NHS England Long Term Plan
RCSLT response

28 September 2018

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Overarching questions

1. What are the core values that should underpin a long term plan for the NHS?

The founding principles of the NHS should remain at its core: meet the needs of everyone; be free at the point of delivery; and be based on clinical need, not ability to pay.

To continue to meet these principles in 2018, the NHS workforce should be guided by strong capabilities. The RCSLT has developed clinical and professional capabilities for speech and language therapists (SLTs) to ensure a skilled and flexible workforce which could be easily adapted for all NHS staff:

- **Communication** is essential. SLTs must be effective and inclusive communicators in all contexts to promote the health and wellbeing of those in their care, applying their knowledge and skills to transform the communication abilities of service-users.
- Collaborative **partnerships** between service-users, their families and health professionals (including non-regulated professionals) promote social inclusion, inclusive communication and participation.
- **Leadership and lifelong learning** is important to keep pace with the clinical and professional landscape, leading innovation within their area of practice.
- Utilise **research and evidence-based practice** to transform lives by accessing, evaluating, applying and informing the latest evidence.
- As regulated health professionals, be **professionally autonomous and accountable;** developing insight into professional practice by working with integrity and commitment.

2. What examples of good services or ways of working that are taking place locally should be spread across the country?

These examples show how NHS remaining efficient and outcomes-focused in an increasingly complex environment:

Joint commissioning

- 'One Service, One Solution' in Worcestershire sees the NHS and Local Authority jointly commission core speech and language therapy services for children and young people with speech, language and communication needs (SLCN). Each school has a named SLT, and the option of commissioning additional top-up activities. Evidence-based programmes are embedded into pathways, resulting in clear routes for early identification, information and resources.
- Impact:
    - Children at risk of SLCN in targeted early years settings have decreased on average by 20%.

- Children are identified earlier: 84% of health visitor referrals are now under the age of three (35% in 2010).

Integrated care

- iCares is an integrated care service in Sandwell, an area ranking high on the 2015 Index of Multiple Deprivation. The service provides a range of functions across numerous pathways under one management structure. These include avoiding unnecessary admissions; case management/specialist interventions; and community rehabilitation.
- Impact (2016):
  - Reduced hospital admissions by 2478 per year.
  - A&E – reduced length of stay.
  - Hospital – reduced length of stay from 10 to 7 days.
  - Reduced re-admission.
  - Saved nearly 17,000 bed days per year.

3. What do you think are the barriers to improving care and health outcomes for NHS patients?

The ability of patients to be able to effectively communicate is key to improving care and health outcomes through more successful understanding, discussion and engagement.

Not only do SLCN commonly affect people at vulnerable times in their lives but they also affect some of the most vulnerable members of our society, including people with learning disabilities, autistic spectrum disorders, dementia and stroke survivors. Creating an inclusive communication environment is essential to reduce communication barriers, and subsequent prejudice and exclusion from society.

The risks of communication exclusion are caused by people misunderstanding or being misunderstood. The impact of these risks include health inequality, poor health literacy, social isolation and poor mental wellbeing, and could ultimately lead to barriers in accessing NHS and social care.

The RCSLT and its partners will soon be launching a nationally recognised symbol to represent communication access in the UK akin to the more widely known disability access symbols such as the wheelchair access symbol and the visual and hearing impaired symbols as well as underpinning standards. If an organisation displays this symbol it will show they are meeting defined standards both at operational and organisational levels, creating a more inclusive environment for people with communication difficulties.

Life stage programmes: Early life

We know that promoting healthy childhoods, maternal health and perinatal mental health is an investment in the country's future. In March 2015, an independently-led National Maternity Review was established to work with experts and representative bodies to provide an assessment of maternity services in England, and recommendations for how they can better meet the changing needs of families.

Children also continue to have specific needs throughout the different stages of their early lives, such as childhood cancers and complex conditions. We have world-leading children's hospitals, but all of the NHS needs to be geared to meet these needs through new models of care that are coordinated around the person not the service.

Two other challenges are emerging: the fact that 2.5 million children in England are overweight or obese; and the rising prevalence of mental health problems among children and young people.

1. What must the NHS do to meet its ambition to reduce still-births and infant mortality?

The NHS should recognise the role of speech and language therapists (SLTs) in enabling parents with communication difficulties, such as those with learning disabilities, to understand information about pregnancy and parenting.

- While encouraged that Better Births highlights the importance of healthcare professionals considering the needs of those who have difficulty communicating, given that much of the information given to families is delivered verbally, it is important that attention is given to supporting parents with communication difficulties to understand spoken language, as well as to express their needs and decisions.
- SLTs can enable pregnant mothers and parents with communication difficulties to understand information that is given to them.
- They also provide training and advice to other healthcare professionals in how to accommodate the needs of those with communication difficulties.

The NHS should ensure that appropriately specialist SLTs are part of the core multi-disciplinary team on all neonatal units.

- SLTs identify infants who are at risk of feeding difficulties (dysphagia) and provide clinical assessment and management of those difficulties.
- There is currently wide variation in extent to which neonatal units provide access to speech and language therapy.
- The risks of untreated neonatal dysphagia include aspiration pneumonia, choking, dehydration, malnutrition and weight loss.

2. How can we improve how we tackle conditions that affect children and young people?

CCGs must identify the needs of children and young people in their local population and jointly commission services to meet their needs.

- More than 10% of children have long-term speech, language and communication needs (SLCN) which require specialist support.
- SLCN and swallowing difficulties co-occur in many long-term conditions that affect children and young people, including autism, learning disability, deafness, cerebral palsy and cleft lip and palate.
- Current provision is not adequate to meet need, with a high degree of local variation; only 15% of survey respondents in the *Bercow: Ten Years On* review said speech and language therapy was available as required in their local area.
- Joint commissioning arrangements are currently the exception rather than the norm.
- The NHS should use the CCG Improvement and Assessment framework as a lever to ensure CCGs enter into joint commissioning arrangements. A separate indicator about SLCN should also be considered.

NHS England should review commissioning arrangements for children with low incidence, high need conditions. This includes strengthening current specialist commissioning arrangements (national and local) for cleft lip and palate and augmentative and alternative communication, and considering commissioning at the level of the Integrated Care System for conditions such as hearing impairment and stammering.

3. How should the NHS and other bodies build on existing measures to tackle the rising issues of childhood obesity and young people's mental health?

Services supporting young people with mental health needs should include speech and language therapists (SLTs) as a core part of the multi-disciplinary team, building on existing good practice such as the Inpatient CAMHS at Parkview Clinic (Birmingham Women's and Children's NHS Foundation Trust).

