Title of Guideline	Community Adult Speech and Language Therapy: AAC Clinical Guideline Care Pathway
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Explicit definition of patient group to which it applies	
Abstract	
Statement of evidence base of the guideline Evidence Base (1-5)	Recommended best practice based on the clinical experience of the team.
Consultation Process	The pathway was developed in consultation with the Community Adult Speech and Language Therapy Team
Target Audience	Community Adult Speech and Language Therapy Team
This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date.	

1a	Meta analysis of RCT
1b	At least 1 RCT
2a	At least 1 well designed controlled study without randomisation
2b	At least 1 other well designed quasi experimental study
3	Well –designed non-experimental descriptive studies (ie comparative / correlation and case studies)
4	Expert committee reports or opinions and / or clinical experiences of respected authorities
5	Recommended best practise based on the clinical experience of the guideline developer

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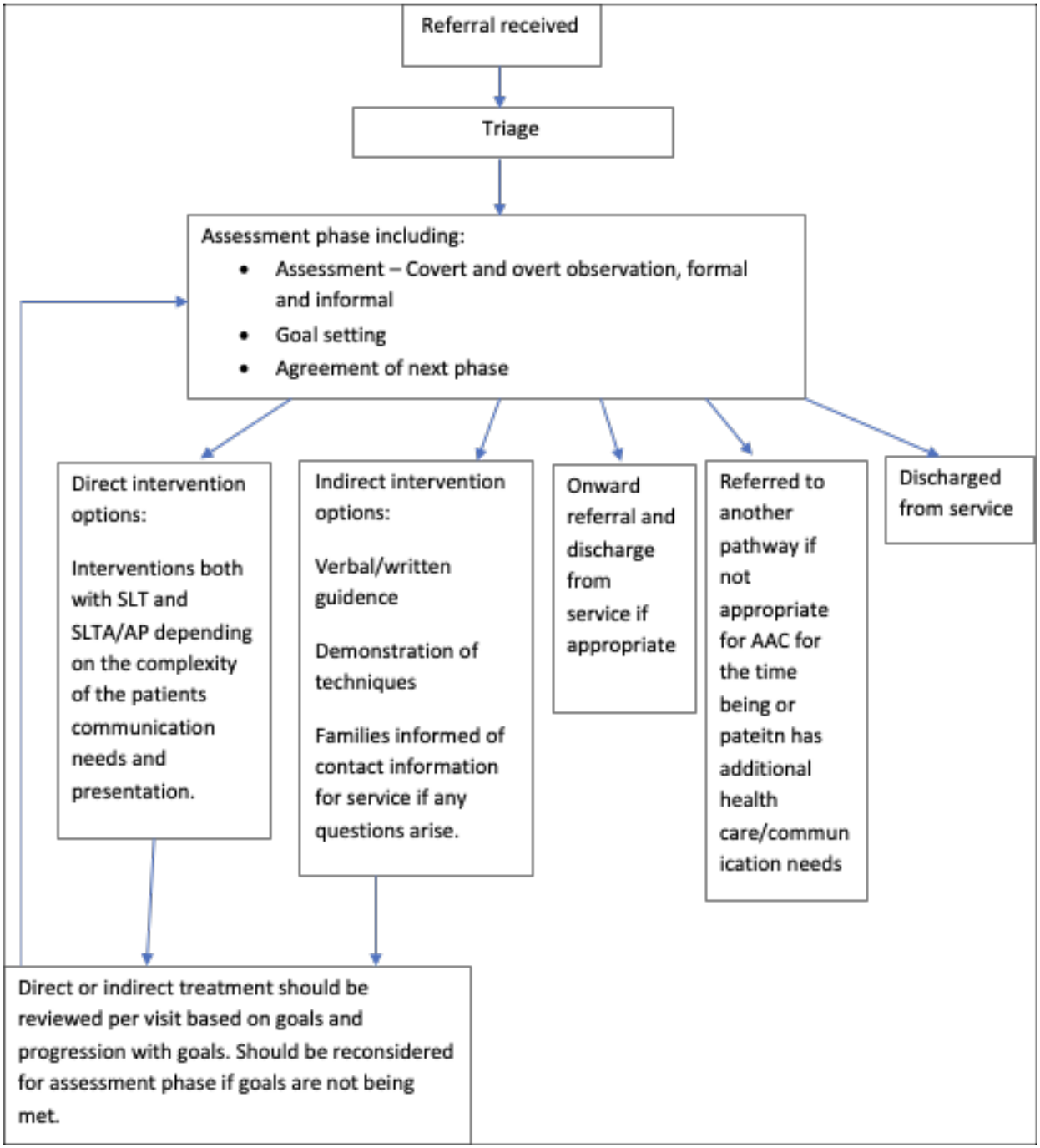
AAC Care Pathway

