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SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	D01/S/b
Service	<i>Complex Disability Equipment – Communication Aids (Specialised AAC services)</i>
Commissioner Lead	Carolyn Young
Provider Lead	
Period	<i>12 months</i>
Date of Review	December 2018

1. Population Needs

1.1 National/local context and evidence base

Communication aids are used to restore communication for people who cannot communicate using speech. They address severe impacts on independence, quality of life and an ability to maintain employment. Communication aids are one strategy in a wider set of strategies and tools known as Augmentative and Alternative Communication (AAC).¹

The communication impairment may be due to physical speech difficulties or cognitive and language difficulties and are found in a very wide array of different diagnosed conditions and across all age groups.

The communication aid service specification described here is more specifically referred to as a specialised AAC service – and this term will be used throughout the rest of this document. The population, for whom these services are provided, are those with complex communication needs who require a specialist assessment resulting in either low or high tech communication aids.

An estimate of prevalence of need for ‘high technology (powered) communication aids and specialist services is provided by the OCC report²

¹ [Communication Matters](#)

² [OCC](#), 2011 and by [Enderby et al.](#) (2013)

Communication aids use language and communication software designed to produce spoken output. The spoken utterances can be accessed using symbols and/or text. The device should be setup to reflect the user's needs and developing language skills.

Communication aids may additionally include any of the following elements:

- Access and control by switches and other control devices, including those operated by hand, foot, body, head, breath and eye.
- Mounting systems for switches and control devices.
- Positioning and support systems provided to the individual (often using a wheelchair) in order to access the communication aid.
- Software designed to produce written output, as part of the communication needs of the individual.

The systems prescribed may be commercially obtained or may be assembled to meet individual need and may include a custom manufactured or bespoke element.

For many years AAC users, professional bodies, service providers and charities such as Scope and Communication Matters, have raised concerns about inequality of access to local AAC services, inequality of access to the more specialised regional AAC services and to AAC and communication aid provision in general.

Specialist Services National Definitions Set – (SSNDS) (3rd Edition 2010) recognised that Specialised Commissioning Groups (SCG) should be commissioning Electronic Assistive Technology (EAT) services (including 'Communication Aid Services') and this is supported by British Society of Rehabilitation Medicine (BSRM) (2000)-'Electronic assistive technology' and 'Specialist equipment services for disabled people –the need for change' Royal College of Physicians of London & Institute of Physics and Engineering in Medicine 2004- ISBN 1 86106 234 7.

John Bercow Member of Parliament (MP) carried out a review which reported in 2008, and led to the appointment of the Communication Champion for children and young people aged 0-19 in England who reported on practice in AAC provision:

- Some primary care trusts and local authorities were providing local multi- agency specialist teams with specific budgets
- Some local services were supported by regional centres of excellence.
- Available data indicated that the estimated level of need was not being met and, while NHS guidance indicated that specialised equipment services should be commissioned regionally, only one of ten NHS regional commissioning teams was fulfilling this function for AAC services.

Like other specialist equipment services, AAC services are characterised by the complexity of service user needs (complex physical/cognitive/language/sensory disability often in combination), need for expert and independent assessment, user and carer training to maximize effectiveness and independence, timely review and re-assessment for changing needs and finally on-going, life-long maintenance/replacement and user support.

The NICE has not issued specific guidance on EAT or communication aids. The [National Service Framework \(NSF\) for long term conditions](#) has clearly identified the need to

provide Equipment in Quality requirement 7. QR 7 has recognised the role of EAT, including communication aids, in improving quality of life, enhancing independence, and in selected cases improve the opportunities for employment.

2. Outcomes

Outcomes will relate to the objectives noted below. Outcome measures such as Psychosocial Impact of Assistive Devices (PIADS), Therapy Outcome Measures or Goal Attainment Scaling are currently in use in some specialised AAC services.

Further guidance on use of outcome measures within AAC has been issued by Communication Matters ³

Specialised AAC services will put in place mechanisms to measure relevant activity such as access to services, high tech AAC system adoption and abandonment rates across the region, as well as activity undertaken to implement local care pathway processes. Specialised AAC hub services will measure indicators of activity to meet the quality standards noted in the sector's Quality Standard for AAC services.

2.1 NHS Outcomes Framework Domains & Indicators

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

3. Scope

³ [Communication Matters guidance on use of outcome measures within AAC](#)

3.1 Aims and objectives of service

Aims

- To provide equitable national specialist AAC services across the country for children and adults with complex communication needs
- To provide appropriate powered communication aids as a long term loan to clients for as long as the client needs and effectively uses the device.
- To maintain a loan bank of powered communication aids for assessment, trial and long term loan
- To provide specialist AAC advice and information and training to individuals, families and professionals involved in the delivery of local AAC services
- To support the establishment, training and development of local AAC services.

Objectives of the delivery of specialised AAC services are:

- To support clients to attain their personal communication goals;
- To provide timely access across England for the population that require specialised AAC services;
- To promote better use of appropriate powered communication aids and minimise abandonment of these;
- To support the development of effective local AAC teams and care pathway procedures by which to manage referrals to specialised AAC services.