- Children and young people accessing mental health services are at higher risk of having unidentified speech, language and communication needs (SLCN).
- Studies consistently observe a higher rate of past early language problems among adults with anxiety disorders.
- Mental health assessments and treatments which are verbally mediated place significant demand on language processes. Unless children's SLCN are identified and accommodated, assessments risk delivering inaccurate results and treatment programmes risk being ineffective.

As part of a multi-disciplinary team, appropriately specialised SLTs can:

- identify SLCN and contribute to differential diagnosis
- support children with SLCN and their families to understand their diagnosis;
- train and advise other members of the MDT to ensure assessments and interventions are accessible and accurate;
- provide speech and language therapy to those children who need it;

- contribute to risk assessment and management including as part of discharge planning;
- enhance children and families' quality of life and wellbeing.

4. How can we ensure children living with complex needs aren't disadvantaged or excluded?

Accountability measures should require local augmentative and alternative communication (AAC) services be delivered in line with the NHS England commissioning guidance (2016).

- Many of the children living with complex needs will have significant co-occurring communication needs, including those with acquired neurological conditions, congenital conditions and developmental disorders.
- Children who have communication needs may have difficulties in social interaction and participating in education and employment, putting them at high risk of being disadvantaged and excluded.
- AAC enables children who find it hard to communicate through speech or writing to communicate as effectively as possible, in as many situations as possible, and can significantly improve their quality of life.
- Specialised AAC services are funded directly by NHS England for those who require a high-tech powered communication aid. However, most children who need AAC (around 90%) are supported by local AAC services, which should be jointly commissioned by CCGs.
- Currently there is a high degree of variation in the provision at a local level. In order to ensure children with complex needs aren't disadvantaged or excluded, accountability measures should require local services be delivered in line with the NHS England commissioning guidance (2016).

Life stage programmes: Staying healthy

Advances in health care have helped people in England to live longer than ever before. However some of us accumulate health problems which lead to unexpectedly greater care needs throughout life and increased vulnerability to complications following acute illness or injury. We also recognise that there is still more to do to systematically address inequalities that are evident between groups of people with different characteristics, and across geographies. Evidence shows that better outcomes and experiences, as well as reduced health inequalities, are possible when people actively shape their own care and support.

1. What is the top prevention activity that should be prioritised for further support over the next five and ten years?
Increase in training led by speech and language therapists (SLTs) for healthcare staff to identify and appropriately refer service users to communication and/or swallowing needs is required across adult pathways, including dementia, stroke, learning disabilities, and mental health. This would enable effective access to a range of healthcare interventions, and early identification for swallowing needs (dysphagia) to prevent the development of secondary infections, pneumonia and hospital admission.
2. What are the main actions that the NHS and other bodies could take to: **a) Reduce the burden of preventable disease in England?**
Gaining access to healthcare often requires a high level of health literacy. Many people have lower levels of health literacy, and as a result information sent regarding screening, health checks, immunisations such as the flu jab, may not be understood and ignored. It is vital that people are supported in understanding information and making health choices. Use of signs and symbols is critical for those with communication difficulties.
b) Reduce preventable deaths?
Increase dysphagia awareness and training Dysphagia is prevalent in care home residents, post head and neck cancer, stroke, and Parkinson's Disease. The side effects of medications, such as mental health medications, can also lead to swallowing problems. Investment in timely access to swallow screening and swallow assessments by SLTs prevents the risk of pneumonia and costly admissions to hospital due to repeat chest infections. Up to 19% of hospital admissions of people with dementia could be prevented by contributions from a SLT at an earlier point. Investment in support of the implementation of the Interprofessional Dysphagia Framework would ultimately reduce preventable deaths, as it upskills the wider workforce in dysphagia management.
c) Improve healthy life expectancy?
Better accessible information and support in understanding it Gaining access to healthcare often requires a high level of health literacy. Many people have lower levels of health literacy, and as a result information on healthy living may be misunderstood. It is vital that people with communication needs are supported in making health choices. For example

adults with learning disabilities often miss population wide screening services if they do not understand the importance of them, for example cervical screening.

d) Put prevention at the heart of the National Health Service?

Ensure that SLTs are part of MDTs to improve recognition of communication needs in addressing health inequalities

In adult services, SLTs have a role in reducing health inequalities, minimising the risk of illness and helping people with speech, language and communication needs to make healthier choices. Better information on risk management and preventive actions is required that recognises that many people have low levels of health literacy. For example men with learning disabilities die on average 13 years sooner than men in the general population and women 20 years sooner. Other contributing factors include low recognition of the impact of communication needs, respiratory problems, dysphagia and mental health.

3. What should be the top priority for addressing inequalities in health over the next five and ten years?

Commissioning of speech and language therapy services

By commissioning speech and language therapy services would identify and support people with communication needs to make good health decisions. The ability of a person to understand language and information is intrinsic to making good decisions, whether about health or otherwise. We know many children have unidentified communication needs that go with them into adulthood – 60% of young offenders and 81% of children with emotional and behavioural disorders have speech, language and communication needs (SLCN) for example. A wide range of people have communication needs that may be unidentified. Those groups include adults with learning difficulties, people with dementia, people who have suffered a stroke or those with other long term conditions such as PD. Those people need support to make good decisions, whether through accessible information, professional speech and language therapy support or through trained healthcare workers.

4. Are there examples of innovative/excellent practice that you think could be scaled up nationally to improve outcomes, experience or mortality?

The **Sandwell and West Birmingham NHS Trust's iCares programme** flags people who are at high risk of hospital admission and has a rapid response service to intervene and support people's needs before they deteriorate further. The system has made it much easier for patients to navigate and supports people to well for longer.

Impact:

- Reduced hospital admissions by 2478 per year
- Reduced length of stay in hospital from 10 days to 7 days
- Reduced re-admission
- The Trust has saved nearly 17,000 bed days per year which has the potential to reduce costs by over £7 million.

5. How can personalised approaches such as paying attention to patient activation, health literacy and offering a personal health budget reduce health inequalities?

Personalised approaches only work where communication needs are identified and supported
We agree that the approaches above are relevant, but they will only work where a person does not have a communication need. We know that large numbers of vulnerable and disadvantaged people do have SLCN, nearly 20% of the adult population experience communication difficulties at some points in their lives and in many cases this may have been unidentified since childhood. For example, 2 children in every class of 30 start school with a developmental language disorder, 7% of children around the age of five and up to 60% of young offenders have SLCN.

6. What is the best way to measure, monitor and track progress of prevention and personalisation activities?

The RCSLT has been working with experts at a UK-wide level to identify resources/tools already available to measure the impact of public health interventions to support school readiness for children in areas of deprivation where communication difficulties are higher than expected (around 50% rather than a prevalence of just of 10% of children expected to have SLCN). This work is now being shared and built upon with Public Health England.