For the use of community adult speech and language therapists only



AAC Care Pathway Guidelines

The Royal College of Speech and Language Therapists (RCSLT) gives the following description “Augmentative and Alternative Communication (AAC) refers to systems which support or replace spoken or written communication, and these communication systems include technology relating to teaching, learning, mobility, environmental control, and employment.”

There are two main types of AAC systems:

- Unaided communication, using just your body
- Aided communication, using tools

Unaided communication refers to the use of systems involving the user’s body, such as body movements, facial expressions, gestures, signing, eye-pointing and vocalisations.

Aided communication can involve low-tech, e.g. paper-based or high-tech, device-based methods. Some people have additional physical difficulties and may need to use different ways to access these AAC methods.

Aided communication systems can be divided into two systems, powered and unpowered:

- Communication charts, symbol levels and books with no power system.
- Technology that makes use of equipment that has a power system. The device usually allows the individual to access speech output or written output.
- A Voice Output Communication Aid (VOCA), for example, allows the AAC speaker to communicate using speech output which may be digitised (recorded) speech or synthesised speech (Schlosser et al, 2003, 2007).
- There are a wide variety of VOCAs available of differing shapes, sizes and weights and can store different amounts of information in different organisations. Patients with physical limitations may need to use alternative access to operate a communication device. This may be a switch, joystick, touch screen or eye gaze unit. VOCAs and communication software can utilise static displays where the symbols are always on display on the device or have dynamic displays that allow the person to navigate between many sets of symbols and across levels or pages (Beukelman & Mirenda 2005).”

1 Triage

Refer to the relevant team’s triage guidelines for further information about the triage process including allocation of pathways and decisions about location of assessment (virtual, home, clinic, day centre).

The triage should be a brief overview of the patient's referral, gathering the information provided and using this to determine the next steps in the patient's care, including allocation of pathways and evidence-based intervention if appropriate.

Suggested questions:

- Has the patient had previous experience of AAC before? What was the outcome of this?
- Who has referred the patient? Who wants the assessment? (GP / social worker / day centre / family).
- Appropriateness for AAC - Do they have intentional communication? How are they communicating currently? Is there communication currently effective?
- What is the patient's general functioning?

If the referral is not for a communication aid, then an onward referral is needed to the appropriate source. For example, environmental controls for an already existing AAC device would need to be referred to Assistive Technology.

After triage the patient will be informed of outcome and informed of expected waiting times.

This process is for patients that are new to the team. If patient has been transferred from another pathway triage information would already have been gathered.

2 Assessment

The assessment phase may occur over several sessions and includes:

- Assessment
- Goal setting (where appropriate)
- Agreement about the next phase

2:1 Assessment

The aim of an AAC assessment is to identify the most effective means of communication possible for the person. This will often necessitate a multimodal approach if the person is to communicate for different purposes and in a variety of contexts and environments (RCSLT 2022).

Light's model of communication competence (1989) suggests AAC users need to have the knowledge and judgment in 4 interrelated areas:

Linguistic – being able to communicate using text or symbols and understanding language

Operational – ability to use the device, motor skills, cognitive and sensory, could they type on a keyboard? Could they use eye gaze, head movement etc. Does the device need to be set at a specific angle?

