

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

Service Specification Number	05/MHLD/0008
Care Pathway/Service	SPEECH AND LANGUAGE THERAPY SERVICES Adult Learning Disabilities Services
Commissioner Lead	CCP for Mental Health & Learning Disability
Provider Lead	Sue Walsh and Kirsty Mayhew, Bournemouth and Poole Community Health Services
Period	1 st April 2013 - 31 st March 2014

NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	√
Domain 3	Helping people to recover from episodes of ill-health or following injury	√
Domain 4	Ensuring people have a positive experience of care	
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

1. Purpose

1.1 Aims

The purpose of the Speech and Language Therapy service for Adults with Learning Disabilities (SALT ALD service) is to anticipate and respond to the needs of individuals who experience communication and / or eating & drinking difficulties.

The service focuses on the prevention and management of communication and eating & drinking difficulties and works across several levels: specialist LD services, mainstream and community, in line with the Royal College of Speech and Language Therapy Position Paper for Adults with Learning Disabilities (RCSLT, 2010).

In accordance with best practice and national guidelines, the SALT ALD service works in partnership with individuals, their families / carers and relevant professional groups, organisations and agencies to:

- Support and promote inclusive communication and safe eating & drinking in the lives of people with learning disabilities.
- Enable others to address the barriers to communication that adults with LDs experience, in order to maximise their independence, choice, control, inclusion and enjoyment of rights.
- Prevent communication and eating & drinking difficulties.
- Reduce the impact and risks associated with communication and eating & drinking difficulties.

The SALT ALD Service contributes to the achievement of national and local policy and strategic plan objectives. These are included in section 1.2.

1.2 Evidence Base

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

Key legislation:

- Equality Act 2010
- Autism Act 2009
- Mental Capacity Act 2005
- Disability Discrimination Act 2005
- Human Rights Act 1998

Key national policies and strategic plans:

- Care Quality Commission (2009) Strategic plan 2010-2015. Position statement and action plan for LD.
- DH (2010) Equity and excellence: liberating the NHS.
- DH (2010) Fulfilling and rewarding lives. The strategy for adults with autism in England.
- DH (2010) Improving the health and well being of people with long term conditions.
- DH (2010) Six lives progress report.
- DH (2009) National dementia strategy.
- DH (2009) Valuing people now: a new three year strategy for people with LDs.
- DH (2001) Valuing people.
- Mansell, J. (2010) Raising our sights: services for adults with profound intellectual and multiple disabilities.
- Mansell, J. (2007) Services for people with LD and challenging behaviour or mental health needs.
- Mencap (2010) Communication and people with the most complex needs: what works and why this is essential.
- Mencap (2007) Death by indifference.
- NPSA (2004) Understanding the patient safety issues for people with LDs.
- Michael, J. (2008) Healthcare for all: report of the independent inquiry into access to healthcare for people with LDs.
- RCSLT (2010) ALD position paper.
- RCSLT (2009) Resource manual for commissioning and planning services for speech, language and communication needs – LD.
- RCSLT (2006) Communicating quality 3.
- RCSLT (2005) Clinical guidelines.

Key local policies and strategic plans:

- Communication For All Action Plan for Bournemouth, Poole and Dorset (2010/11)
- LD Health Self Assessment and Action Plan for Bournemouth & Poole (2010/11)
- LD Health Self Assessment and Action Plan for Dorset (2010/11)
- Bournemouth Joint Community Team for People with Learning Disabilities – Draft Operational Policy
- Poole Integrated Community Learning Disability Team – Draft Operational Policy
- Dorset Integrated Community Team for Adults with a Learning Disability – Draft Operational Policy
- Intensive Support Service – Operational Policy
- Bournemouth, Dorset and Poole Vulnerable Adult Protection Policy and Procedures (2007)

1.3 General Overview

The SALT ALD Service is provided for adults with LDs who are:

- living in Bournemouth, Poole and Dorset with a registered GP under Dorset CCG

Learning disability is defined in Valuing People (DH, 2001) as including the presence of:

- a significantly reduced ability to understand new or complex information and to learn new skills (impaired

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

intelligence);

- a reduced ability to cope independently (impaired social functioning);
- which started before adulthood, with a lasting effect on development.