7. What are the main challenges to improving post-diagnostic support for people living with dementia and their carers, and what do you think the NHS can do to overcome them?

Appropriate assessment of capacity
A challenge within the NHS is that people with dementia are at risk of being excluded from decision-making as defined by the Mental Capacity Act. They are perceived to lack capacity because their communication difficulties mask competence and risk being deprived of their liberty unnecessarily. SLTs are critical to support these people, as they are experts in assessing capacity and ensure they have appropriate communication support to help people express their wishes. This also helps prevent an assumption of incapacity.

Sufficient training of healthcare staff
Safe medicine compliance can be difficult due to swallowing problems preventing oral administration of drugs or a person's memory loss means they might not take their medication correctly. Patient Safety Alert NHS/PSA/W/2015/002 highlighted patient safety issues around the use of thickening agents in care homes for people with dementia. Research has shown that 19% of hospital admissions of people with dementia could be prevented by earlier contributions from a SLT. SLTs are experts in dysphagia management and are a key member in the MDT working with these people. The RCSLT has received funding to update the Interprofessional Dysphagia Framework (IDF), which up-skills the wider workforce, including care home staff, to appropriately manage dysphagia.

8. What is your top priority to enhance post-diagnostic support for people living with dementia and their carers?

Regular training of carers and healthcare staff by SLTs – not just one-off
Due to the growing numbers of people living with dementia all health and care staff and carers should receive training on the specific needs of people with dementia, including communication

skills training and dysphagia awareness. As mentioned above, the IDF is an excellent framework to ensure that healthcare staff have the appropriate skills and knowledge to manage dysphagia safely. By including the IDF in the NHS long-term plan, people living with dementia (and other long-term conditions) would be adequately supported in their dysphagia management.

Life stage programmes: Ageing well

Supporting individuals to age well by preventing the start of frailty and slowing its progression is critical. In 2017 the NHS in England became the first health system in the world to begin routine identification and assessment of older people living with frailty so that we can proactively identify those with the greatest needs, to target and plan their care and support in ways which prioritise what matters most to them. New approaches to meeting their needs have also been put in place across the country through new models of care and then by Sustainability and Transformation Partnerships. For example by bringing different services – like GPs, hospitals, community and social care services – together to integrate care around the person, based on 'what matters' to them and their individual strengths and needs. Now we want to help local NHS and social care leaders go further in implementing their plans to bring care together to meet the needs of people in their area.

1. What more could be done to encourage and enable patients with long-term health issues to play a fuller role in managing their health?

People with long-term conditions remain at risk of being excluded from decision-making and service planning. People can still make decisions on care and treatment with the right communication support. Speech and language therapists (SLTs) are qualified to assess an individual's ability to understand and then communicate that understanding to optimise a person's choice, degree of control and capacity to consent to care and treatment.

People with for example dementia therefore can and should be included in the decision-making process around their own care, nutritional management and future. For example, patients might be asked:

a) Do you choose to continue to eat and drink despite developing chest infections, or would you prefer to receive your nutrition and hydration through a tube?
b) Do you wish to be admitted to hospital every time you develop a chest infection, or would you rather be managed in your own home/care home?

SLTs report that some of the self-management approaches rely heavily on memory, linguistic skills and weighing up information, which may be very hard for someone with dementia. It is therefore important that the concept of self-management and expectations of family members/carers is introduced early, including how technology can be used productively in supporting self-management.

2. How can we build proactive, multi-disciplinary teams to support people with complex needs to keep well and to prevent progression from moderate to severe frailty for older people?

Nearly 20% of the adult population experience communication difficulties at some point in their lives. Communication difficulties put people at risk of being unable to communicate that they are hungry or thirsty, express they are ill or in pain, resulting in their needs going unmet or being misdiagnosed.

The RCSLT recommends that there should be training for health care staff and others working

with people with complex needs, especially on good communication. Data on individuals' communication needs must be shared to facilitate provision of better care.

Furthermore, an integrated, collaborative decision-making process in the community will improve out-of-hospital care for people with dementia. Principles might include eating and drinking at risk: goal of care; determine mental capacity; assessment of swallowing; MDT; and advance care plan, which could be incorporated into the NHS.

However, this can be challenging for community teams, as people with dementia have reduced access to the various professionals, including SLTs, required to input into decisions on their eating, drinking and swallowing (dysphagia) management. This can be improved by using the Interprofessional Dysphagia Framework, which equips the wider workforce with appropriate skills and knowledge to manage dysphagia safely (the RCSLT is leading the update of this).

3. What would good crisis care look like, that can help prevent unnecessary hospital admissions for older people living with various degrees of frailty?

A collaborative, integrated decision-making process would enable teams to improve out-of-hospital care at no added cost, but with the use of existing resources in a co-ordinated way. For example, if a person with dementia develops chest infections or symptoms of a chest infection, necessary steps in a collaborative decision-making process can be followed to ensure that the individual can receive the treatment and care they need in their own home/care home. Readmissions to hospital for people with advanced dementia as a result of chest infections are common.

Chest infections could be a sign of dysphagia and is a recognised challenge for people with dementia. Dysphagia is often an early sign of frailty, as there are age-related changes in swallowing function, particularly due to loss of muscle mass and strength (sarcopenia). If unidentified or unmanaged, dysphagia can lead to malnutrition, dehydration, aspiration, choking, pneumonia, admission to hospital and in some instances death. Data suggests that up to 19% of hospital admission of people with dementia could be prevented by intervention from an SLT. Shared record-keeping and regular combined health and social care checks to identify preventable complications could also prevent unnecessary hospital admissions.

4. What measures should be put in place so that we know that we are improving patient outcomes for older people with various degrees of frailty?

The RCSLT recommends setting up tracking of readmissions from nursing/care homes to hospital as a result of chest infections. This would establish effectiveness of a collaborative decision-making process. Collecting this data and other health and social care data regularly, and using algorithms that have already been developed, it would be possible to identify levels of frailty and link with the level of need.

The RCSLT further recommends that nutritional discussions should occur at the early onset of a dementia diagnosis, ie when the person still has capacity. This means that choices regarding tube feeding and eating and drinking at risk can be documented. It is subsequently important

that advance care plans are being used consistently and accompany the individual between transfers of care, ie between the hospital and the home. By putting these measures in place, the NHS would be able to ensure that patient outcomes for older people are improved.

5. How can we ensure that people along with their carers, are offered the opportunity to have conversations about their priorities and wishes about their care as they approach the end of their lives?