Social – are they aware of the social rules of communication, pragmatics, turn taking, can they initiate communication?

Strategic - are they aware of compensatory strategies to facilitate communication i.e., ask for help use of word prediction.

This was further revised in 2014 by Light and McNaughton to include;

psychosocial attributes: Motivation, attitude, confidence, and resilience.

AAC assessment should include:

- Case history
    - Taken with the patient and/or significant others.
    - Medical history- including diagnosis, recent hospital admissions, any planned medical procedures, medication.
    - Education, occupation, and cultural and linguistic backgrounds
    - Time frame of communication difficulties
    - Impact of communication difficulties
    - Sensory difficulties / preferences
    - Timetable / activities
    - Communication preference if not stated on referral - unaided gestures, vocalisation, signing, pointing
- Consider the views of the individual and their family/ those around them
- Review current communication system and consider previous AAC used if appropriate.
- Patient motivation
- Levels of support around the patient
- Expressive and receptive language skills
- Reading skills
- Symbolic development
- Cognition
    - Attention
    - Memory
    - Alertness
    - Understanding of cause and effect / purpose of communication aid
- Gross and fine motor skills
- Physical disability limitations
- Wheelchair / device mounting
- Environment that patient accesses
- Visual perception
- Hearing
- Individuals likes and dislikes.
- Impact on quality of life

An initial assessment may use formal and informal methods to gather relevant information.

It may involve significant others (parents, carers) and the service user. For example, the assessment could also be appropriate in the presence of a carer or family member who has regular contact with the patient.

A comprehensive assessment should be conducted with the consent of the individual and may include their if appropriate/applicable. Consent must be documented and include what was gained (verbal, nonverbal, best interest).

Observations

Observations are useful for assessing language and communication skills in a patient's familiar environment. The SLT may observe the patient with different communication partners, at different times or in different environments.

Formal assessments

Formal assessment should be considered during the initial assessment session. Decision to complete formal assessment will depend on the patient's cognition and alertness, time and how long the case history has taken, whether formal assessment will change the outcome of the session, whether the formal assessment is appropriate for the client group (consider English as a second language or when English is not spoken). It may be deemed inappropriate to complete formal assessment at the initial assessment appointment if the environment is not appropriate.

Formal assessments provide the opportunity to assess the individual's use and acceptance of a range of AAC devices, aids, symbol systems, techniques, and strategies. The speech and language therapist should consider the following formal assessments;

- Frenchay Screening Tool

Assessing a person's ability to use an AAC device – physical access i.e., their ability to point and select, visual acuity, clarity of vision (does the potential device need bigger symbols/words/letters), spelling, are they able to type what they want to say? Promoting longer sentences, broader conversations, word to picture matching consolidates patients' visual recognition skills and semantics.

- ACE Pragmatics profile

The ACE pragmatics profile is used to assess communication skills within everyday life. The Profile was based on the pragmatic approach to understanding language, which emphasises how communication is achieved, how language is used to communicate a variety of intentions, the related needs of the listener, and how children participate in conversation and discourse (Bates 1976).

- Tobii dynavox AAC Needs Assessment

Considers the appropriate topics that the patient would wish to discuss when using AAC, particular communication skills they have, the different environments in which they communicate, and finally what they want or need in a communication partner. Can help create a baseline of ability and identifies breakdowns in the communication environment. Can help identify needs and goals for the AAC user.

Assessments available however not commonly used by the team at present can also be considered as part of the assessment phase, it is felt that more information is needed to guide next steps.

- Dynavox InterAACt framework -Dynamic AAC goals grid

Tool for assessment and measurement of individual's current level of communication across communicative competencies. Can assist with planning more appropriate future communication goals, in order to achieve successful independent communication. Helps to class communication ability as emergent, context dependent and independent for different age groups. Looks at linguistic, operational, social and strategic elements of communication

- The Dynamic AAC Goals Grid 2 (DAGG-2)

Considers components for successful AAC use. Checklist to determine level person is currently communicating at, consider Light's competencies model. Allows analysis of strengths and weaknesses for next steps. Prompting hierarchy use indicates progress towards goals.