It is widely accepted that an assessment of social functioning and communication skills should be taken into account when determining need, and that a low intelligence quotient of 70 or below is not, on its own, a sufficient reason for deciding whether an individual should be provided with additional health and social care support.

Prevalence

The Care Quality Commission (2009) reports that there are an estimated 800,000 adults with learning disabilities in England, with approximately a quarter, mostly those with more significant disabilities, being known to services. The majority of people with mild or moderate disabilities do not have access to social care or specialised healthcare support.

The number of people with a Learning Disability is increasing due to:

- Improved survival rates among young people with severe and complex disabilities.
- Reduced mortality among older people with a LD.

Local health and social care figures

	No. of adults registered with a GP as having LD in 2010	No. of adults with LD known to Local Authorities in 2010
Bournemouth	784	521
Poole	549	510
Dorset	1278	1,222
Total	2,611	2,253

Figures supplied by NHS Bournemouth & Poole, NHS Dorset and Local Authorities.

Health needs of people with LDs

People with LDs are recognised as having poorer health than the rest of the population and being more likely to die at a younger age. Their access to the NHS has been reported as often being poor and characterised by problems that undermine personalisation, dignity and safety. A number of national reports have identified abuse, undiagnosed illness and in some cases avoidable death (Valuing People Now, 2009).

SALTs have two key areas for assessment and intervention:

- Communication
- Eating & drinking

Communication difficulties

Up to 90% of people with a LD have communication difficulties, with half having significant difficulties (RCSLT, 2010).

These include difficulties with:

- vision and hearing

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

- understanding non-verbal, verbal and written communication
- understanding time
- understanding and making choices
- expressing needs, feelings and wishes
- speech production
- social understanding, communication and interaction

Eating and drinking difficulties

Although there are no figures available, the National Patient Safety Agency has identified eating & drinking difficulties as one of the five key areas of risk for people with LDs. It has reported that eating & drinking difficulties are more common in people with LDs and that, if not managed safely, they can lead to respiratory tract infections, a leading cause of early death for people with a Learning Disability (NPSA, 2004).

The nature of eating & difficulties can be wide ranging:

- Physical e.g. delayed or disordered swallow
- Side effects from medication e.g. reduced alertness and muscle co-ordination
- Sensory e.g. aversion to certain foods
- Communication e.g. difficulties expressing needs, feelings and wishes
- Behavioural e.g. rushing, cramming, taking food and drinks from other people
- Environmental e.g. being distracted by surrounding stimuli
- Eating non food substances (Pica)

An increase in the number of people with severe and complex disabilities means that there will be more people requiring higher levels of support with communication and eating & drinking.

An increase in the number of people with LDs living longer means that there will be more people who experience communication and eating & drinking difficulties associated with acquired conditions, such as dementia and stroke.

Integrated Service Delivery:

The RCSLT Position Paper for Adults with LDs (RCSLT, 2010) states that SALTs should be commissioned as core members of multidisciplinary teams working with this client group due to the high incidence of communication difficulties.

The SLT ALD service is part of the wider LD service covering Bournemouth, Poole and Dorset, and works in partnership with the multidisciplinary LD teams to deliver, whenever possible, a joint service. The LD service is currently undergoing a process of service redesigned in order to integrate health and social care services and support people included in the NHS campus re-provision programme to live in the community.

The redesign of the LD service for Bournemouth, Poole and Dorset includes the following elements:

- Integrated Community LD Teams
- Intensive Support Service

Integrated Community LD Teams (CLDT)

The aim of the CLDTs is to provide a health and social care service for people with LDs that promotes their independence, choice, control, inclusion and enjoyment of rights. This is achieved by:

- Assessing the health and social care needs of service users.