3.2 Service description/care pathway

The proposed service model is a hub and spoke model. This recommendation is based on existing good practice which has in turn been recommended by many high level reports such as: Specialist AAC Provision: Commissioning National Services⁴ (from the Communication Champion) and John Bercow's Review of Speech, Language and Communication Needs, and in the previous SSNDS.

When treating children, the service will additionally follow the standards and criteria outlined in the Specification for Children's Services (attached as Annex 1 to this specification)

The term 'specialised AAC service' indicates a range of integrated activities to be undertaken, collectively managed (see service model section) rather than a presumption that there must be a centralised hub location or provision of services by a single organisation.

The service has to be sustainable, based on the size of its geographical catchment area and population which constitutes a cost-effective level of specialism.

In line with government policy the services may be provided by statutory, voluntary or private sector organisations, or by a consortium of organisations, dependent on compliance with the required standards and capacity to meet commissioners'

⁴ [Office of the Communication Champion](#)

expectations of service delivery.

Taking into account the SSNDS document and the OCC report recommendations on the activities to be undertaken by specialised AAC hub services, the following areas of service will be undertaken:

- Specialised assessment of AAC needs
- Provision of powered communication aids (meeting the criteria described below)
- Regional management, including procurement, of powered communication aids
- Training and service development of local AAC teams
- Regional co-ordination of care planning, service standard development, quality assurance and improvement of local AAC teams.

In order for a specialised AAC hub service to deliver the required range of activities, in addition to those administrative and management staff required by any organisation, the hub team should include staff with the following competences:

- Electronic assistive technology
- Speech and language therapy with AAC specialism;
- Learning and educational development competence to support the AAC assessment and intervention service to younger clients;
- Seating and positioning;
- Access and control methods and mounting of equipment;
- Equipment procurement and stock management.

The service will consist of a multi-disciplinary team which can meet the competencies required to fulfil the aims and objectives of this service. The team will include staff from most or all of the following professions as appropriate: Speech and Language Therapists (SLT), Clinical Scientists, Clinical Technologists, Occupational Therapists (OT) and specialist education professionals (if providing a service to children). If not on the primary team, the team should have reliable access to these professionals. The team should also have access to Physiotherapists and Psychologists where necessary.

The specialist AAC service should also be able to evidence that it has processes and contracts in place to access, in a timely way, staff with the following competences:

- Personalisation and customisation of equipment (software, electronic and mechanical);
- Cognitive assessment competence to support AAC assessment and intervention service to older clients;
- Health informatics , quality improvement and research methodology competence;
- Training and workforce development competence to support the development and competence of local AAC spoke services.

In addition, the specialised AAC service will provide:

- Technological and engineering facilities for customisation and modification to the individual.
- A loan bank of communication aids offering a diverse range of solutions.
- An extremely wide range of software, vocabulary packages and resources.
- An ability to issue, monitor, maintain, recall and refurbish equipment.
- An ability to manage, aggregate and analyse user information to enhance the service and streamline day to day operations.

- An ability to integrate services and equipment with other assistive technologies such as Environmental Control.
- An ability to educate and train a wide range of stakeholders from the user, families, spoke service members and local team members.
- An ability to take account of co-morbidity issues such as postural support needs.
- Work with local health and social care professionals in areas where service uptake is low to facilitate referral of those who could benefit from communication aids.
- Experience, capacity and remit to deliver services across a wide geographical region
- An expertise in complex low tech AAC strategies and techniques

The specialised AAC services will work with the developing local AAC teams to provide training to develop the competencies and skills locally. The specialised services will need to establish a collaborative approach with the local teams to outcomes measurement and data gathering on which to base quality assurance, service development and to inform future commissioning practice.

Specialised AAC services will work with their local AAC teams to build their capacity to manage directly the needs of 90% of the region's AAC population and to jointly manage the needs of the 10% of the region's population that require powered communication aids or specialised AAC assessment.

Local AAC services will be able to access provision of some powered communication aids via the specialist AAC service, and will be supported to provide these devices where appropriate and where the competence of the local team to do so has been assessed.

The care pathway will be as follows:

- Referrals will be accepted from health, education and social care professionals working in local teams
- Additional information to the referral may be required from other health, education or social care agencies or the individual's General Practitioner (GP), especially for self-referrals or those from non- health professions
- All referrals will be acknowledged within 10 days of receipt by the service and it be stated if there is reason to delay the assessment or referral acceptance, such as insufficient referral information
- Otherwise, the service will assess all patients fulfilling the acceptance criteria, typically within 6 weeks from the date of acceptance of the referral.
- Prioritisation criteria will be applied as follows:
 - Priority will also be given to patients with a rapidly degenerative condition, e.g. MND and efforts will be made to ensure these patients are assessed and / or provided with equipment as soon as is practically possible.
 - Priority will be given to patients who have communication aid equipment currently but that has ceased to be functional or is significantly unreliable, in order to meet their communication needs.
 - Priority will be given to patients facing a transition to a new sector / school / college / workplace environment or currently in rehabilitation provision.
 - Priority will be given to patients who are at risk of developing significant psychological / challenging behaviour as a consequence of their inability to

communicate without a communication aid.