- Multimodal communication screen task for persons with aphasia (MCST-A)

Systemically assesses whether people with severe aphasia can use AAC to communicate via pictorial symbols. For use also with people who have global aphasia. Helps to determine the best candidate for AAC by gaining a clearer understanding of the cognitive-linguistic competencies by aphasic communication, considering specific AAC strategies or techniques

Other formal and standardised assessments may be used to assess language skills.

Therapeutic assessment

It may also be appropriate to trial patients with several different AAC devices. This may happen over an agreed time, e.g., a few weeks. This is recommended with appropriate support provided by regular SLT/SLTA/SLTAP visits to reconvene with the patient and carer to discuss any issues or positive feedback they may have. The community speech therapy team have a spreadsheet with available equipment both paper based and powered devices that can be used.

If the SLT department does not have the equipment to trial, these can be loaned from ACE centre through the LAACES group.

2.2 Goal setting.

Goal setting should always be patient centred. Goals should be set with the patient and/or family and carers. Shared decision-making will also help provide realistic, attainable goals for the given time frame for a patient.

Goals should be SMART and consist of short- and long-term goals. Saltillo, provide a helpful framework for goal setting with AAC patients. The framework offers setting goals to consolidate with Light (1989) communication competencies model, setting goals for linguistic, operational, social and strategic skill sets. The framework encourages SLTs to set two objectives for each skill set, which is then ranked between 1-5, 1 being the baseline, 3 being the expected goal to be met during the given time frame (short-term goal), and 5 being the long-term goal.
https://saltillo.com/uploads/2018.3_AAC_Ready_Set_Goal_Handout_Packet.pdf

Goals and plans should be documented in a patients record and shared with relevant multidisciplinary team. An example carelpan can be found on the shared drive.

2.2.1 Reviewing goals

Goals can be reviewed and refined throughout SLT input e.g. if the SLT feels that the patient will be unable to achieve what has already been set, skills/circumstances change, or patient changes their views on their goals.

2.3 Agreement of next steps

Agree the outcomes of the assessment phase:

- Direct Intervention
- Indirect Intervention
- Referral to another SLT pathway
- Onward referral to another service
- Discharge

Upon completion of the AAC assessment, the SLT should review the results of assessment trials, describe, and give a rationale for the preferred AAC system components, describe a recommended AAC intervention program, and indicate the patient's/client's (and family/caregivers') response to the recommended system and program.

There is a range of management options to be evaluated between the SLT and patient/patient care providers, which are included in the intervention section of this pathway. However, the selected management option must be supported, underpinning quality evidence based on the assessment findings and individual concerns. Recommendations may include the need for further assessment, follow-up, or referral.

Patients should be informed about the purpose and aim of AAC if necessary. In addition, SLT should illustrate the effectiveness of implementing AAC.

The SLT must ensure that the patient understands the management plan.

TOMS (therapy outcome measures) should be used as an outcome measure.

3 Intervention

The RCSLT state “The SLT will aim to incorporate different communication approaches, including both unaided and aided methods, that best meet the communication needs of the person. The SLT should have experience of working with AAC or be working and consulting with a SLT who is a specialist in AAC. They must know when to refer on to an appropriately skilled colleague and/or a regional AAC Service.”

3.1 Funding options

If non-paper based AAC is identified, consider funding options. This could be self-funded, charitable funding or local authority.

ACE Centre – See ACE centre website for eligibility criteria.

Individual Funding Request (IFR) – device funding is requested from the local authority. Refer to IFR process on the shared drive. This has changed March 2023- Rebecca Martin updating guidance on shared drive- contact Rebecca in interim for advice.

A few charitable and community- based organisations who may be able to provide financial aid in terms of fundraising and grant applications. See Appendix 1 for example charities.

3.2 Direct intervention

Considering the complexity of the patients' needs will affect what level of staffing and intervention is needed.

The patient should be considered for reviews throughout the intervention block, with SLTA or AP present if they are completing intervention sessions.