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

- Informing service users and their families / carers about support and treatment options.
- Providing person-centred support and treatment that enables service users to achieve their goals.
- Assisting service users to access a range of mainstream services.
- Safeguarding people with LDs.

The following integrated teams have been identified:

- Bournemouth Community LD Team
- Poole Community LD Team
- East Dorset Community LD Team
- West Dorset Community LD Team
- Weymouth & Portland Community LD Team

The SALT ALD service has contributed to the draft operational policies for these teams and has been included in the plans to co-locate team members.

The SALT ALD service has not been included in the Section 75 Agreement detailing the joint working arrangements between the Local Authorities and DHUFT. At present, it has been agreed that there will be a partnership approach to CLDT working and that the SALTs will continue to be line managed by the SALT ALD Team Leader.

Intensive Support Service (ISS)

The aim of the ISS is to provide a specialist service for adults with LDs living in the community who present with behaviours that challenge services, including people who have moved on under the campus re-provision programme. It will supplement the service offered by the integrated CLDTs by:

- Providing support for service users with more complex needs.
- Offering rapid and intensive support which helps service users to remain in their own homes.
- Helping the CLDTs to identify and respond to more severe and risky behaviours which might threaten the viability of the person continuing to live in the community.
- Informing life plans based on a thorough understanding of the needs of service users in terms of their complex behaviour and experiences.
- Helping to design and support improvements in local services so as to enable people in out of area placements to return to their home area.

The SALT ALD service has contributed to the operational policy for this service and has been included in the plan to co-located team members.

Any changes required to the existing SALT ALD service framework as a result of the redesign of LD services will need to be reviewed through contract negotiations.

1.4 Objectives

The objectives of the SALT ALD service are to:-

- Work in partnership with service users and their families / carers and other professions, organisations and agencies to maximise their abilities and opportunities to communicate and / or eat & drink safely.
- Assess service users' communication and eating & drinking difficulties.
- Provide person-centred management plans and packages of care that are evidence based and in line with

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

best practice.

- Support service users to access mainstream adult community and acute SALT services.
- Work in partnership with paediatric SALT services to support the transition of young people with LDs and communication and / or eating & drinking difficulties.
- Advocate on behalf of individuals with communication and / or eating & drinking difficulties when required.
- Alert services to risks and safeguarding issues when required.
- Provide advice, consultancy and training.
- Provide agreed clinical placements for SALT students.
- Contribute to relevant networks by sharing information, ideas and good practice.
- Support services to make reasonable adjustments in relation to communication as required by the DDA.
- Contribute to service developments that promote inclusive communication and safe eating & drinking.
- Provide services as efficiently as possible within allocated resources and ensure timely discharge of individuals.

1.5 Aims / Outcomes including improving prevention

The aims of providing a specialist SALT service for adults with LDs are to:

- Provide person-centred, individually tailored support that maximises the individual's abilities and opportunities to communicate and / or eat & drink safely.
- Improve health and well being.
- Increase independence.
- Increase choice and control.
- Increase social inclusion.
- Improve access to mainstream services.
- Reduce anxiety, frustration, distress and behaviour that challenges.
- Prevent placement breakdown and crisis.
- Prevent unnecessary hospital admissions.

2. Scope

2.1 Service Description

Description of SLT ALD service within RCSLT ALD tiered model (RCSLT, 2010)

Tier	Description of local SALT ALD service
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Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