The RCSLT recommends proactive promotion of palliative care information and that this is provided to all individuals approaching the end of their lives. This would allow people to have discussions about their priorities and wishes to make an informed decision about their future care. It would also facilitate a collaborative decision-making process to develop advance care plans, which would offer individualised nutritional plans focusing on maintaining quality of life in addition to whether treatment is preferred to be provided in their own home/care home.

It is essential, however, to make such information accessible for people with language difficulties and their families. There is often insufficient understanding of the language/communication profile of individuals to determine what information to present and how to present it. RCSLT members highlight reliance on one medium of communication, for example being given a leaflet, rather than looking at multi-modal repeated information. SLTs can support those with comprehension difficulties to ensure that the person receives the information necessary in an appropriate manner.

This would ultimately lead to high quality end of life care. It would also ensure that the provision of a 'good death' is more achievable, as it may result in avoiding admissions over medicalisation of individuals.

Clinical priorities: Cancer

We all know someone affected by cancer. One in two of us born after 1960 will be diagnosed with cancer in our lifetimes. Our cancer survival rates are higher than ever and fewer people are dying from their cancer thanks to advances in our understanding of cancer, diagnosis and treatment.

But we know that there is more to do. Through better prevention, earlier diagnosis and new treatments and technology, we can reduce the number of people developing cancer and ensure more people survive their cancer and live well during and after their treatment.

Cancer remains a priority. The long term plan for the NHS presents a chance to build on the foundations set by the Five Year Forward View and the report of the independent Cancer Taskforce (2015). Over the next ten years we want to build on the progress that has been made so far, accelerate what we know works and embrace research and innovation, so that every person diagnosed with cancer has the highest chance of survival.

1. What are your top three priorities for improving cancer outcomes and care over the next five and ten years?

1) A skilled and flexible workforce
Speech and language therapy services must be funded and designed to be responsive and flexible to meet the needs of patients with acute, fluctuating, persisting and late onset treatments.

2) Investment in Research
The RCSLT recommends ongoing funded research to better understand the role of speech and language therapists (SLTs) in improving functional outcomes across the cancer pathway and in relation to living with and beyond cancer.

3) Living with and beyond cancer
With the introduction of advanced surgery, radiation therapy and targeted treatments, people are living longer after cancer with the consequences of their treatment.

The latest Macmillan data shows that speech and language therapists are seeing the largest percentage of patients seen once initial treatment is complete (due to patient living with long term effects of cancer treatment). This shows a need for longer term intervention and follow up support.

This long term support can be for swallowing difficulties (dysphagia) which can persist up to one year after cancer treatment is completed and are a substantial threat to a patients' quality of life. Long term support is also needed for communication problems as a result of radiation treatments or surgery such as laryngectomy.

2. What more can be done to ensure that:
a) More cancers are prevented?

- Gaining timely access to healthcare often requires a high level of health literacy. Many people have lower levels of health literacy, and as a result information on risk management around cancers will need to be presented in a clear and concise manner.
- An increased focus on risk stratified population care needs and the capabilities of the workforce

to meet these needs.
- Education for the public on healthy lifestyles and preventative changes.
- Greater promotion of the changing demographics and risks around cancer.

b) More cancers are diagnosed early and quickly?

- Early intervention has a significant impact on achieving the best outcome for patients including improving quality of life, management of symptoms and the consequences of treatment. SLTs have a significant role in early intervention.
- Swallowing difficulties can be a sign of head and neck cancer, so greater understanding of swallowing needs is crucial. This needs to be communicated to the public but also to GPs and other health professionals.
- Making every contact count. Ensuring that all staff are aware of the signs of early cancer.
- AHPs and speech and language therapists being aware of the signs of cancer for prompt referral.

c) People can maintain a good quality of life during and after treatment?

- With the introduction of advanced surgery, treatment and techniques people are living longer with the consequences of their treatment. An experienced workforce of SLTs is needed to provide tailored care across the pathway, pre-, during and post-treatment.
- The latest Macmillan data shows that across the allied health profession, speech and language therapists are seeing the largest percentage of patients seen once initial treatment is complete. This shows a need for longer term intervention and follow up support.
- Increased access to appropriate and evolving treatments for patients.

d) People with cancer have a good experience of care?

- Asking patients about their experience of care so this can be constantly improved.
- Information should be provided in plan and accessible English.
- Gaining access to healthcare services often requires a high level of health literacy. People with communication difficulties are increasingly likely to have lower levels of health literacy, and as a result may have reduced access to information.
- Health and care professionals should be trained by speech and language therapists to have a better understanding of communication and how to support this.
- Improved communication along the clinical pathway between organisations and providers.
- Using audits to ensure that MDTs (incl. AHPs) reflect and improve on their services.

3. How can we address variation and inequality to ensure everyone has access to the best diagnostic services, treatment and care?

- Better sharing of information between teams
- Benchmarking of service provision to ensure staffing numbers across caseloads are consistent
- Consistent provision of a highly skilled workforce to meet the needs of patients, especially in light of the numbers of people living with and beyond cancer.
- Ensure that Trust managers recognise that diagnosis and time to treatment are just one

part of the pathway – specialist rehabilitation may be required for months and years following treatment and should be appropriately provided to patients

Clinical priorities: Cardiovascular and respiratory

Cardiovascular and respiratory conditions are amongst the leading causes of premature death in England, as well as long term ill health for many. In common with some cancers, many conditions are linked to lifestyle and are therefore preventable. Where conditions are caught early enough, relatively simple interventions can slow or halt the progression of illness. The long term plan for the NHS now gives us the opportunity to assess how big a difference we can make in outcomes for this range of conditions over the next decade, and what further actions need to be taken locally and nationally to achieve these ambitions.

1. What actions could be taken to further reduce the incidence of cardiovascular and respiratory disease?
Population-wide preventative interventions would facilitate reducing the incidence of cardiovascular (CVD) and respiratory disease. A combination of high-risk and population strategies are likely required to reduce the risk distribution of the overall population. Smoking cessation remains a proven key preventative strategy. The Greater Manchester Health and Social care partnership plan, Making Smoking History (2017-21), aims to reduce those smoking within the region by a third and achieve 13% prevalence by the end of 2020. It advocates a comprehensive, multi-component approach to tackling tobacco and its strategy is aimed at empowering patients to stop smoking. Despite such examples, there are inequalities in accessing appropriate integrated preventative services. National schemes would have positive impact on incidence reduction.
2. What actions should the NHS take as a priority over the next five to ten years to improve outcomes for those with cardiovascular or respiratory disease?
Chronic cough affects approximately 12% of the UK population, equating to 40% of respiratory referrals. Currently there are no licensed therapies for patients who are refractory to treatment of underlying causes. There have been two positive randomised control trials looking at speech and language therapy (SLT) treatment of cough with outcomes at least as good as drug treatment. Despite this, use of SLT for cough is not widespread. By making this a standard of care for all secondary care services, not just specialist cough centres, healthcare utilisation and morbidity can be reduced and quality of life for patients improved. Speech and language therapists are experts in swallowing management. There is a known relationship between difficulties associated with swallowing and COPD exacerbation, to understand this relationship better it is vital that more research is undertaken to support SLT-guided multi-professional treatment strategies. Accurate diagnosis and management is essential. For example, in asthma populations it is known there is considerable crossover/misdiagnosis with inducible laryngeal obstruction (ILO). The NHS spends approximately £1bn a year caring for those with asthma. Without the utilisation of SLT, an ILO component may remain undetected and untreated, resulting in inappropriate patient morbidity and unnecessary escalation of healthcare utilisation.

