltip@awdry-demon.co.uk with as much information as possible.

If clients express any dissatisfaction with contacting ASLTIP, please send feedback to the office, asltip@awdry.demon.co.uk. Any queries that concern therapy rather than administration should be sent to a member of the ASLTIP executive. They are: Chair, Jenny Jackson asltipuk@aol.com; Vice chair, Shelagh Urwin family@urwin9969.freeserve.co.uk; Secretary, Di Gibson altipsec@ntlworld.com

Bilingual workers scoping exercise

At RCSLT we have recognised for some time the difficulties and lack of consistency SLT services face in recruiting and training bilingual co-workers, and we have been working on this area in an attempt to address these issues.

When a bilingual co-worker is recruited training is often given on an *ad hoc* basis, and so it varies greatly from one trust to another. It is, therefore, essential for effective service provision of speech and language therapy that structures are in place which ensure a good quality in recruitment, induction and training, as well as continuing professional development.

RCSLT began scoping work last year on speech and language therapy and the bilingual community in the UK. We contacted various trusts throughout the country to find out what provisions there were for members of bilingual communities who required speech and language therapy. This is an ongoing piece of work, and the initial focus has been on the recruitment of bilingual co-workers. The responses were interesting, some areas with significant minority communities had no bilingual co-workers, but generally the feedback has been informative and very encouraging.

We now have valuable information on current methods and procedures. We also received feedback on how trusts advertise jobs, the interview process and induction programmes, along with the continuing professional development of new members of staff.

Following the scoping exercise, the next stage has been to collate the various job descriptions and person specifications, and draw together all the vital threads which make up the job of a co-worker. The document will shortly go to all the trusts who fed into the original exercise, for their feedback and comments. We welcome comments on the work from any other interested services. These will then feed into other work on standards, including the revision of CQ2.

For further information, contact Glenn Palmer, policy lead - co-workers on 020 7378 3003, or email: glenn.palmer@rcslt.org

Calling all final year students

As part of its clinical effectiveness and research strategies, RCSLT awards an annual prize for a final year SLT student research project. The object of the prize is to encourage consideration of the clinical implications of research, by recognising final year projects that can demonstrate clear relevance for clinical practice. The closing date for initial submissions is 25 July 2003. Contact your university department for further information.

Last year's winner was Gina Sutcliffe who studied at the Department of Psychology and Speech Pathology, at Manchester Metropolitan University. Her study investigated the relationship between the level of behavioural adherence to dysphagia guidelines by carers of adults who have a learning disability, and the level of their dysphagia-related knowledge. Ms Sutcliffe will receive her award at the CPLOL Congress/RCSLT conference in September when she will also be presenting a poster.

Therapists encouraged to take up trustee posts

We have a number of trustee positions available for RCSLT members who want to contribute to the development of the profession nationally and gain valuable experience of working at a strategic level for the organisation.

From October 2003, we are seeking a Councillor for Professional Development who will chair the professional development board, taking the lead in ensuring that the board implements and reviews RCSLT's new strategic framework. The mission statement of the professional development board is 'to enable all levels of the profession to engage in critical reflective practice and maintain client-focused professional integrity'.

Other positions being advertised are: deputy treasurer, councillor for Wales and board and committee members. Please see the mid July *Supplement* for further details.

Minister formally recognises the Welsh Therapies Advisory Committee

The Welsh Therapies Advisory Committee (WTAC) was formally recognised earlier this year, and provides advice to the National Assembly for Wales.

The committee consists of seven professions: speech and language therapy, occupational therapy, physiotherapy, dietetics, podiatry, arts therapies and orthoptics.

Each profession has two representatives, one reflecting the views of NHS managers, the other staff from the profession in Wales. The SLT managers' representative is Natalie Vanderlinden. Her alternate is Sue Dimmick. Nigel Miller represents members of the RCSLT in Wales; his alternate is Alison Clarke.

The WTAC has joined All-Wales Advisory Committees covering dentistry, medicine, nursing and midwifery, pharmaceuticals as well as the Welsh Optical Committee and the Welsh Scientific Advisory Committee.

During the past 12 months, the shadow committee of WTAC has worked hard to meet the National Assembly's demands. Therapists have sat on 16 task-and-finish groups, the Assembly has appointed a therapy adviser, requested a scoping exercise of the therapy professions and has appointed a project manager to co-ordinate the writing of a 10-year therapy strategy for Wales. Also a speech and language therapy action group (SALTAG) was formed to advise on the provision and funding for SLTs working with children 0-19 years.

The committee is currently discussing a range of issues, including therapy and IT strategies, workforce planning and the health professions in Wales, strategic direction for palliative care, health, social care and wellbeing strategies, outline cancer services development plan, strategy for older people and therapy appointments to local health boards. It is also looking at clinical governance issues for the therapies, including: risk management, clinical audit, clinical effectiveness and staff management.