	<p>Work in partnership with referred individuals and relevant others e.g. family, carers, support providers, multidisciplinary team members, advocates.</p> <p>Complete triage and assessment of individual's communication and / or eating and drinking.</p> <p>Provide advice and written guidance.</p> <p>Agree goals for SALT intervention to ensure planning is realistic and takes account of the priorities for the individual.</p> <p>Provide / support agreed intervention, including specific training on how to support the individual with their communication and / or eating & drinking difficulties.</p> <p>Discuss and agree plans for discharge.</p> <p>See section 3.2 for more details</p>
	<p>Tier 2: Capability in specialist LD services</p> <p>Interventions which contribute to the creation and maintenance of capable specialist LD services.</p> <p>Ensuring that specialist LD services are able to support the individuals referred to the SLT ALD service is a core activity at this level.</p> <p>Help people with LDs to make and / or use communication passports, tools and equipment to support their communication with people in specialist LD settings.</p> <p>Provide mealtime guidelines so that people with LDs can be supported to eat & drink safely in specialist LD settings.</p> <p>Support multidisciplinary team members to use inclusive communication through joint working around individuals e.g. mental capacity, safeguarding.</p> <p>Provide specific training on how to support an individual with their communication and / or eating & drinking difficulties.</p> <p>Provide general staff training programmes:</p> <ul style="list-style-type: none"> • Total Communication • Dysphagia awareness training <p>Contribute to projects, training and events e.g. LD health days.</p> <p>Support services to complete a Communication Action Plan.</p> <p>Provide advice and consultancy re improving communication access in specialist LD services.</p> <p>Contribute to strategic planning for specialist LD services:</p> <ul style="list-style-type: none"> • LD Health Action Groups • Communication For All Group • Intensive Interaction Steering Group
	<p>Tier 3: Capability in mainstream</p> <p>Intervention to enable the development of</p> <p>Help people with LDs to make and / or use communication passports, tools and equipment to support their communication with people in mainstream settings.</p> <p>Provide mealtime guidelines so that people with LDs can be supported to eat & drink safely in mainstream settings.</p> <p>Support adults with LDs to access mainstream services related to their communication and eating & drinking difficulties:</p> <ul style="list-style-type: none"> • Adult community and acute SALT services.

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

<p>capable mainstream services to address the needs of people with LDs with communication and eating & drinking difficulties</p> <p>Supporting adults with LDs referred to the SLT ALD service to access mainstream services related to their communication and eating & drinking difficulties is a core activity at this level.</p>	<ul style="list-style-type: none"> • Audiology - SALT ALD assistant employed to support clinic for adults with LDs. <p>Support staff working in mainstream services to use inclusive communication through joint working around individuals e.g. police service.</p> <p>Contribute to projects, training and events e.g. supporting patients with LDs in acute hospitals.</p> <p>Provide advice and consultancy re improving communication access in mainstream services.</p> <p>Contribute to strategic planning for mainstream services:</p> <ul style="list-style-type: none"> • LD Health Action Groups • Communication For All Group • LD & Criminal Justice Steering Group • SALT Dysphagia Working Party
<div style="text-align: center;">  </div> <p>Tier 4: Capability in the community</p> <p>Interventions to promote health, well being and inclusion of people with LDs at a general population level.</p> <p>Supporting adults with LDs referred to the SLT ALD service to access community settings is a core activity at this level.</p>	<p>Help people with LDs to make and / or use communication passports, tools and equipment to support their communication with people in community settings.</p> <p>Provide mealtime guidelines so that people with LDs can be supported to eat & drink safely in community settings.</p> <p>Provide advice and consultancy re improving communication access in the community.</p> <p>Work in partnership with local self advocacy groups to support projects, training and events.</p>

The level of involvement and input into these four tiers is dependent on the resources available and the commitment of partner organisations and agencies.

2.2 Accessibility/acceptability

Adults with LDs who have communication and / or eating & drinking difficulties have a right of equal access to the SALT ALD service regardless of age, disability, economic status, ethnic, cultural and linguistic background.

Once a referral is accepted, individuals are prioritised according to risk to ensure that resources are targeted where the greatest risks lie.

Working within allocated resources, SALT is provided in the location that is most conducive to achieving the aims of assessment and / or intervention.