SLT intervention is needed if:

- The patient is a more complex case (such as fluctuating physical abilities)
- May be subject to change in communication skills (step-up/step down)
- Have a complex background e.g., safeguarding
- Initial assessment or case history is unclear, and more information through observation and intervention is needed

Intervention may also be completed by SLTA and AP if the patient is:

- Less complex
- Intervention is likely to be consistent
- Assessment gives a clear picture for moving onwards with the intervention
- If sessions require a regular and frequent speech therapy presence, e.g. training patient and family how to use the device

3.2.1 Direct Intervention options

Implementing AAC – Setting up communication aids, editing communication aids, support for patient/family/carers in using the device.

Aided AAC modelling – If a patient is finding difficulty in selecting the right words/symbols for what they want to say, modelling the AAC aid via conversation may be beneficial. It allows the user to see the communication aid being used in real-time and build an understanding of how it works. (Arnott & Alm, 2013)

Improving narrative skills – Rather than the AAC communication aid being used exclusively for choice-making, the communication aid can also be used to strengthen narrative skills. Scaffolding fictional/real-life stories and allowing the patient to choose what happened next expands a patient's communication ability. (Solomon-Rice & Soto, 2010)

Keywords – Adding or reducing the number of words and phrases, making the communication aid personable to the patient. In addition, reducing unnecessary words can promote clarity on the device.

Functional phrases - promoting independence can improve confidence and self-esteem by having the ability to converse in public settings and on the telephone. (Ordering a coffee, asking for an item in a shop). Or to ask to go to the toilet or to express they are in pain/feel sick etc.

Planned communication opportunities – making sessions more relevant to goals in between using the communication aid throughout the day. For example, if the patient's goal is to be able to ask for help on two occasions throughout the day, the plan for that session would be to illicit opportunities for the patient to ask for help, i.e., encouraging them to point to the help symbol during sessions.

3.3 Indirect intervention

Indirect intervention is important as it empowers both the patient and the family/carers around them to acquire the skills they will need once SLT input is longer the case.

Guidance for families/carers can be provided both at the initial assessment and throughout the block; encouraging the patient to both use the AAC communication aid themselves and with their relative/carer will benefit both parties and encourage the patient to use the device in their natural environment on a regular basis.

Conversation partner training – if the patient has a family member/carer/day centre staff who the patient converses with regularly, providing training to be able to provide supportive conversation strategies (Kent-Walsh et al., 2015).

Aided language input – encouraging conversation partners to use the AAC communication aid while communicating. Some patients benefit from being in informal environments where they see and hear the device all day (O'Neill et al., 2018).

Staff training – Educating staff and carers how to use the AAC and how to encourage the patient to use this. Consider the key people that will be communicating with the client (such as activities co-ordinator). This could be at the patient's home or a community setting that they attend.

Signposting – To charities such as 'Communication Matters' that provide support to patients and family/ carers with AAC devices.

3.4 Frequency of sessions

- The patient should be visited as frequently as deemed appropriate by SLT/SLTA/AP dependent on complexity with continued consistent input being provided to family members, friends, carers etc. in the interim between visits. For example, this could be weekly initially while determining needs, or more frequently when editing is needed.
- The frequency of sessions will be agreed with the patient and family/carers following initial assessment
- If there is limited support for the patient, more frequent visits by the team may be needed.
- Patient goals should be reviewed regularly when appropriate and adaptations may be needed depending on achievements.
- Consider patient cognitive skills and physical health for time length of sessions, for some 40-minute session may be sufficient for others this is unobtainable about of time if attention span is fleeting.
- The number of sessions is dependent on the circumstances, this would be consistently reviewed considering goals.