Clinical priorities: Mental health

As a result of our hard-working staff, the contributions of service users and partner organisations and the investment objectives set out in the Five Year Forward View for Mental Health and the independent taskforce report, one million more people of all ages will have access to high quality care for their mental health need.

In the past year alone, we've seen a record high recovery rate for people with depression and anxiety, with improved access to services, meaning 7,000 extra women getting perinatal mental health care and thousands more children getting timely help with eating disorders.

However, there remains a long way to go and achieving parity between mental and physical health will take time. Our goal post-2021 remains to deliver world-class mental health care and the long term plan for the NHS provides an opportunity to think about what more needs to be done – including addressing gaps in care and taking a more preventative approach, reducing the likelihood of mental ill health and providing the right level of support at the right time to avoid people getting to crisis point wherever possible.

1. What are your top three priorities for meeting the mental health needs of people of all ages in England? Over the next five, and ten years?

Priority: Improving access to psychological therapies by identifying and accommodating individuals' communication difficulties

People accessing mental health services are at an increased risk of communication needs. For example, 84% of those accessing psychiatric services have language impairment and 74% have communication difficulties. Communication difficulties present a barrier to accessing psychological therapies, which are verbally delivered. Communication difficulties which have not been identified also prevent accurate assessments of a person's mental health needs being undertaken.

Solutions to address this priority:

1) Training for the mental health workforce in raising awareness of the range of communication difficulties at both pre- and post-registration

Speech and language therapists (SLTs) should be commissioned to provide training to the mental health workforce (in both community and in-patient teams) to enable better identification of communication needs, and timely access to individualised support.

2) Embedding speech and language therapists in mental health services (community and acute)

As part of a multi-disciplinary team, specialist SLTs can improve access to psychological therapies by providing a detailed assessment of an individual's communication difficulties, and provide advice and strategies to the other members of the team on how to adapt written materials and verbal interventions to make them accessible.

2. What gaps in service provision currently exist, and how do you think the NHS should address them (these can overlap with Q1 but may include a longer list)?

Gap: Access to community mental health teams

Providing community health services to people in their local area is best for their wellbeing, and makes economic sense. However, a shortage of mental health nurses, combined with increasing demand, means that many people are facing long waits for community mental health support, with the risk that their problems escalate to the point of requiring (expensive) crisis services.

Solution: Extend the mental health workforce to other registered professionals

The NHS should consider filling the gap in the community mental health workforce with appropriately skilled allied health professionals. Speech and language therapists can add huge value to community mental health teams by:

- Accurately identifying and assessing people's need; for example, in line with NICE guidance on recognising and diagnosing ASD, speech and language therapists should be core members of the autism team.
- Adapting verbal interventions and written materials to make them accessible, thereby improving engagement with psychological therapies.
- Providing bespoke advice and training to the rest of the team on communication and swallowing difficulties.
- Facilitating people with mental health needs to express their views, and be actively involved in decisions about their care.
- Supporting safe swallowing and adequate hydration.

3. People with physical health problems do not always have their mental health needs addressed; and people with mental health problems do not always have their physical health needs met. How do you think we can improve this?

Problem:
Physical health problems increase the risk of poor mental health and vice versa. People with both mental health and physical health problems are at higher risk of poor swallowing and/or communication problems.

These communication difficulties mean that people with mental health problems struggle to articulate their physical needs. For example, if they are experiencing a psychotic episode they will find it difficult to focus on or verbally express their physical health problems.

Solution:
Mental health services should have embedded speech and language therapists (SLTs) to support the discussion and identification of physical health needs, especially when these needs are masked by complex mental health issues.

Embedded SLTs can support and train other practitioners to understand the different ways that people communicate, including through non-verbal communication and behaviour.

As SLTs work with people with both physical and mental health conditions they are well placed to be the integrators of care.

We recommend that people with physical and/or mental health problems have their communication and swallowing needs periodically flagged up via regular health and development checks, for example, GP and mental health team checks.

4. What are the major challenges to improving support for people with mental health problems, and what do you think the NHS and other public bodies can do to overcome them?

Challenge:
Mental health services are limited in capacity and often not tailored to the needs of an individual, whose mental health needs can present in many different ways.

People can fall between the gaps in service provision. A person with autism and mental health needs might not be seen by the learning disability team if they do not have a registered learning disability, but may not fit into mainstream mental health services either.

Failure to support communication needs will result in difficulties accessing psychological and talking therapies, and unidentified swallowing needs can lead to pneumonia or death.

Solution:
More individualised packages of care are needed, tailored to the individual.

Speech and language therapists should be embedded in all mental health teams to support communication and swallowing needs before these reach crisis. Extending the community mental health service will help to avoid costly in-patient admissions and out of area placements.

The NHS benchmarking mental health project and the National Workforce Dataset need to be amended to capture the contribution of SLTs, to allow SLTs to improve the service they offer and for wider workforce planning decisions.

5. How can we better personalise mental health services, involving people in decisions about their care and providing more choice and control over their support?

Problem:
Communication problems can have a significant impact on an individual's understanding, expression and thinking skills. Communication needs present a barrier to accessing psychological therapies, which are verbally delivered.

Too frequently sweeping judgements are made on whether someone has or does not have capacity. People with communication difficulties can be perceived to lack mental capacity because their communication difficulties mask competence. This is then mistaken for a lack of capacity, and they may be deprived of their liberty unnecessarily.

Solution:
Embedding SLTs in mental health teams will enable the individual to participate as fully as possible in decision-making, through supporting their understanding and supporting them to express their

preferences.

SLTs can modify verbal psychological programmes to make them accessible and improve engagement.

With appropriate support from an SLT a person may have capacity to make a decision. SLTs should be commissioned to support capacity assessments and best interest decisions, including supporting decisions around complex medical care and support. This can avoid costly litigation resulting from someone being denied of their liberty unnecessarily.

Placements are less likely to break down if someone has been appropriately assessed and supported to make decisions in the first place.

