How are People with Communication Difficulties Supported in Advance Care Planning?

Sophie Whitehead

Learning from my Churchill Fellowship 2024

U.S.A and Europe

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Useful Terminology and Used Abbreviations

AAC – Alternative and Augmentative Communication

ACP – Advance Care Planning

EoLC – End of Life Care

MND – Motor Neuron Disease

RCSLT – Royal College of Speech and Language Therapists

SLT – Speech and Language Therapy/ Therapist

SPC – Specialist Palliative Care

Alternative and Augmentative Communication – a range of strategies and tools to help people who have difficulties speaking. This can be something simple like a letter or picture boards (low tech AAC) or something more complex like a computer based device (high tech AAC) (Communication Matters, 2025). At times referred to as a communication aid.

Dysphagia – difficulties swallowing (assessment and management is part of the role of a SLT).

End of Life Care – care for people in the last months or year of life (NHS England, 2022).

Palliative Care - an approach that improves the quality of life of people with life limiting diseases and their families. It aims to prevent and relieve suffering through the early identification, assessment and treatment of pain and other complex symptoms, including physical, psychosocial and spiritual (World Health Organisation, 2020).

Simulation based learning - a learning tool that supports development through experiential learning by creating or replicating a particular set of conditions which resemble real life situations (Health Education and Improvement Wales, 2025).

Total pain – suffering that encompasses all of a person’s physical, psychological, social, spiritual and practical struggles (University of Glasgow, 2025).

Executive Summary

Communication is a basic human right. Throughout their lives up to 20% of the UK population will be affected by communication difficulties, this impacts many people with a palliative diagnosis. Speech and Language Therapists (SLTs) have the training, knowledge and skills to support these communication difficulties and ensure that everyone is given the opportunity to participate in advance care planning (ACP) and decision making at the end of life. This role in palliative care is still evolving globally. Through my Churchill Fellowship I learnt about areas of outstanding and developing practice within the U.S.A. and Europe.

The following themes came out of my learning:

- Training and Education
- Use of Resources and Foundational Learning
- SLTs as Gatekeepers
- Defining the Role

These are my recommendations for change:

(1) All people with a palliative diagnosis and communication difficulties, should have access to a SLT, to provide specialist assessment and provision of AAC that can be used in ACP and assist in facilitating ACP conversations as required.
(2) All health care professionals should receive awareness training on communication difficulties and how to support those individuals in ACP, and when to refer on for specialist input from SLT.
(3) SLTs should receive training and education in palliative and end of life care (EoLC), from an undergraduate level onwards. Advanced skills and training in palliative and EoLC should be available at postgraduate level.
(4) Resources should be utilised to support understanding in ACP conversations.
(5) People with communication difficulties should be given access to the language they need to initiate and make decisions about their future care.
(6) SLT needs to be a recognised role in palliative and EoLC. SLTs need to continue to define this role, provide evidence, promote and raise awareness, in a bid to influence MDT members, funders and policy makers.

About Me

My name is Sophie Whitehead, an adult Speech and Language Therapist (SLT) working in Specialist Palliative Care (SPC) in the National Health Service. I chair the UK Clinical Excellence Network for SLTs interested in palliative and end of life care (EoLC), this role involves organising and hosting national study days and webinars. I am also a national adviser for the Royal College of Speech and Language Therapists (RCSLT) in palliative care. This has included reviewing and producing written publications and education materials, taking part in awareness raising campaigns and contributing to national policy; most recently representing the RCSLT at the Government's Commission on Palliative and EoLC.

Locally I am passionate about the development of the role of SLT in palliative care across hospital, hospice and community settings; completing projects, developing services and providing training and education for SLTs and the wider Multi-disciplinary Team (MDT).

I truly believe SLTs have an essential and unique role in palliative care, particularly in utilising our skills and training in managing communication difficulties.

Figure 1 Visiting Keukenhof Gardens in the Netherlands.

Project Breakdown

Throughout their lives up to 20% of the UK population will be affected by communication difficulties. Many people receiving palliative and EoLC will have diseases which affect their ability to communicate, most commonly brain tumours, head and neck cancers and progressive neurological diseases. People may experience difficulties with talking, writing and understanding spoken or written language, slurred speech or a weak voice.