ILLUSTRATION: RACHEL BUSCH

"We are pleased to see speech and language therapy getting official recognition and a higher profile in Wales," said Nigel Miller and Natalie Vanderlinden.

Restricted prescribing for SLTs?

Advisers Sue Fox and Fiona Robinson represented College at a recent Department of Health meeting for Allied Health Professionals (AHPs) on patient group directions (PGDs).

The meeting discussed issues surrounding the supply and administration of medicines, such as patient benefit, safety, and competencies, and the process of extending PGDs to all professions regulated by the HPC. Currently, podiatrists, orthoptists, physiotherapists, radiographers, ambulance paramedics, optometrists, as well as nurses, midwives, health visitors and pharmacists can use PGDs, but only as named individuals. All AHPs can also supply a medicine to an individual patient under a patient-specific direction, that is a written instruction from a doctor or dentist for a medicine or appliance. PGDs are not about prescribing per se, but about the supply and administration of medicines in defined circumstances under general directions, and there are specified legal requirements that each PGD must meet.

AHPs from professions not yet covered by PGDs, including SLT and occupational therapy, provided examples of clinical conditions and circumstances warranting the use of PGDs.

This information was due to be considered last month by a joint committee of the Committee on Safety of Medicines and the Medicines and Healthcare Products Regulatory Agency. If the committee agrees, consultations will be held and legislative changes introduced, a process that could take a year. College representatives outlined clinical scenarios/areas of practice/types of medicines as examples of where SLTs could act under PGDs to improve patient care. PGDs are likely to vary according to local needs and situations.

Examples of scenarios included:

- topical anaesthesia in FEES, laryngoendoscopy and surgical voice restoration procedures
- antifungal medication
- antireflux medication
- artificial saliva
- topical skin preparations post radiotherapy
- medication for mouth ulceration and oral discomfort

It is important that the profession responds during the 12-week consultation period (check the RCSLT webiste for dates), and encourages input from colleagues.

Further details and information can be found on the following websites:
www.doh.gov.uk/coinh.htm - Health Service Circular relating to PGDs
http://www.doh.gov.uk/ahpbulletin/ahpbulletin15.pdf - Allied Health Professionals Bulletin
www.groupprotocols.org.uk - for examples of PGDs

Children's National Service Framework

Last month we alerted readers to the publication of two documents *Getting the Right Start: Emerging Findings* (we hope SLTs have been able to respond to this - consultation deadline 10 July) and *Standards for Hospital Services* that are part of the NSF for Children.

The children 's NSF aims "to improve the lives and health of children and young people…and their experiences and satisfaction with services…through the development of effective, evidence based and needs led services."

Getting the Right Start: Emerging Findings sets out the framework for the complete NSF and is admirable in its vision, scope, inclusivity and objectives. The NSF sets a challenging agenda right through from maternity services to the transition to adult services.

There are three key objectives:

- care to be child/young people and family focused
- to develop effective partnership working
- to deliver needs led services

and three key aims:

- to improve services
- tackle inequality
- enhance partnership working.

The NSF places considerable emphasis on the whole child in the context of their family, school and community, which further emphasises the need for joined-up interagency working. RCSLT welcomes the re-statement of collective responsibility. "Supporting families should be the responsibility of the whole community and of the many agencies in the statutory, independent and voluntary sectors." RCSLT initiatives such as The Competencies Project and ICAN's Joint Professional Development Framework could assist services in developing interagency working through joint training.

Not surprisingly, since NSFs are part of the NHS programme to improve services, the components of clinical governance – staff development, evidence based practice, quality and audit, clinical effectiveness, partnership working with client/families, risk management - run throughout the document. Shortage of skilled staff is an acknowledged barrier to change and the document details some of the work being piloted and commissioned.

The focus on 'looked after' children and concern about their unmet needs and underachievement mirrors work and concerns of the Department for Education and Skills. A challenge for SLT services will be to ensure 'looked after' children are not further disadvantaged in accessing services.

The document rightly acknowledges the need for joint finance and joint commissioning of services – but little is said about how to ensure this happens.

The document is rather medically focused. SLTs (and others) offer services and care that do not necessarily fit a medical model so the NSF will need to consider other models. Perhaps related to this rather medical focus is the less strategic planning for schools when talking about integrated services. '*Extended schools'* is the only section that seems to specifically look at schools. We are aware of different local education authorities responding differently to this potentially valuable initiative, and it will be interesting to see how this works out given the different priorities of each agency.