Clinical priorities: Learning disability and autism

Over the last few years there has been increased focus on improving services, and therefore outcomes, for people with a learning disability, autism or both.

Over the next ten years we want to continue building on these foundations, taking further steps to ensure that the right specific support is available where it is needed, and that children, young people and adults with a learning disability, autism or both, and their families, don't face barriers to accessing both specific and more general health, education and care services.

1. What more can the NHS do, working with its local partners, to ensure that people with a learning disability, autism or both are supported to live happy, healthy and independent lives in their communities?
Speech and language therapists (SLTs) play a key role in identifying communication and eating, drinking and swallowing (dysphagia) needs for people with learning disabilities (LD), autism or both. The NHS should ensure that there are joined up, well-coordinated services between health, social care and education that support these people throughout their lifetime, to ensure that every child and young person is screened for communication difficulties (RCSLT is working with PHE on the identification of appropriate screening tools for pre-school children), and to improve identification and management of health needs. By accessing specialist speech and language therapy, individual needs can be met and appropriate measures can be made to their communication environment. It is therefore crucial to improve access to and availability of SLTs to meet needs across the community and acute settings as an integral part of MDTs. SLTs can also provide education and training to the wider workforce to develop and use specific strategies to support inclusive communication and dysphagia management. Developing an e-learning tool similar to the RCSLT's existing resource 'The Box' would help raise awareness of communication difficulties, while dysphagia management can be improved through using the Interprofessional Dysphagia Framework (RCSLT has secured funding to update this).
2. How can we best improve the experiences that people with a learning disability, autism or both have with the NHS, ensuring that they are able to access the full range of services they need?
It is vital that professionals are able to communicate appropriately with these individuals. The RCSLT developed the Five Good Communication Standards. These are good practice standards providing advice to commissioners and providers on making reasonable adjustments to communication that individuals with LD/autism should expect in specialist hospital and residential settings. They also have wider relevance for ensuring people with communication needs have their needs responded to appropriately. By using CQC and regulation as a lever for the enforcement of these, the experiences of people with LD/autism would improve

significantly.

Another way to improve the experiences of these people is to support the development of an inclusive communication environment. The RCSLT and its partners will shortly launch a nationally recognised symbol to represent Communication Access in the UK, akin to the more widely known disability access symbols, as well as underpinning standards. If an organisation displays this symbol it will show they are meeting defined standards that have been developed for use at both operational and organisational levels, creating a much more inclusive environment for people with communication difficulties. The NHS may wish to consider how this symbol and its standards could be used as a lever.

Enablers of improvement: Workforce

There is no NHS without the dedicated, professional and compassionate staff who are there to provide care and ensure services are planned and delivered. However, we know that, while the workforce is growing overall, there are staff shortages in certain areas of the country and we struggle to recruit to some roles. This, together with the rising demand on services can affect patient care and experience.

A number of programmes are already underway to increase recruitment and retention of staff, including the largest ever NHS recruitment campaign. This ten year plan provides an opportunity for the NHS to think about how it can make best use of the skills and experience of its workforce to deliver care in a better way for patients. It is a chance to look at how we make the NHS a better, more inclusive and modern place to work, which attracts and retains more staff.

1. What is the size and shape of the workforce that we need over the next ten years to help deliver the improvements in services we would like to see?
Utilise speech and language therapists (SLTs) better in multi-disciplinary teams SLTs must be more fully utilised within MDTs; providing focus on community-based care and significant contribution to the integration agenda, reducing system pressures. They can help improve productivity, through job planning. They can take on extended roles, for example SLTs taking on the newly formed Designated Clinical Officer role (traditionally reserved for a paediatrician), and in helping to reduce the waiting times for identification of head and neck cancer through voice clinics (usually led by ENT consultants). **Address the workforce vulnerability of the smaller professions** Reductions to services have a big impact on SLTs whose numbers in a setting may already be small. While the speech and language therapy profession has grown in the last 10 years, most of this has been outside the NHS, with managers reducing by 23% since 2010 (NHS digital). This is having an impact in terms of leadership with reducing band 7/8 SLTs, crucial to ensuring professional capability, development of leadership roles and expertise.
2. How should we support staff to deliver the changes, and ensure the NHS can attract and retain the staff we need?
Commitment in the NHS to supporting equitable access to CPD and training CPD in the professions is a regulatory and professional requirement as the mechanism through which high quality patient care is maintained and developed further. From an SLT viewpoint there is currently inequity in access. Employer support is essential in providing equity of access to CPD and other training opportunities, such as in advanced clinical practice, in terms of funding and time allocated. The plan should flag a commitment to the NHS supporting this. **Support all the routes into healthcare professions including apprenticeships** The NHS should actively support providing placements to students, both in terms of equitable access to funding and to supporting the smaller professions in being able to offer them. The reducing leadership at band 6 and 7 is increasing pressure in relation to those able to support placements or apprenticeships. In relation to healthcare apprenticeships, if they are to succeed

for smaller professions there will need to be flexibility in terms of apprentice experience across different Trusts to support learning. Apprentices cannot be a replacement for band 5 staff as they are not qualified.

3. What more could the NHS do to boost staff health and well-being and demonstrate how employers can help create a healthier country?

More support and flexibility

Flexibility is important in helping to manage their work life balance and wellbeing, especially in the SLT context as the profession is 97% female. There needs to be recognition of this in the workforce planning process. We know that despite numbers of SLTs growing significantly in the last 10 years outside the NHS, this increase is not reflected in the NHS. Increasing pressures upon the NHS and low morale may impacting on retention and recruitment of SLTs. RCSLT is taking part in the HEE returners initiative to help address this issue.

Develop an attractive career path and support small professions to make it a reality

SLTs want to see a visible career path that leads to senior roles. This is currently unclear, including for assistants for whom a traditional degree not fit with other commitments. In addition, the impact of austerity is resulting in reductions in senior clinical leadership posts, providing fewer aspirational leaders for the profession. New developments on advanced clinical practice and apprenticeships have potential – but only if professions are supported to make them available. Given that SLT students now have to pay for their own training, a career pathway is critical.

Enablers of improvement: Primary care

The vast majority of people who use the NHS are seen and treated by primary care services such as their local doctors' surgery or local pharmacy. Local NHS services continue to evolve and this includes closer working in local networks to offer improved services.

The primary care workforce is expanding to offer a greater range of treatment options for patients, including clinical pharmacists, advanced nurse practitioners, physiotherapists and mental health therapists. With a growing population and more patients with complex conditions, the pressure on these services continues. Ensuring our primary care services are supported, so they can continue to provide the best care and support for all patients, providing better access to services in local communities and reducing health inequalities and reliance on hospital services, is therefore essential to the a strong and sustainable NHS.