SLTs manage speech, language and communication difficulties across the life span. Currently there are too few SLTs working in palliative and EoLC in the UK (estimated under 15) with significant variation across the UK. This means that people with communication difficulties do not have the specialist support to partake in advance care planning (ACP) and decision making at the end of life.

ACP is a voluntary process of person - centred discussions between individuals and their care providers about their preferences and priorities for their future care (NHS England, 2022). This is likely to involve a number of conversations over time. When ACP is done well, people feel they have had the opportunity to plan for future care and are being listened to. ACP is a key means of improving care for people nearing the end of life and of enabling better planning and provision of care to help them live and die well in the place and the manner of their choosing. The main goal is to clarify peoples' wishes, needs and preferences and deliver care to meet their needs (The Gold Standards Framework, 2025).

As a SLT I see the huge unknown and unmet need for our role within palliative care, to ensure people with communication difficulties are supported to make decisions about their future and care. Palliative Care is an evolving field for SLTs, across the world. I believe that supporting people with communication difficulties to engage and partake in conversations about their future wishes and care is a unique selling point for the need for SLTs to be part of palliative care MDTs, this was my motivation to carry out this fellowship project.

For my Fellowship I travelled to the U.S.A and Europe. Visiting Oregon, Southern California, New York, Boston, the Netherlands and Austria.

These destinations were chosen for the following reasons:

- Research suggests they are some of the countries doing the most work around ACP and it is a well-established process
- All countries have SLTs as a recognised profession
- Similarly to the UK, in the Dutch Health Care System ACP conversations are often not initiated until after a hospital admission or admission to a nursing home
- Like in the UK they have specific laws in regards to advance directives
- All countries have legislation around assisted dying, which is in process in the UK
- The U.S.A and the Netherlands have published research into supporting ACP in those with dysarthria (slurred speech).

I anticipated that conversations in regards to ACP and EoLC would share common themes to the UK. However, I also recognised that experiencing conversations related to assisted dying would provide valuable insight into something that may become a future challenge in the UK. For these reasons I selected these countries, as I felt my learning would be highly relevant to the UK context.

As my project question was broad and I was looking to learn from a wide spectrum of professionals and establishments, I arranged my Fellowship all as individual meetings and visits.

Aims

- Improving how people with communication difficulties are supported to partake in advance care planning (ACP).

- Highlight the role SLTs can play in supporting ACP. As well as develop solutions for communication support during ACP, in the absence of SLTs which is the current scenario in most palliative care services in the UK.

- Have an impact on the perception of the value of SLTs in palliative care & supporting ACP at a national level.