- Patients will be assessed in the most effective location e.g. their home, place of residence, hospital, school, or workplace by competent, experienced personnel and in collaboration with other services where necessary or by remote access if appropriate.
- Equipment shall only be provided after the assessment. The assessment recommendations shall be confirmed in writing to the patient, referrer, GP and other stakeholders as appropriate
- Opportunity for a temporary trial of suitable sample equipment shall be recommended and made available when indicated, such as when there is doubt over the patient's motivation or ability to use the equipment. The outcome of the trial, either to continue with or to cease provision shall be based on suitable outcome measurement
- When equipment provision is recommended at the assessment, this shall normally be available for use by the patient within 12 week of the assessment. Exceptions to this target may occur due to dependencies on other agencies or when the recommended solution involves custom or bespoke or integrated equipment
- All patients provided with equipment shall receive adequate training in its use with necessary information in an appropriate format to them. Additional tuition shall be available as required, in consideration of the possible cognitive impairment of some users
- Each user of equipment shall receive ongoing support in case of its malfunction, an annual service maintenance visit including statutory testing of equipment and timely review of equipment appropriateness for them
- In response to reported malfunctions of the equipment, the service shall ensure that the user is contacted as soon as possible and remedial action for critical functions taken within a clinically appropriate time
- The frequency of user and equipment review shall be determined on a case by case basis by service personnel with the ability to respond appropriately to changes in clinical conditions (e.g. people with rapidly progressing neurological conditions)
- Adjustments, modifications or change of the equipment provision shall be provided when indicated following review due to change in patient clinical condition, functional impairment or circumstances. A full re- assessment of their needs shall also be available when appropriate
- Equipment no longer required by users due to change in their circumstances, shall be reclaimed, decontaminated and refurbished to standards agreed with manufacturers prior to becoming available for re- issue.

In addition the service will undertake (or arrange through subcontractors);

- Re-conditioning of equipment ready for re-use
- Technical evaluation and management of equipment to ensure it is fit for purpose
- Development of custom or bespoke or integrated equipment solutions for individual patient's EAT needs when these are identified.

General Paediatric care

When treating children, the service will additionally follow the standards and criteria outlined in the Specification for Children's Services (attached as Annex 1 to this

specification)

3.3 Population covered

The service outlined in this specification is for patients ordinarily resident in England*; or otherwise the commissioning responsibility of the NHS in England (as defined in *Who Pays?: Establishing the responsible commissioner* and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a General Practitioner (GP) Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

The population, for whom these services are provided, are those with complex communication needs who require a specialist assessment resulting in either low or high tech communication aids.

Specialised AAC services deliver high-cost, low-volume interventions that aim to restore a degree of communication for severely or profoundly communication impaired people.

Communication impaired people in this context means those adults and children who have an impairment that impacts on their ability to communicate using speech and/or language. This does not cover those people with communication problems arising primarily from hearing or vision impairments.

Communication impairment may result from physical, sensory, intellectual, learning or cognitive disabilities. The population includes both those born with a communication impairment (for example and in no order of precedence, those resulting from cerebral palsy, developmental disorders and learning disabilities such as autism) and those who acquire a communication impairment (for example through stroke, cancer, brain and spinal injury and neurological diseases such as Parkinson's, Alzheimer's, Multiple Sclerosis or Motor Neurone Disease).

3.4 Any acceptance and exclusion criteria and thresholds

An individual who would access a specialist AAC service would have both of the following:

- a severe/complex communication difficulty associated with a range of physical, cognitive, learning, or sensory deficits
- a clear discrepancy between their level of understanding and ability to speak.

In addition, an individual *must*:

- be able to understand the purpose of a communication aid;
- have developed beyond cause and effect understanding;
and may:
- have experience of using low tech AAC which is insufficient to enable them to

realise their communicative potential.

An individual may have a deteriorating condition and in these cases it is expected that services should anticipate their needs. The inclusion/exclusion criteria should be applied with regards to the anticipated abilities of these individuals within a clinically appropriate time period. Referrals can be accepted 'in advance' of these individuals presenting with a severe communication difficulty and should be sent at the time felt to be most clinically appropriate for the individual.

Please see the prioritisation criteria within section 3.2 The Care Pathway.

NHS England will fund all equipment which has been recommended for an individual who meets the criteria for an assessment by a specialist service.

A decision chart supporting the decision making process for acceptance of referrals is set out within Appendix 2 of this document.

Exclusion criteria would be:

- preverbal communication skills;
- not having achieved cause and effect understanding;
- have impaired cognitive abilities that would prevent the user from retaining information on how to use equipment.

3.5 Interdependencies with other services/providers

AAC Services should have a relationship with the following:

Quality Standard for AAC services: the Standard notes a requirement for continuity of AAC services between children and adult services and between AAC services, other relevant local and specialised electronic AT services, including wheelchair and environmental control services and allied services such as for posture and seating. The SSNDS Definition 5 also highlights the importance of these linkages.

NHS Electronic Assistive Technology and Environmental Control Services: with some functions common between environmental control systems and powered communication aids, it would be expected that specialised services demonstrate how they intend to work collaboratively with NHS EAT services and to provide electronic assistive technology services in an integrated way.

Local services: the care pathway outlined in this specification indicates the close interdependence required between local spoke AAC teams and specialised hub teams. Specialised AAC services are not viable without local AAC services that will be the source of all referrals in to the specialised AAC services. Local AAC services will be able to access provision of some powered communication aids via the specialist AAC service, and will be supported to provide these devices where appropriate and where the competence of the local team to do so has been assessed. The specialised services will be responsible for providing training to the local services, responding to their local need.