2.3 Whole System Relationships

The SLT ALD service is part of the wider LD service covering Bournemouth, Poole and Dorset and works in partnership with other organisations and agencies in order to deliver joint services, achieve shared objectives and meet the needs of people with LDs. These include:

- Bournemouth People First

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

- Poole Forum
- Dorset People First
- Dorset Advocacy
- Bournemouth Borough council
- Borough of Poole
- Dorset County Council
- Dorset CCG should this not be the CCG now??
- NHS Dorset as above
- Dorset HealthCare NHS University Foundation Trust
- Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust
- Poole Hospital NHS Foundation Trust
- Dorset County Hospital NHS Foundation Trust
- Housing & Support Providers
- Residential / Nursing Care Providers
- Schools and FE Colleges

2.4 Interdependencies

The SALT ALD service is reliant on working in partnership with adults with LDs and the people who support them. Successful outcomes for individuals with communication and / or eating & drinking difficulties are usually dependent on the level of commitment to partnership working, the resources available and the way in which agreed plans are implemented by those involved.

Partnership working includes:

- People with LDs
- Families and carers,
- Support and care providers
- Multi-disciplinary team members
- Advocates
- GPs
- Consultants
- District nursing
- SALTs from local adult & paediatric services and out of area specialist centres
- Dietitians
- Audiology staff
- Teachers and tutors
- Community police officers
- Interpreters

Working within allocated resources, SALT is provided in the location that is most conducive to achieving the aims of assessment and / or intervention. Locations may include:

- Client's home
- Residential / nursing homes
- Respite services
- Day services
- Workplaces / Employment service

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

- Community settings
- Schools
- Further education colleges
- Out patient clinics
- Inpatient settings

2.5 Relevant Clinical Networks and Screening Programmes

- SALT ALD National Network
- SW Total Communication Network
- SALT Dysphagia Working Party
- LD Partnership Boards and sub-groups e.g. Communication For All Group
- LD Health Action Group for Bournemouth, Poole & Dorset
- LD & Criminal Justice Steering Group for Bournemouth, Poole & Dorset
- Intensive Interaction Steering Group for Bournemouth, Poole & Dorset
- Long-term Conditions Network
- GP Health Checks for adults with LDs

2.6 Sub-Contractors

Although there are no formal sub-contracting arrangements for this service, private practitioners may occasionally be employed as locums.

The SALT ALD service may train staff to support referred individuals with communication and / or eating & drinking difficulties as part of SALT intervention. There is no charge for this specific, service user related training.

General training for the wider workforce is commissioned separately.

3. Service Delivery

3.1 Service model

See 2.1 for tiered model.

3.2 Pathways

In general, SALT ALD care pathways include the following:-

Phase 1: Triage

A telephone risk impact assessment is completed within 2 working days in order to determine:

- Appropriateness
- Need for onward referral / signposting
- Urgency
- Complexity

Phase 2: Assessment

SALT assessment is completed in order to:

- Determine the individual's mental capacity to consent to assessment and establish consent / best interest

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

decision.

- Gain an overview of the service user's communication / eating & drinking, and any issues relating to their communication / eating & drinking and / or their communication / mealtime environment(s).
- Clarify any aspects where the current evidence and / or opinion is limited, ambiguous, conflicting or non-existent.
- Determine the need for additional specialist assessment e.g. communication aids, video fluoroscopy examination.
- Provide appropriate advice and support strategies to minimise risks to health and well-being.
- Identify relevant resources and equipment.
- Determine whether or not further SALT intervention is required, and the nature of intervention if required.

Service users with complex needs who require a communication aid and service users who require a high tech communication aid may require additional assessment from a regional specialist centre e.g. Frenchay Communication Aid Centre, Oxford Centre for Enablement. This assessment will need to be commissioned separately.

SALT assessment involves the service user and relevant others e.g. family members / carers, support provider, multi-disciplinary team members, advocate, and may contribute to multidisciplinary assessment and / or differential diagnosis. The timescale for completion varies according to the complexity of the person's difficulties and situation.

Plans for discharge are discussed with the service user and / or relevant others where further intervention is not indicated. See Discharge Criteria and Planning (Section 5) for more information.

Phase 3: Planning

The goals for SALT intervention are discussed and agreed with the service user and / or relevant others in order to establish consent / best interest decision, and ensure that planning is realistic and takes account of the priorities for the individual and available resources.