1. How can the NHS help and support patients to stay healthy and manage their own minor, short-term illnesses and long-term health conditions?

Speech and language therapists (SLTs) actively signpost clients to community groups to support their health and wellbeing and to prevent isolation and depression, which are risk factors for people with communication needs.

SLTs play a key role in providing training and strategies to people with communication and swallowing needs (including people with dementia, stroke survivors, and neurological conditions), families and wider workforce to support people express their wishes and live independent lives.

SLTs help support people:

- communicate effectively;
- eat and drink, balancing safety and enjoyment;
- connect and belong;
- exercise their right to self-determination;
- fulfil their day-to-day needs;
- participate in, and contribute to, their community;
- learn to their full potential;
- expand and achieve their life choices

SLTs can also help identify training needs and provide relevant education to people close to patients (including relatives, carers, nursing homes and other professionals) in order to increase knowledge and awareness of the management of a person's speech, language and swallowing disorders. This approach offers a joined up approach between health and social care for those patients presenting with multiple and complex needs. This approach reduces demand on GPs and reduces hospital admission and has been shown to keep people with dementia at home longer.

2. How could services like general practice and pharmacy, work with other services like hospital services to better identify and meet the urgent and long-term needs of patients?

The iCares (integrated care services) model is an example. Developed by the Sandwell and West Birmingham Hospitals NHS Trust in Sandwell, it provides pro-active, integrated and multi-disciplinary community interventions (including SLTs).

The service collaborates with members of primary, intermediate, and secondary care teams and the wider health and social care economy to ensure needs of patients and carers are met as fully, effectively and as efficiently as possible and is delivered through protocol led interfaces with other services, included in the Directory of Services.

For patients with multiple long term conditions iCares provide case managers ensuring integrated care provision for those who are the most vulnerable within the caseload. It is GP led, with regular interaction between GP practices, Community Nursing and iCares.

Local risk stratification tools such as the SWBH frequent fliers data base, LACE and GP MDT referrals are used to identify people at risk of admission to hospital and develop multidisciplinary care plans to reduce risk of admission.

Teams are equipped to look after patients from referral to discharge, across different settings e.g. community clinics, GP surgeries, leisure centres, work-places. This includes meeting prescribing needs and initiating direct access referrals for diagnostics, consultant opinion and hot clinics.

3. What other kinds of professionals could play a role in primary care, what services might they be able to deliver which are currently delivered elsewhere, and how might they be supported to do so?

SLTs already undertake a number of roles as part of primary care teams with the aim of maximising independence and avoiding hospital admission.

SLTs actively signpost clients to community groups to support their health and wellbeing. Working alongside GPs we have examples of SLTs supporting social prescribing.

There is emerging evidence of non-pharmacological treatment approaches, specifically SLT interventions in the treatment of coughs. Cough is the most common symptom for which patients seek medical advice and thus if SLT were to be considered as a routine treatment for the estimated 20% of chronic cough patients for whom medication is ineffective, there could be a significant positive impact on the reducing the economic burden of this condition.

SLTs can provide telephone triage to care homes managing the communication and swallowing problems of those in their care, removing the need for a GP visit. They provide training to care home staff and others to manage decline in swallowing performance from age and disease. SLT intervention is proven to reduce morbidity, mortality and prevent hospital admissions. SLTs have also been developing telehealth solutions in this regard. Evidence from a telehealth project in care homes has indicating savings of £60 on each tele-swallowing assessment.

4. How could prevention and pro-active strategies of population health management be built more strongly into primary care?

SLTs can:

- Directly access care homes - SLTs provide telephone and/or skype triage to care homes using specialist expertise to manage the communication and swallowing problems of those in their care, removing the need for a GP visit. In addition, they provide training to care home staff and others in the community to manage decline in swallowing performance from age and disease. SLT intervention is proven to reduce morbidity, mortality and prevent hospital admissions.
- Actively signpost to a range of community groups to support clients with communication needs to remain active, engaged in their local community and to prevent isolation and depression.
- Support with mental capacity assessment, best interest decisions and 'feeding at risk' policies to offer alternatives to hospital admission towards end of life.
- Support a transformed model for clients with voice loss and vocal disorders, who currently experience long waits within a complex pathway, who could see signposting from wellbeing centres to SLT led 'vocal hygiene' groups (without referral) supported by information on the internet on closed groups online.

Enablers of improvement: Digital innovation and technology

As with any organisation looking to the future, it is also vital that the NHS does as much as possible to implement the new digital and technological innovations that have the most significant potential to change the way that care is provided to patients, improving both outcomes and experience, and to modernise how the NHS operates.

We know that the digital revolution is transforming how the public interact with many different services they receive. The NHS is no different and needs to take advantage of the latest ways in which people access services, in our case their health and care. This could mean a fundamental revolution in how services are provided but it is important we plan carefully so that the public and the NHS understand how to get the best from these changes, better supporting our workforce in their role but also the public in preventing illness and accessing their care.

1. How can digital technology help the NHS to:
a) to improve patient care and experience?

For patients receiving care from allied health professions (AHPs), digital technology has the potential to improve care and experience in the following ways:

- Improving the recording of clinical information through the use of electronic patient record systems compliant with information standards (eg use of SNOMED CT)
- Electronically sharing information relevant to direct patient care between professionals
- Increasing access to services by enabling service users and parents/carers to join appointments by videoconferencing
- Improving patients' ability to access information about their health and care, including access to health records and access to resources (eg apps) to support with monitoring, self-management etc.

Whilst there are a number of opportunities to use digital technologies, eg artificial intelligence within the health service, these building blocks are essential to have in place for AHPs before we can get the most out of new developments. It would be helpful to look at the current level of access to digital technologies and systems by AHPs working in the NHS to scope what is required to support AHPs to be more digitally mature (eg infrastructure requirements) in order to improve patient care and experience. This can be delivered through NHS England's Digitally mature AHP service framework.

b) enable people and patients to manage their own health and care?

Some examples include:

- Apps are available to support patients with monitoring and managing their own health, and possibly to support prevention initiatives (eg apps to support parents to carry out language enrichment strategies to support the communication skills of 'late talkers' that would otherwise be referred to speech and language therapy services).
- Text message reminders about appointments can be sent to support patients to attend appointments.
- Online appointment bookings for some services can support patients to access services.

It is essential to consider the support for digital literacy available to citizens to use digital technologies to support with managing their own health and care.

c) improve the efficiency of delivering care?

