CPD profile

1.1 Full name: SLT profile 3
1.2 Profession: Speech and language therapist
1.3 Registration number: **AB1234**

2. Summary of recent work/practice
I work as a principal therapist in a primary care trust. I co-ordinate a team of therapists and support workers who work with adults across a large urban rural area in the North West. The team covers a medical rehabilitation unit and a neurological rehabiliation unit as well as providing services to the acute wards, outpatients departments and a community service. My responsibilities include day-to-day management and development of the service, clinical work and training. I have particular clinical interest in work with adults with long-term medical conditions who have been disharged from hospital and who live with at home. I have regular contact with my SLT team, with the line managers of the wider multi-disciplinary team and with commissioners. I also liaise with the local stroke volunteer service, where I am involved in planning and delivering the volunteer training scheme.

Total words: 141
(Maximum 500 words)

3. Personal statement
I have used RCSLT's electronic diary to keep an ongoing record of my CPD activities since July 2007 (Example 1). The diary provides a record of all the CPD activities I have undertaken since that date, and maps these against the HPC categories of work based learning, formal educational activities, professional activity and self-directed learning. In addition, I have kept a CPD portfolio, a sample of which I have included with this submission. In my annual personal development plan, I have ensured that I have undertaken CPD a mixture of CPD activities as required by Standard 2. The combined evidence from my diary and portfolio shows how I have met Standards 1 and 2. If required, I can submit all my entries from the diary in addition to the ones I have selected for this audit. These include a description of the activity and reflections on my learning for each one.

I have selected seven CPD activities from my diary which illustrate how I have met Standards 3 and 4, as they have had a direct impact on the quality of my work and on the clients I work with. My 'clients' include people with acquired communication disability, their relatives, volunteers, and therapy and medical colleagues, to whom I deliver training.

Short course on living with aphasia (Example 1)
I attended this course in October 2007. It was my first encounter with the Connect approach, and I have since attended one other course run by this voluntary sector organisation. Attending the course had a significant effect on my practice, as I had been reflecting for some time on the fact that people living with stroke and aphasia over a longer period of time are not well served by our service. The course addressed the long term impact of communication disability, and offered new ways of

supporting people with aphasia and their families once they leave hospital. The techniques discussed were practical and transferable, and we have implemented many of these within the SLT service in our area.

Audit (Example 2)

As a result of the new knowledge acquired at the Connect course, we decided that as a team we needed to look more closely at the level of service provided to adults with communication disability in the community. Our data collection systems were revised so that we collected more detailed information on discharges from different hospitals and rehabilitation units in the area, and what community-based services were able to offer. The audit found a number of discrepancies in the way patients were followed up, depending upon where they lived. We found that some patients were in effect 'lost' to the system, and as the GPs had no record of them as communication disabled there was no obvious way in which such patients could be traced. As a result, we initiated more robust system for tracking patients seen in hospital to ensure that they remained in contact with the SLT service for as long as they required it, strengthening links with the local stroke volunteer scheme (see below). Although the audit was conducted by the team, I held overall responsibility for the design and implementation as well as the analysis and writing up of the audit. It allowed me to put into practice some of the principles I had learned about through a course on audit methods.

Courses for doctors

Another key aspect of my work is training. As a result of the audit we undertook as a Department, I decided to approach the Medical Deanery about offering training to doctors on communicating with people with communication disability. I began working with the course leader to design a short course for hospital doctors and GPs at different stages in their training – undergraduate and post graduate – that was delivered over an eighteen month period. Drawing on experience from the Connect course I chose to prioritise practical aspects of communication skill training and the involvement of people with aphasia as trainers rather than the more medical approach I used previously. The course evaluations (Example 3) are attached. 86% of doctors attending the courses said they were 'highly satisfied', and the remainder were 'satisfied' teaching this course also provided me with an opportunity to meet medical colleagues and to raise awareness of the role of SLT in working with people with acquired neurological conditions.

Clinical Leadership (Example 4)

In my 2007 PDP, my manager and I agreed that there was a need to develop my leadership skills, as I had not received any formal training in this area. I was given the opportunity to enrol on a clinical leadership course locally. Although the course was demanding in terms of time, and I had concerns about its impact in the short term on my work, I found very quickly that there were benefits not only for me but for my team. As a result of going on this course, I had a better understanding of the role of leadership in a health setting, and observed some examples of good practice in leadership which I felt I could translate into my own setting. I also received new insights into my own skills and abilities, and was introduced to the challenges of 360 degrees appraisal for the first time. As a team, we are now considering how we might introduce this system alongside the KSF Developmental Review process.

Volunteer Training (Example 5)

Historically, the SLT service had not had good links with the stroke volunteer service in our area. In January, a new co-ordinator was appointed, and this seemed an opportunity to begin to develop a better relationship with the volunteers. A small team was established to start developing a programme of training, based on the Connect model, which involved volunteers and people with aphasia in the planning the courses as well as the delivering the courses. This initiative was a further opportunity for me to develop my skills in working within a multi-disciplinary team, design and deliver training, and gain a better understanding of the experience of volunteer work with people with aphasia. The initiative was evaluated and the results indicated that the volunteers welcomed this step towards working more closely with SLT colleagues.

Advanced Dysphagia Training (Example 6)
The advanced course involved not only developing skills in assessment and treatment but also in training others to work with patients with dysphagia. It includes intensive training as well as ongoing case study work, and was a challenging course to undertake. I felt the training was of benefit to my patients, as it gave me more advanced clinical skills, which were assessed and approved by a senior practitioner. It also had benefits for my colleagues, both SLT and non SLT, whom I felt better equipped to train in dysphagia management.

The BAS Conference is a major event for therapists and academics working with people with aphasia. Although I had attended many of these conferences, I had not presented to colleagues before. Preparing and presenting at the conference was an important 'landmark' for me. I chose to present a paper which described the challenges of introducing a new approach to working with people with aphasia into a mainstream NHS setting. Although therapy with people with long term medical conditions has always been part of the work of SLTs, becoming involving in more complex areas such as the impact of stroke and aphasia on quality of life, self confidence and the impact of stroke on identity has not. I feel I am gaining a greater understanding how these interact, and I have much still to learn if my service is to be of benefit to patients and their families. My presentation on this topic was well received, and several colleagues in other parts of the country have agreed to work with our service on taking this further. One of the other benefits of attending this conference was hearing a qualitative paper about patients' expectations of health services. The presenter concluded that patients want health professionals who are respectful and good at listening as well as technically competent. Being one or the other is no longer sufficient in today's health service. This seemed to me to be an important message to take back to my service and to exercise in my own practice.

Total words: 1377
(Maximum 1500 words)

4. Summary of supporting evidence submitted

Evidence number	Brief description of evidence	Number of pages, or description of evidence format	CPD Standards that this evidence relates to
Example	Eg: 'Case studies' or 'Critical literature reviews'	Eg: '3 pages', 'photographs', or 'video tape'	Eg: Standards 2 and 4
1	RCSLT electronic diary Jan 07/July 09	7 pages	Standards 1,2
2	Connect short course	2 pages	Standard 3
3	Audit	7 pages	Standard 3
4	Course programme evaluation (Doctors)	4 pages	Standard 3
5	Clinical Leadership training	17 pages	Standard 4
6	Volunteer training	4 pages	Standard 3,4
7	Advanced Dysphagia Training	20 pages videotape	Standard 4