Phase 4: Intervention

When required, SALT intervention includes at least one episode of care, involves the service user and relevant others, and is reviewed and amended as necessary.

The role of the SALT varies according to the nature of the intervention required. This may include specific training on how to support the service user with their communication and / or eating & drinking difficulties.

Phase 5: Discharge

See Discharge Criteria and Planning (Section 5) for more information.

Specific SALT care pathways for adults with LDs include:

- Dysphagia
- Communication
- Paediatric to FE / Adult Services SALT Transition Care Pathway

SALT works in line with multi-disciplinary / agency care pathways for adults with LDs where these exist e.g. Dementia care pathway.

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage / boundaries

Bournemouth, Poole and Dorset

4.2 Location(s) of Service Delivery

Main office:

Hillcrest 31 Slades Farm Road Ensbury Park Bournemouth BH10 4EU

Other bases:

Delphwood Ashdown Close Canford Heath Poole Dorset

1a Acland Road, Dorchester, Dorset, DT1 1EF

Working within allocated resources, SALT is provided in the location that is most conducive to achieving the aims of assessment and / or intervention. Locations may include:

- Client's home
- Residential / nursing homes
- Respite services
- Day services
- Workplaces / Employment service
- Community settings
- Schools
- Further education colleges
- Out patient clinics
- Inpatient settings

4.3 Days/Hours of operation

The service is delivered 52 weeks of the year within the capacity funded by the commissioners. The service operates Monday to Friday during normal office hours. Staff may work flexible hours in order to achieve the aims of assessment and intervention e.g. undertaking breakfast and evening mealtime assessments.

4.4 Referral criteria & sources

The SALT ALD service operates an open referral system.

Access criteria

A service is currently offered to people who have a learning disability, are over 16, and are known to learning disability services with a registered GP in B&P PCT or a Dorset GP, and where there is one or more of the following:

- Concern about the person's communication and / or eating & drinking
- Change in the person's communication and / or eating & drinking
- Other change affecting the person, such as moving from child to adult services

A service is only offered where there is someone to support and follow up SALT input.

4.5 Referral route

Referrals can currently be made by post or fax. Referrals are accepted by phone if they are a self-referral or for a

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

person with eating & drinking difficulties.

4.6 Exclusion criteria

- Adults who do not have a learning disability.
- Where SALT services have not been commissioned as a part of local LD services. A limited service will be offered in order to minimise clinical risk e.g. Low secure service / Adults with Aspergers.

The service will endeavour to provide cover to meet the minimum specification requirement in the event of long term leave such as maternity leave, however, should this not be possible for operational reasons, the parties will meet to agree a way forward.

4.7 Response time & detail and prioritisation

The SALT ALD service aims to:

- Complete a telephone risk impact assessment within 2 working days in order to prioritise new referrals.
- See clients with high risk eating & drinking difficulties within 10 working days.
- Provide treatment within 18 weeks.

5. Discharge Criteria and Planning

Discharge is at the discretion of the SALT. Plans for discharge are discussed and agreed with the service user and relevant others e.g. family members / carers, support provider, multi-disciplinary team members, advocate.

Plans for discharge may be discussed when:

- Agreed goals have been achieved.
- An appropriate plan is in place to manage communication and / or eating & drinking difficulties.
- Alternative SALT provision is available
- Communication and / or eating & drinking issues are no longer a priority.
- Further intervention is not indicated.
- Non compliance.
- Failure to attend appointments.