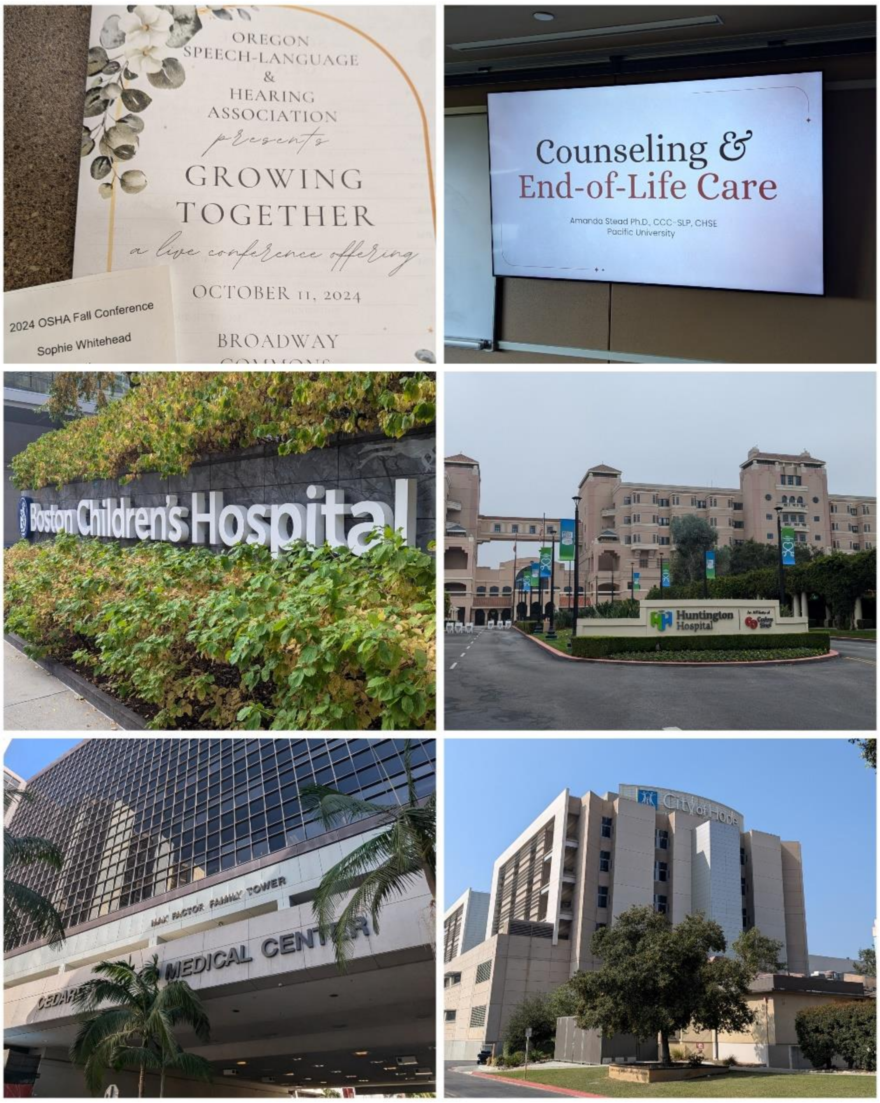


Figure 2 Pictures from the U.S.A.

Summary of Travels & Meetings

U.S.A October 2024

Oregon

- Professor Amanda Stead - SLT, Coordinator of Simulation Education at Pacific University
- Oregon Speech –Language Hearing Association Conference

Southern California

- Sanora Yonan- SLT + Team at City of Hope Hospital
- Alyssa Kenton- SLT+ Team at Huntington Health
- Emily Downing-Mahli - Nurse Practitioner Supportive Care Medicine (Neuro Palliative Care) at Cedars-Sinai
- Dr Jessica Besbris - Assistant Professor of Neurology and Medicine/ Director of Neuro Palliative Care / Lead Consultant, Supportive Medicine at Cedars- Sinai
- Dr Philip Chang - Assistant Professor Physical Medicine and Rehabilitation at Cedars- Sinai

New York / Boston

- Tami Altschuler - SLT/ Clinical Specialist in Patient-Provider Communication at NYU Langone Health
- Rachel Santiago - SLT, Clinical Coordinator Inpatient Augmentative Communication Programme at Boston Children's Hospital + Team
- Lauren Cramer Finnerty - Paediatric Advanced Care Team Social Worker at Boston Children's Hospital
- Meghan O'Brien- SLT, Clinical Coordinator Augmentative Communication Programme / MND Programme at Boston Children's Hospital

Additional

- Dr Steven Leuthner - Professor of Paediatrics and Bioethics, Medical College of Wisconsin/ Medical Director of Palliative Care, Children's Wisconsin
- Meagan Williams - Manager, Clinical Education / Clinical Engagement Team at Compassion and Choices.
- Dr Ashley Fry - Nurse practitioner/ Director of Clinical Advocacy at Compassion and Choices.