4. Applicable Service Standards

Complex Disability Equipment – Assistive and Augmentative Communication (AAC) Core Requirements

1. A specialised service should be delivered through a multi-disciplinary team (MDT) and have access to:
 - Speech and Language Therapists (SLT)
 - Clinical Scientists and Technologists
 - Occupational Therapists (OT)
 - Specialist Teachers
 - Physiotherapists
 - Psychologists
2. The service should have access to technological and engineering facilities for customisation and modification.
3. The specialised service should provide an assessment and loan bank of possible technologies offering a diverse range of solutions with a range of software, vocabulary packages and resources.
4. An ability to issue, monitor, maintain, recall and refurbish equipment
5. An ability to integrate services and equipment with other assistive technologies such as Environmental Control.

4.1 Applicable national standards e.g. NICE

There are a number of quality standards that have been developed for the AAC sector specifically and some which relate to the wider scope of SLT services which may provide contextual guidance.

Standards that are AAC specific:

- The most directly relevant quality standard is the Quality Standard for AAC Services which was developed by 'Communication Matters', as a result of a 2 year project working closely with the AAC and SLT sectors.⁵

Standards relating to assistive technology provision more generally:

- Care Quality Commission: All providers of health and social care in England have by law to be registered with the Care Quality Commission, initially by meeting its 'Essential Standards of Quality and Safety', and then by continuing to meet these as evidenced by inspections and assessment. All NHS hospitals and community services, adult social care and independent healthcare providers in England, including EAT and AAC services, must be registered. The Standards are based on statutory regulations. Standard 3 covers safety, including infection control and use of

⁵ [Communication Matters National Standards for AAC services](#)

equipment, in all settings including the home.

- Department of Health's publication: 'The Code of Practice for health and adult social care on the prevention and control of infections and related guidance'.
- BSRM (2000) 'Electronic assistive technology'

Standards relating to speech and language therapy (SLT) services:

- Department for Education and Science (2000) 'Report of the working group on the provision of speech and language therapy services to children with special educational needs (England)'
- Department for Children, Schools and Families (2008) 'Better communication: An action plan to improve services for children and young people with speech, language and communication needs'

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Quality Standard for AAC Services was developed by 'Communication Matters'⁶

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

Kent Children's and Adult's Communication and Assistive Technology Service
Regional Communication Aid Service, Newcastle
Barnsley Assistive Technology
Compass Assistive Technology Service, Royal Hospital for Neurodisability
Chailey Heritage Clinical Services
Cambridge University Hospitals NHS Foundation Trust
Access to Communication and Technology (ACT), Birmingham Community Healthcare NHS Trust
Bristol Communication Aid Service
ACE Centre
Lincolnshire AAC Service
Communication, Learning and Technology Service, Great Ormond Street Hospital for Children
Dame Hannah Rogers School and Young Adult provision and AAC assessment service, Devon
Guys & St Thomas' NHS Foundation Trust
Assistive Communication Service, Central London Community Healthcare NHS Trust

7. Individual Service User Placement

⁶ [Communication Matters National Standards for AAC services](#)

Not applicable

Appendix One

Quality standards specific to the service using the following template:

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Domain 1: Preventing people dying prematurely			
Domain 2: Enhancing the quality of life of people with long-term conditions			
1) Assessment within 6 weeks of acceptance of referral 2) Equipment provision within 12 weeks of assessment 3) Repairs to be carried out within 2 weeks	To be agreed with commissioners	Contractual monitoring	
Domain 3: Helping people to recover from episodes of ill-health or following injury			
Domain 4: Ensuring that people have a positive experience of care			
1) Flexible appointment system. 2) Patient centred assessment, to include family input 3) Training to be delivered in conjunction with provision of equipment	To be agreed with Commissioners	Patient survey Patient survey	Breach of contract

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm			
All providers must be registered with the Care Quality Commission Standard 3 covers safety, including infection control and use of equipment, in all settings including the home.	As agreed with commissioner following CQC thresholds being met	Meeting CQC 'Essential Standards of Quality and Safety'	

ANNEX 1 TO SERVICE SPECIFICATION:

PROVISION OF SERVICES TO CHILDREN

<p>Scope</p>
<p>Aims and objectives of service</p> <p>This specification annex applies to all children's services and outlines generic standards and outcomes that would be fundamental to all services.</p> <p>The generic aspects of care: The Care of Children in Hospital (HSC 1998/238) requires that:</p> <ul style="list-style-type: none"> • Children are admitted to hospital only if the care they require cannot be as well provided at home, in a day clinic or on a day basis in hospital. • Children requiring admission to hospital are provided with a high standard of medical, nursing and therapeutic care to facilitate speedy recovery and minimize complications and mortality. • Families with children have easy access to hospital facilities for children without needing to travel significantly further than to other similar amenities. • Children are discharged from hospital as soon as socially and clinically appropriate and full support provided for subsequent home or day care. • Good child health care is shared with parents/carers and they are closely involved in the care of their children at all times unless, exceptionally, this is not in the best interest of the child; Accommodation is provided for them to remain with their children overnight if they so wish. <p>Service description/care pathway</p> <ul style="list-style-type: none"> • All paediatric specialised services have a component of primary, secondary, tertiary and even quaternary elements.