A discharge report will be completed and sent to the service user and / or relevant others. This will include:

- Reason for referral
- Summary of input and outcomes
- Current action plan / recommendations
- Re-referral details

6. Prevention, Self-Care and Patient and Carer Information

- General SALT information sheets for service users and carers
- General training e.g. Total Communication training programme
- Sign posting to other services and organisations

7. Continual Service Improvement/Innovation Plan

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

<i>Description of Scheme</i>	<i>Milestones</i>	<i>Expected Benefit</i>	<i>Timescales</i>	<i>Frequency of Monitoring</i>
Integrated Community LD Teams	Agree Operational Policies. Provision of accommodation for co-location.	More timely and co-ordinated delivery of SALT as part of the integrated health and social care service provided by the CLDTs.	this has been completed	Monthly
Intensive Support Team	Agree Operational Policy. Provision of accommodation for co-location.	More timely and co-ordinated delivery of SALT as part of the specialist health service provided by the Intensive Support Team.	completed	Monthly
Integrated Electronic Service User Record	IT services to enable SALT access to RiO from office at KPH. Arrange RiO training for SALTs working as part of the CLDTs.	Access to live, up to date, electronic records, multi disciplinary risk assessments, care plans and notes.	completed	Monthly
Dysphagia Policy	Consult SALT Teams and relevant stakeholders. Agree policy.	Clarify the roles and responsibilities of relevant stakeholders in supporting people with eating & drinking difficulties.	December 2011	Bi monthly
Care pathways to support ALD access to mainstream adult community & acute SALT services	Consult SALT Teams and relevant stakeholders. Agree pathways.	Improved joint working between ALD and mainstream adult SALT services.	April 2011	Monthly
Communication aid care pathway, care plan & toolkit for adults with LDs	Complete care pathway, plan & toolkit.	More consistent SALT practice across area.	December 2011	Monthly
Communication Action Plan for services	Complete document Produce document in an easy read format.	Services able to undertake an inclusive communication self assessment and produce an action plan for making service improvements.	June 2011	Monthly
Total Communication training programme Total Communication training programme	Agree funding for people with LDs to be co-trainers. Update training to include the Mental Capacity Act, and ways of supporting people with LDs to make choices and decisions.	Inclusion of people with LDs as co-trainers. Help people to work within the law when supporting people with LDs to make choices and decisions.	September 2011	Monthly

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

8. Baseline Performance Targets – Quality, Performance & Productivity

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Frequency of Monitoring</i>
<u>Quality</u>				
Insert relevant Vital Signs indicators				
Insert relevant indicators from National Indicator Quality Improvement Programme				
Insert selected indicators from Transformation Guides				
Service User Experience Experience Improvement Plan Reducing Inequalities Reducing Barriers Personalised Care Planning				
Outcomes				
[Any additional local indicators]				
<u>Performance & Productivity</u>				
Insert relevant indicators from Transformation Guides				
Improving Productivity				
Unplanned admissions				
Access				
<i>Additional Measures for Block Contracts:-</i>				
Staff turnover rates				
Agency and bank spend				
Contacts per FTE				

9. Activity

9.1 Activity

<i>Activity Performance Indicators</i>	<i>Method of measurement</i>	<i>Baseline Target</i>	<i>Threshold</i>	<i>Frequency of Monitoring</i>
Referral To Treatment	B&P CHS data collection Exception reporting	18 week national referral to treatment waiting time	95 %	Monthly
Number of initial contacts per year	SALT data collection	190		Monthly
Number of follow up contacts per year	SALT data collection	2640		Monthly

Service Specification: Speech and Language Therapy Services Adult Learning Disability Services (Final)

9.2 Activity Plan / Activity Management Plan

- Prioritise high risk referrals.
- Clinical decision making based on assessment and differential diagnosis.
- Scope of SALT involvement based on risk assessment and available resources.
- Caseload management based on risk assessment.

Activity data is currently collected monthly and is based on:

- Number of initial contacts
- Number of follow up contacts

9.3 Capacity Review

SALT capacity is monitored monthly.

10. Currency and Prices

10.1 Currency and Price

Basis of Contract	Currency	Price	Thresholds	Expected Annual Contract Value
Block/cost & volume/cost per case/Other _____*		£		£
Total		£		£

**delete as appropriate*

10.2 Cost of Service by Commissioner

Total Cost of Service	Co-ordinating Commissioner Total	Associate Total	Associate Total	Associate Total	Total Annual Expected Cost
£	£	£	£	£	£