4 Onward referral to another service

ACE centre https://acecentre.org.uk/services/nhs/assessments	To be eligible for the NHS England Specialised AAC Services, a person must: • Be resident in England • Be registered with a GP practice in England

	• Have a severe/complex communication difficulty associated with a range of physical, cognitive, learning, or sensory deficits • Have a clear discrepancy between their level of understanding and their ability to speak • Be able to understand the purpose of a communication aid • Have developed beyond cause and effect understanding • Link ideas/ semantic categories and syntactic functions beyond basic requests.
Northwest Assistive Technology service	The Assistive technology team provides specialised equipment (access) or integrating AAC to environmental controls. They work with local teams to combine the AAC for communication and external environment.
Wheelchair service	If the patient has requires further wheelchair support to enhance the use of AAC.
Other health professions (eg community therapy, learning disability/neuro colleagues)	If patient requires posture/ positioning support to enhance the use of AAC and support is needed from a physiotherapist or occupational therapist.
GP	If patient is not following an expected pattern in their diagnosis, inform the GP of this and consider further investigation.

5 Referral to another speech and language therapy pathway

After conducting assessment or providing treatment, the SLT may be recognise other needs which can be supported by speech and language therapy within a different team, or another speech therapy need within the adult community team, they should consider the relevant clinical pathway and make required referrals.

6 Discharge

Follow individual teams discharge process, including discharge from SystmOne using SOP.

- **The reason for discharge from the service**

There are multiple reasons related to why SLT's may discharge patients from the service. Thus, the SLT is required to expand on the reasoning behind the decision for discharge. For example, but not limited to; therapy is complete, and patient has achieved goals, patient requested discharge, patient not understanding the purpose of a communication aid, consistently missing appointments or not engaging, other methods would be more appropriate at this time e.g., sign language, significant contextual factors mean speech therapy is not suitable at this time e.g., moving house to different area.

- **Re-referral information**

Discharge procedure includes a discharge letter to patient/ carers which should be completed within two weeks of agreeing discharge. Discharge may involve signposting or referring to appropriate agent, as other support and services may be more suitable at this time. Reasons for re-referral can include changes in patients needs or circumstances, for AAC review. The discharge information presented to patient may be different depending on the content and the patient's understanding.

- **Information sharing on discharge**

Consider providing a thorough detailed report including information on how to use AAC, edit if appropriate, and how it should be set up should be sent within two weeks of determining the information

- **Maintenance of AAC**

Patients/carers should be made aware that the local SLT teams are not responsible for maintenance or repairs of AAC resources/devices.

Abbreviation list

SLT – Speech and Language Therapist
SLTA – Speech and Language Therapy Assistant
AP – Assistant Practitioner

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Appendix 1

This list is not exhaustive and other charities may be able to fund AAC.

The Princes Trust – Can provide young adults aged 16-30 with the tools they need to reach their potential, gain employment and become an individual in their community. Providing them with the resources they need to reach this. Including funding to contribute to their communication device.

The Sequel Trust - If the patient requires funding support. The charity provides funding and sources communication aids for the disabled, including but not limited to Light writers, Grid Pads and eye gaze technology.

Motor Neurone Disease Association support services Funding for AAC for those with complex needs should be met through specialised commissioning. For those with needs that do not qualify for referral to specialist AAC services, funding for AAC should initially be sought from local statutory services. If NHS funding has been explored without success, and the welfare of the person with MND is compromised, an application can be made to the MND Association to request an equipment loan or financial assistance.

Multiple Sclerosis Association -The MS Society provides grants to people with MS for an item needed as a direct result of their MS. This is when there is no health or social care services funding available for it. This could include communication aids.

Headway- Headway have grants available for patients who have survived head injusry. They do not specify that the grant can be used for communication aid but also do not specify that it cannot be used.

Find a voice Find A Voice provides a service where communication equipment can be loaned free of charge. They have an mobile resource library which enables them to demonstrate their equipment at schools and hospitals, as well as during home visits.

Barchester Health Care Foundation – a foundation that can provide help for adults and older people with a disability across England, Scotland and Wales. Their aim is to connect or re-connect people with disabilities back into their communities.

The Big Boost- can provide support to social entrepreneurs who wish to make an impact in their community. The charity may fund the project including the use of AAC devices for the individual to enhance potential and break down barriers.