- The efficient and effective delivery of services requires children to receive their care as close to home as possible dependent on the phase of their disease.
- Services should therefore be organised and delivered through “integrated pathways of care” (National Service Framework for children, young people and maternity services (Department of Health & Department for Education and Skills, London 2004)

Interdependencies with other services

All services will comply with Commissioning Safe and Sustainable Specialised Paediatric Services: A Framework of Critical Inter-Dependencies – Department of Health

Imaging

All services will be supported by a 3 tier imaging network (‘Delivering quality imaging services for children’ Department of Health, March 2010). Within the network:

- It will be clearly defined which imaging test or interventional procedure can be performed and reported at each site
- Robust procedures will be in place for image transfer for review by a specialist radiologist, these will be supported by appropriate contractual and information governance arrangements
- Robust arrangements will be in place for patient transfer if more complex imaging or intervention is required
- Common standards, protocols and governance procedures will exist throughout the network.
- All radiologists, and radiographers will have appropriate training, supervision and access to continuing professional development (CPD)
- All equipment will be optimised for paediatric use and use specific paediatric software

Specialist Paediatric Anaesthesia

Wherever and whenever children undergo anaesthesia and surgery, their particular needs must be recognised and they should be managed in separate facilities, and looked after by staff with appropriate experience and training. All UK anaesthetists undergo training which provides them with the competencies to care for older babies and children with relatively straightforward surgical conditions and without major co-morbidity. However those working in specialist centres must have undergone additional (specialist) training and should maintain the competencies so acquired*. These competencies include the care of very young/premature babies, the care of babies and children undergoing complex surgery and/or those with major/complex co-morbidity (including those already requiring intensive care support).

As well as providing an essential co-dependent service for surgery, specialist anaesthesia and sedation services may be required to facilitate radiological procedures and interventions (for example Magnetic resonance imaging MRI scans and percutaneous nephrostomy) and medical interventions (for example joint injection and intrathecal chemotherapy), and for assistance with vascular access in babies and children with complex needs such as intravenous feeding.

Specialist acute pain services for babies and children are organised within existing departments of paediatric anaesthesia and include the provision of agreed (hospital wide) guidance for acute pain, the safe administration of complex analgesia regimes including epidural analgesia, and the daily input of specialist anaesthetists and acute pain nurses with expertise in paediatrics.

*The Safe and Sustainable reviews of paediatric cardiac and neuro- sciences in England have noted the need for additional training and maintenance of competencies by specialist anaesthetists in both fields of practice.

References

1. Guidelines for the Provision of Anaesthetic Services (GPAS) Paediatric anaesthetic services. [Royal College of Anaesthetists \(RCoA\)](#) 2010
2. Certificate of Completion of Training (CCT) in Anaesthesia 2010
3. CPD matrix level 3

Specialised Child and Adolescent Mental Health Services (CAMHS)

The age profile of children and young people admitted to specialised CAMHS day/in-patient settings is different to the age profile for paediatric units in that it is predominantly adolescents who are admitted to specialised CAMHS in-patient settings, including over-16s. The average length of stay is longer for admissions to mental health units. Children and young people in specialised CAMHS day/in-patient settings generally participate in a structured programme of education and therapeutic activities during their admission.

Taking account of the differences in patient profiles the principles and standards set out in this specification apply with modifications to the recommendations regarding the following:

- Facilities and environment – essential [Quality Network for In-patient CAMHS](#) (QNIC) standards should apply
- Staffing profiles and training - essential QNIC standards should apply.
- The child/ young person's family are allowed to visit at any time of day taking account of the child / young persons need to participate in therapeutic activities and education as well as any safeguarding concerns.
- Children and young people are offered appropriate education from the point of admission.
- Parents/carers are involved in the child/young person's care except where this is not in the best interests of the child / young person and in the case of young people who have the capacity to make their own decisions is subject to their consent.
- Parents/carers who wish to stay overnight are provided with accessible accommodation unless there are safeguarding concerns or this is not in the best interests of the child/ young person.

Applicable Service Standards

Applicable national standards e.g. NICE, Royal College

Children and young people must receive care, treatment and support by staff registered by the Nursing and Midwifery Council on the parts of their register that permit a nurse to work with children (Outcome 14h Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

- There must be at least two Registered Children's Nurses (RCNs) on duty 24 hours a day in all hospital children's departments and wards.
- There must be an Registered Children's Nurse available 24 hours a day to advise on the nursing of children in other departments (this post is included in the staff establishment of 2RCNs in total).

Accommodation, facilities and staffing must be appropriate to the needs of children and separate from those provided for adults. All facilities for children and young people must comply with the Hospital Build Notes (HBN) 23 Hospital Accommodation for Children and Young People NHS Estates, The Stationary Office 2004.

All staff who work with children and young people must be appropriately trained to provide care, treatment and support for children, including Children's Workforce Development Council Induction standards (Outcome 14b Essential Standards of Quality and Safety, Care Quality Commission, London 2010).

Each hospital who admits inpatients must have appropriate medical cover at all times taking account of guidance from relevant expert or professional bodies (National Minimum Standards for Providers of Independent Healthcare, Department of Health, London 2002). "Facing the Future" Standards, Royal College of Paediatrics and Child Health.