- Electronic patient records offer the opportunity to enable information to be captured digitally and shared with relevant professionals involved in a person's care quickly and easily, but more needs to be done to support professionals across health and social care to access IT systems that are compatible and facilitate information sharing.
- The development of minimal datasets for different client groups would improve audit, quality improvement and research. Additionally, the development of existing NHS datasets such as the National Workforce Dataset, which has the potential to support services to make informed decisions at a local and national level to deliver quality workforce and job planning, resulting in more efficient delivery of care.
- Mobile devices can assist with remote working to reduce travel time to office, increasing the amount of time for clinical activities. They also enable clinicians to check and manage their diaries on visits.

2. What can the health and care system usefully learn from other industries who use digital technology well?

- Joint planning and note writing applications (eg Doodle, Trello, Slack) offer the potential to make services more efficient. Often there is duplication of paper-based systems as paper-based notes lead to repetition of information and within an integrated service, make working across different sites less efficient.
- The health and care system can learn from digital transformation projects from other industries, especially the lessons learned around the implementation of new technologies. Digital transformation projects involve change management as the technology requires and supports new ways of working. Supporting the workforce and patients to develop their skills is crucial for successful change.

3. How do we encourage people to use digital tools and services? (What are the issues and considerations that people may have?)

- Connectivity issues have been a challenge when providing therapy or liaison via video-conferencing. Trials before the session increase confidence in the system. Easy user guides for therapists, parents and schools, as well as confident users being available for support in the office, have been beneficial.
- Access to training is important to support professionals and citizens with using digital tools and services.
- Infrastructure is a crucial enabler for both professionals and citizens, including access to devices and internet connection.
- Improving public confidence in cyber security and use of patient data for purposes other than direct care.

4. How do we ensure we don't widen inequalities through digital services and technology?
• Ensuring we are allowing people to access services via smartphones as well as tablets and desktop computers, allowing service users to use computers in local settings eg libraries or a local health centre to access services in a more appropriate setting. • Ensuring that there are a variety of ways of accessing services and information, not just through digital media ie not 'digital only'. For example, people who have had a stroke or have neurological conditions might find computers a barrier.

Enablers of improvement: Research and innovation

Continuing to support research and innovation will be critical to meeting many of the ambitions which will be set out in the long term plan. The NHS is a world leader in this field, and in the most recent development the 100,000 Genomes Project - which involved 70,000 people with rare diseases and cancer in a study of how best to use genomics in future NHS care - has provided the foundation for a new era of personalised medicine. This will benefit patients through the ability to develop targeted therapies tailored to people's individual health needs based on improved understanding of our genetic makeup.

The NHS's ambition is to continue to be one of the best health systems in the world in which to research, develop and trial new treatments and services that can make meaningful differences for patients. We will also be looking into how we can go further to attract researchers and innovators, while at the same time maintaining the confidence of patients in trials and the use of their data to support vital research.

1. How can we increase opportunities for patients and carers to collaborate with the NHS to inform research and also encourage and support the use of proven innovations (for example new approaches to providing care, new medical technologies, use of genomics in healthcare and new medicines)?
Public health campaigns need to raise awareness of research beyond drugs trials. Opportunities to get involved in research should be advertised routinely so that people are regularly invited and encouraged. By streamlining access across organisations, administration could be reduced, whilst maintaining rigour. Patient and carer representation on patient and public involvement panels associated with research centres is imperative. Innovative, multiple approaches are needed to engage people with communication difficulties in research. Additional time and resources will ensure people with communication difficulties can access research involvement opportunities. SLTs are uniquely placed to work with these individuals and research has demonstrated that involvement of people with communication difficulties is possible. To provide an evidence-based service, clinicians need to be informed regarding current research and need designated/protected time to consult and critically appraise this. Service managers need to consider how to implement research into practice. Funding needs to be available for implementation science projects and innovations should be shared. The RCSLT has developed a learning journey on eHealth to develop knowledge and skills in new medical technologies. This expert group continue to think of innovative ways to share information about emerging medical technologies and how these can be incorporated into practice.

2. What transformative actions could we take to enable innovations to be developed, and to support their use by staff in the NHS?

Funding is required for low-risk, small scale health technology assessments that are structured for robust evaluation, with a clear roll out process in place if successful and shut down process in place if not.

In order to provide evidence based care funding for services needs to be increased to allow services to follow protocol set out in research studies, such as increasing SLT contact time. Funding service design and data collection also needs to take into consideration the indirect contact time that professionals provide (for example, providing support to parents/carers as part of role) in order to be a truly evidence based profession.

We need to consult with stakeholders about priorities for research funding including populations with communication disability who are currently excluded.

3. How can we encourage more people to participate in research in the NHS and do so in a way that reflects the diversity of our population and differing health and care needs?

- Promote current research needs through a variety of channels, encouraging evidence-based practice and alerting patients and the public, including those with communication difficulties, to opportunities for involvement.
- Provide funding and support to facilitate opportunities for people with speech, language and communication needs to participate in research projects at the design, set up and dissemination stages.
- Build on current PPI initiatives – i.e. the RCSLT, in collaboration with the National Institute for Health Research, has successfully engaged service users and therapists in a research priority setting exercise for people with dysphagia and learning disabilities, resulting in a 'top 10' list of clinically relevant research priorities.
- Create opportunities for clinicians and their patients to get involved in research projects – this is particularly vital in trusts that do not have an R&D department – highlighting the benefits participating in quality improvement and research.
- Strengthening the requirement to develop minimal datasets associated with different client groups to increase the quality of audit, quality improvement and research.
- Publicise the outcomes and impact of public/patient involvement in research.

4. What should our priorities be to ensure that we continue to lead the world in genomic medicine?

N/A

Enablers of improvement: Engagement

On-going engagement with stakeholders, staff, patients and partner organisations will be central to the long-term success of the plan. As well as the current engagement on the content of the long term plan, we will also be developing our thinking around how we build on existing processes and functions to create a space that encourages regular, meaningful and effective engagement opportunities that:

- Embed people's experiences into evaluation of performance against the plan's ambitions and,
- Ensure that the NHS continues to respond to the needs of patients, including those whose voices often go unheard as the plan is delivered.

1. How can the NHS encourage more people to share their experiences in order to provide an evidence base for checks on whether changes introduced under the long term plan are driving the changes people want and need?
The NHS should ensure that people with speech, language and communication needs (SLCN) are able to provide feedback and to understand that this feedback is being listened to. This may require the provision of adapted materials and modes of communication. It is also important that there are local initiatives to support and engage the diverse population within the NHS.
2. How can the NHS improve the way it feeds back to people about how their input is shaping decisions and demonstrate that the NHS is the world's largest learning organisation?
As well as being in formats accessible to those with communication needs, feedback options should minimise the impact on service users. Examples include a short survey at the end of an appointment, completing a questionnaire in the waiting room, feedback via text/email.