The second document - *The Standard for Hospital Services* is the first published standard of the Children's NSF. The standard presents and elaborates on three principles of good practice:

- child-centred hospital services
- quality and safety of care
- quality of setting and environment

The aim is that all hospital departments and services are needs led, and provided through partnership working between appropriately trained staff, children, young people and their families in a child friendly and safe environment.

There may a number of issues and opportunities for paediatric SLT hospital departments. For example, service design and delivery to reflect cultural diversity and evidence based practice, health promotion and prevention, and training others in communicating with children. Clinical governance is the main theme in quality and safety of care, and issues for clinicians and manager centre around staff training and responsibilities for child protection, developing joint interagency working, audit and delivering evidence based practice.

Both documents detail what is required of services and what they are expected to look like. Although targets are given (from the improvement, expansion and reform section), neither document gives any time-scales or states minimal standards. However, a range of practical guidance is to be developed to support local implementation.

Our hope is that these documents are more than statements of aspiration.

The complete *Standard for Hospital Services* is available on the Department of Health website. http://www.doh.gov.uk/nsf/ children/-standardhospserviceindex.htm

Emerging Findings is out for consultation, and can be downloaded from: www.doh.gov.uk/nsf/children.htm

Please send comments, views and examples of good practice to Yvette Johnson, tel: 020 7378 3020; email: yvette.johnson@rcslt.org

1 Voice – Communicating together

SLT **Tamsin Crothers**, co-founder of the charity, reviews its work

Rebecca McCormack and friend Louise Marsh

1 VOICE

1 Voice – Communicating together, a UK charity, provides support and information for children and families using augmentative and alternative communication (AAC). In 1999, Katie Clarke (parent of a child using AAC) and I founded the charity to raise the profile of people using AAC into mainstream awareness. A committee of parents, professionals and adult role-models who use AAC, work together to organise events and workshops and continuing support for anyone interested in or involved with AAC.

Few people beyond "the field" have heard of a communication aid. At the Communication Matters Symposium (the national voluntary organisation concerned with AAC), held at Lancaster University in 2002, Pam Enderby, professor at Sheffield University described the need to make AAC mainstream.

A terrifying experience

Even as a professional, the first time I spoke with an adult using AAC was a terrifying experience. Would I say something wrong? Would I go too fast? For people who have never met someone using AAC, that fear is multiplied, if indeed, "Joe public" ever meets anyone using AAC at all. We hope that the question "AA what?" will become a thing of the past.

Being unable to speak isolates both children and adults from their peers and families, and also isolates families themselves. We support families and friends in trying to overcome that isolation and share experiences with others who understand their situation. 1 Voice can help them realise that they are not alone. All family members and friends are included in all aspects of 1 Voice.

One of the most valuable aspects of 1 Voice is the team of role-models – adults who successfully use communication aids. They inspire children and families who are learning to use AAC, and pass on tips from personal experience. They draw on the questions they would have liked to ask at a young age, and answer those questions for children, siblings, parents and professionals.

1 Voice holds workshops for parents, usually run by other parents or role-models. We are also producing a parent pack with information and contacts for carers whose child has recently been recognised as needing some form of alternative communication. 1 Voice wants to bring people together to share the successes and good practice already established.

We also offer professionals a chance to share the everyday realities of AAC. In 1996, I attended Camp Chatterbox, a residential camp in the USA for children and are the users of AAC. My experience there highlighted the 24-hours-a-day nature of the difficulties faced by those who are not able to speak and are users of AAC. For example, at meal times, with a family of four, and the dinner going cold, the last thing on your mind is the correct use of a communication board.

Events

At 1 Voice events children and families can share their communication system requirements and professional support. The professionals can also learn from the families. It is all about sharing information and supporting each other.

We have an annual family weekend in Blackpool. It is a fantastic chance for families and role-models using high-tech AAC to get together in a fun and understanding atmosphere. (See *www.1voice.info/events/blackpool02.*) So far we have held three weekends and plans for 2003 are underway.

Our annual family network day is a relaxed outing to an accessible countryside setting where families using any type of AAC can meet. For details of our last network day and forthcoming events see *www.1voice.info/news*

Between events, people keep in touch via a four-monthly newsletter, the 1 Voice website and a parent-run email support group. This active group shares experiences via group emails. 1 Voice is also starting a link scheme for families to contact others in their locality, aiming to overcome some of the geographical isolation that is so often reported.

Our next event will be the Blackpool weekend (for children using high-tech communication aids), 5-7 December 2003. Our next family network day will be held in 2004. We are always looking for more families, role-models and volunteers.

We plan to hold more events throughout the UK, as the organisation grows. There is certainly a high demand for 1 Voice support.

For more information please contact us via our website www.1voice.info *or phone Katie Clarke 0845 330 7862.*