Staff must carry out sufficient levels of activity to maintain their competence in caring for children and young people, including in relation to specific anaesthetic and surgical procedures for children, taking account of guidance from relevant expert or professional bodies (Outcome 14g Essential Standards of Quality and Safety, Care Quality Commission, London 2010).

Providers must have systems in place to gain and review consent from people who use services, and act on them (Outcome 2a Essential Standards of Quality and Safety, Care Quality Commission, London 2010). These must include specific arrangements for seeking valid consent from children while respecting their human rights and confidentiality and ensure that where the person using the service lacks capacity, best interest meetings are held with people who know and understand the person using the service. Staff should be able to show that they know how to take appropriate consent from children, young people and those with learning disabilities (Outcome 2b) (Seeking Consent: working with children Department of Health, London 2001).

Children and young people must only receive a service from a provider who takes steps to prevent abuse and does not tolerate any abusive practice should it occur

(Outcome 7 Essential Standards of Quality and Safety, Care Quality Commission, London 2010 defines the standards and evidence required from providers in this regard). Providers minimise the risk and likelihood of abuse occurring by:

- Ensuring that staff and people who use services understand the aspects of the safeguarding processes that are relevant to them.
- Ensuring that staff understand the signs of abuse and raise this with the right person when those signs are noticed.
- Ensuring that people who use services are aware of how to raise concerns of abuse.
- Having effective means to monitor and review incidents, concerns and complaints that have the potential to become an abuse or safeguarding concern.
- Having effective means of receiving and acting upon feedback from people who use services and any other person.
- Taking action immediately to ensure that any abuse identified is stopped and suspected abuse is addressed by:
 - having clear procedures followed in practice, monitored and reviewed that take account of relevant legislation and guidance for the management of alleged abuse
 - separating the alleged abuser from the person who uses services and others who may be at risk or managing the risk by removing the opportunity for abuse to occur, where this is within the control of the provider
 - reporting the alleged abuse to the appropriate authority
 - reviewing the person's plan of care to ensure that they are properly supported following the alleged abuse incident.
- Using information from safeguarding concerns to identify non-compliance, or any risk of non-compliance, with the regulations and to decide what will be done to return to compliance.
- Working collaboratively with other services, teams, individuals and agencies in relation to all safeguarding matters and has safeguarding policies that link with local authority policies.
- Participates in local safeguarding children boards where required and understand their responsibilities and the responsibilities of others in line with the Children Act 2004.
- Having clear procedures followed in practice, monitored and reviewed in place about the use of restraint and safeguarding.
- Taking into account relevant guidance set out in the Care Quality Commission's Schedule of Applicable Publications
- Ensuring that those working with children must wait for a full CRB disclosure before starting work.
- Training and supervising staff in safeguarding to ensure they can demonstrate the competences listed in Outcome 7E of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010

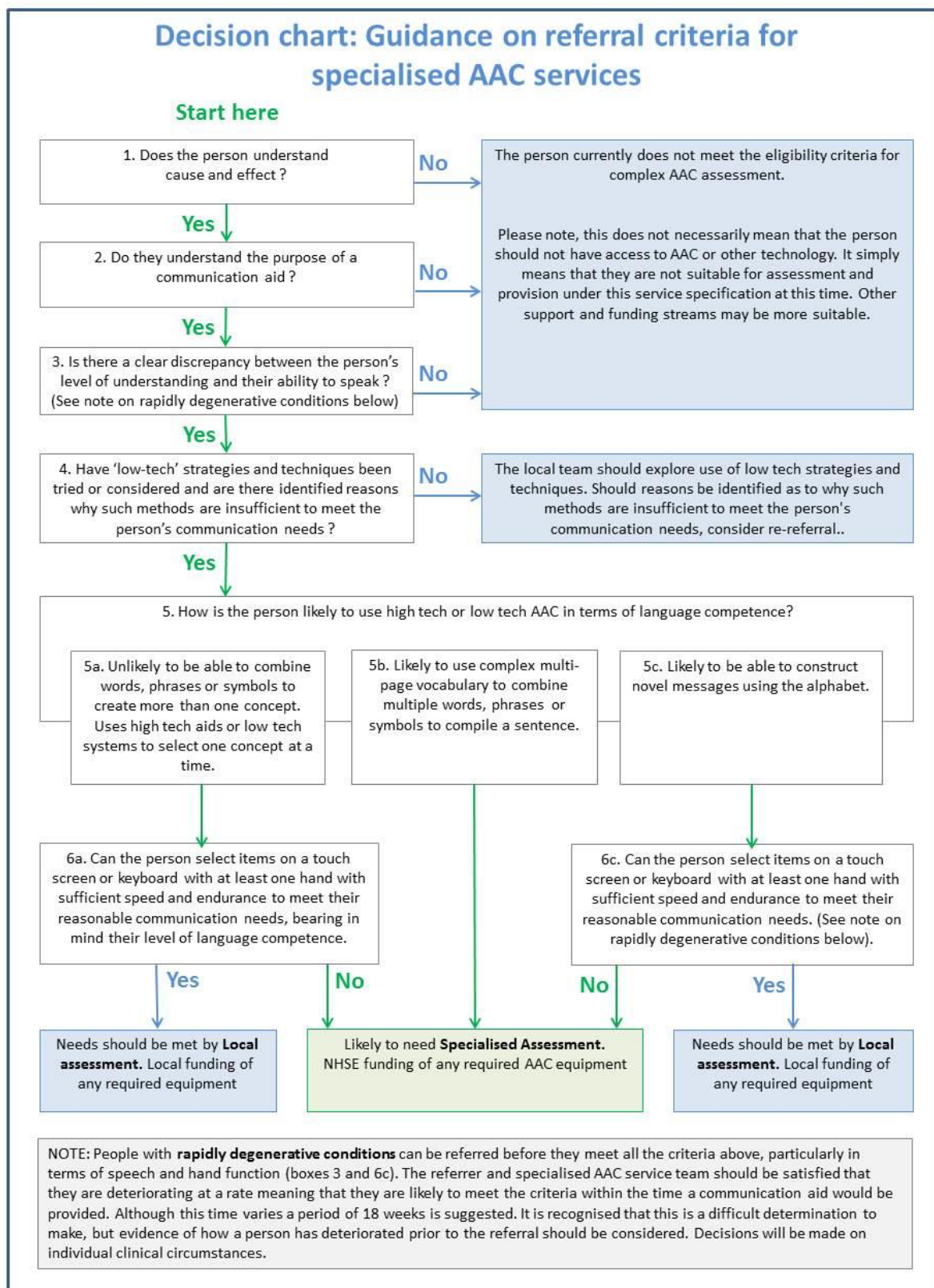
All children and young people who use services must be

- Fully informed of their care, treatment and support.
- Able to take part in decision making to the fullest extent that is possible.
- Asked if they agree for their parents or guardians to be involved in decisions

they need to make.

(Outcome 4I Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

Annex 2



Specialised AAC service referral decision chart. V4.1. August 2015.

Referral criteria for specialised AAC services

August 2015

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1. Introduction

1.1 Criteria for acceptance of referrals for specialised Alternative and Augmentative Communication (AAC) assessment are set out in the Service Specifications for AAC Services.

1.2 This document is intended to give guidance on the operational interpretation of the service specification. A decision chart also accompanies this document.

1.3 If someone does not meet the criteria for assessment or provision by a specialised AAC service, this does not necessarily mean that the person should not have access to AAC or other technology. It means that they are not suitable for assessment and provision under this service specification at this time. Other support and funding streams may be more suitable.

1.4 The NHS England Service Specification (D01/S/b) recommends a 'Hub and Spoke' approach to the provision of AAC. Hub and spoke services are also known as specialised and local services and this terminology will be used in this document. The NHS England Service Specification is for the specialised services and these referral criteria relate to referrals which can be accepted by those specialised services.

1.5 If potential referrers are unsure whether a person is eligible for referral, they are encouraged to contact their local specialised AAC service in order to discuss a case prior to making that referral.

2. Service specification acceptance criteria

2.1 The service specification for AAC services states:

An individual who would access a specialised AAC service would have both of the following:

- a severe/complex communication difficulty associated with a range of physical, cognitive, learning, or sensory deficits;
- a clear discrepancy between their level of understanding and ability to speak.

In addition, an individual must:

- be able to understand the purpose of a communication aid;
- have developed beyond cause and effect understanding;

and may:

- have experience of using low tech AAC which is insufficient to enable them to realise their communicative potential.

2.2 The following exclusion criteria will apply to all referrals:

- pre-verbal communication skills;
- not having achieved cause and effect understanding;
- has impaired cognitive abilities that would prevent the user from retaining information on how to use equipment.

3. Purpose of the equipment

3.1 People eligible for assessment for specialised AAC should have a need for a Voice Output Communication Aid (VOCA).

3.2 It is recognised that email, other computer applications, texting and other technologies are forms of communication, however the primary aim of referrals to a specialised AAC service must be related to a significant difficulty communicating through speech.

3.3 The responsibility for assessing and providing equipment to support access to a computer for purposes other than voice output will vary depending on the circumstances of computer use. This may be, for example, via [Access to Work](#), [Environmental Control Services \(D01/S/c\)](#), Education or other routes.

3.4 Provision of a VOCA should broaden the range of communicative functions and the contexts in which a person can participate.

4. Eligibility for referral

4.1 A person being referred for a specialised AAC assessment should have significant difficulty communicating through speech.

4.2 If a person has variable speech, (i.e. is able to speak intelligibly at some times but not at others), then a clinical decision will need to be made on an individual basis as to whether a voice output communication aid is appropriate. This is likely to be determined by the proportion of time the person can and cannot speak intelligibly, their communication environment and which communication partners find them intelligible.

4.3 A person who has intact literacy and no or mild language delay / disorder AND who has the physical ability to control equipment using at least one hand at reasonable speed and accuracy would not be considered to require a specialised assessment for AAC. Such a person should be supported by their local team and should be eligible for other sources of funding.

4.4 A person with impaired literacy to the extent that they cannot construct messages by spelling, but who has sufficient language skills to combine multiple words, phrases or symbols into messages with multiple concepts is likely to require specialised assessment regardless of whether they can control a touchscreen or keyboard with a hand.

4.5 A person who can use a touchscreen or keyboard with a hand but has a severe language delay / disorder to the extent that they cannot combine words or phrases to create more than one concept may benefit from AAC but the assessment itself and the equipment required are unlikely to be complex. In most cases the needs of such people can be met by the local team.

4.6 A person with severe language delay or disorder as in point 4.5, but who cannot use a touchscreen or keyboard with a hand, is likely to require specialised assessment.

4.7 In a person with developing AAC skills the following factors will apply:

4.7.1 The person should be able to consistently make purposeful choices. Evidence of this will be required.

4.7.2 The referring therapist should evidence that the person is moving beyond basic choice making and would now benefit from the use of technology in order to communicate a larger variety choices for increased communicative functions e.g. to make requests, question, comment, interact etc.

4.7.3 The person should demonstrate ability to link ideas/ semantic categories and syntactic functions beyond basic requests.

4.8 In addition, where identified impairments of social communication are present, consideration should be given to how these impairments would impact on the functional use of an AAC system. The following factors should apply:

4.8.1 As with other groups, provision of a system should look to broaden the range of communicative functions and contexts in which a person can participate.

4.8.2 In common with other areas of this pathway, examples of low-tech use and why this is not suitable or not sufficient to meet the communication needs of the person would need to be provided.

4.8.3 Communicative intent would need to be demonstrated, as this funding stream is not intended to cover devices provided for the purposes of language modelling, behaviour management and the development of social interaction skills.

4.9 In most circumstances, a referral should indicate that low-tech AAC has been considered and must identify why this does not meet the person's needs. A case for why a VOCA might better meet their needs should be presented. If low tech AAC has not been considered, the referral should justify why this is the case.

4.10 If a person meets the eligibility criteria the assessment will include considering the need for mounting of the required AAC equipment. If a person meets the eligibility criteria and has appropriate equipment in place, a referral can be made for consideration of mounting options.

5. Timing of referrals

5.1 Most people referred to the service should meet the criteria for referral at the time they are referred, with the exceptions below.

5.2 People with rapidly degenerative conditions can be referred to the service prior to their meeting all of the referral criteria. However the following factors will be taken into consideration:

5.2.1 The referring professional and the specialist team receiving the referral should be satisfied that the rate of deterioration is such that the referral criteria are likely to

be met within the time in which a device would be provided from referral. Although this time is variable, a time of 18 weeks is suggested.

5.2.2 It is recognised that this is a difficult determination to make in many cases, but some evidence of how deterioration has occurred in the period prior to referral should be included in the referral. Decisions will be based on the individual clinical circumstances of each case.

5.3 Patients undergoing rehabilitation who meet the referral criteria are eligible for AAC provision, however the following considerations may apply:

5.3.1 The referring team and specialist service should be satisfied that it is likely that the person being referred will continue to meet the referral criteria even when rehabilitation is complete.

OR

5.3.2 The person is likely to benefit from high tech voice output AAC for a significant period within rehabilitation when there is evidence that low-tech communication will not meet their reasonable needs.

5.3.3 Likely means of support of the AAC device after discharge from rehabilitation should be identified. Where possible, the professionals that will take on this support should be actively involved in the referral and assessment process.

5.3.4 It is not the remit of the specialised AAC services to provide rehabilitation equipment, equipment to work on motor, cognitive or language skills (for example aphasia therapy software) as part of rehabilitation therapy sessions.

6. Who can refer?

6.1 Referrals should be made by health, social care or education professionals who are registered with the HCPC or other appropriate statutory body responsible for their profession.

6.2 The referrer should have prior and regular ongoing involvement with the person being referred and be prepared to support that person through the assessment.

6.3 Whatever the source of the referral, the specialised AAC service must be satisfied that ongoing monitoring of any AAC device provided will be carried out throughout its expected lifetime. If any additional cost implications to the AAC user or their family arise from the means of monitoring (i.e. payment to independent professionals) the AAC user or their family must be aware of these implications.

6.4 It is at the discretion of the AAC service to refuse a referral if they believe that there will not be sufficient support throughout the assessment process or ongoing support in place to ensure continued use of AAC. If other referral criteria are met, then such a refusal would usually be accompanied by a recommendation to seek involvement of a local team

who would be able to provide ongoing support. Once this is in place, a re-referral can be made.

6.5 Referrals will not be accepted from employees of commercial companies involved in the manufacture or sale of AAC devices.

6.6 By making a referral, referrers agree to a joint working model with the specialised AAC service. This agreement is to be involved in the whole process of assessment, training, provision and on-going support to the client and their network of support.

7. Referral Process

7.1 Referrals can only be made to a single service. Referrals should not be made to several services simultaneously in order to determine which service can see the person most quickly. Ongoing funding for AAC will depend on accurate data reflecting need and multiple referrals will compromise the validity of data.

7.2 People who have been declined as ineligible by one service may not be re-referred to another service unless there has been a significant clinical change.

7.3 Referrals must be made using a fully completed form as supplied by the relevant specialist service and failure to do this will result in a delay to the referral being considered and may result in the referral being refused.

7.4 Referrers should contact individual services to obtain the relevant form and determine the most suitable means of submitting the form to that service. Referrers are encouraged to discuss referrals with the specialist service before making them.