Europe April 2025

The Netherlands

- Arjan van Binsbergen- Care Manager at Hospice Kuria
- Dr A.F.Offeringa- SLT at University Medical Centre Amsterdam
- Dr Dorine Boersema- Wijma and Kim Geerlings- Grootscholten- Research Coordinator at Topaz Overduin Huntington Expertisecentrum + Team

Austria

- Rainer Simader- Education and Diversity Director at Hospice Austria
- Professor Susanne Javorszky- SLT / Researcher at FH Campus Wien

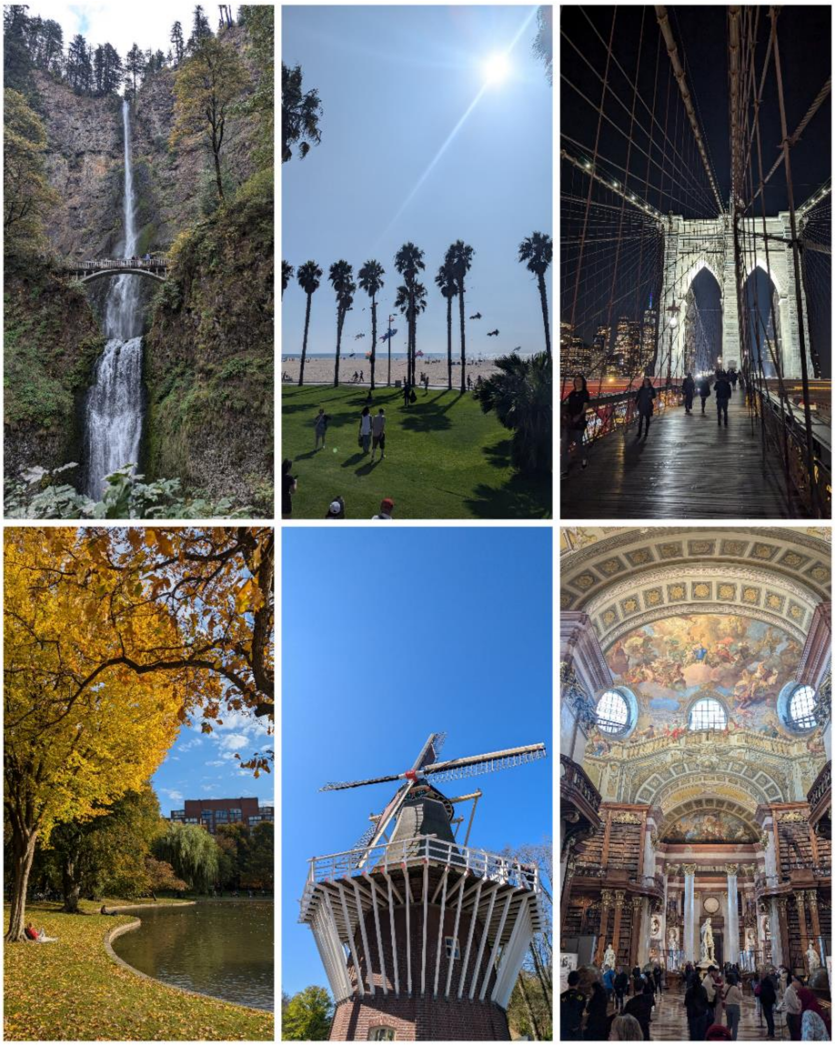


Figure 3 A picture from each city visited.

Findings and Reflections

During my travels I kept a blog where I recorded in detail about my visits, conversations and immediate reflections. This can be viewed at:

https://palliativecareslt.wordpress.com/

When thinking back to my original question and aims. There were 4 main overarching themes that came out from my learning and reflections, with lots of overlap.

(1) Training and Education
(2) The Use of Resources and Foundational Learning
(3) SLTs as Gatekeepers
(4) Defining the Role

Training and Education

For Speech and Language Therapists (SLTs)

Undergraduate Level:

Stepping outside of my clinical role allowed me to really think about the whole career span of a SLT, in particular the need to introduce palliative care to student SLTs to change the fear and stigma attached to it. This was evident at both the universities I visited in Oregon and Austria, with this often stemming from having a specific staff member employed who is knowledgeable and passionate about palliative care. In Oregon I witnessed learning and discussion through simulation based learning**.** The goal of the simulation exercise was an opportunity for student SLTs to demonstrate the ability to navigate a care conference with a family, demonstrate counselling skills, articulate their role and responsibilities in the care for a person nearing the end of life and explain the evidence base. The students were really receptive to the exercise and reflective of the challenges during debriefing. It is vital for student SLTs to practice these challenging conversations, as newly qualified SLTs often face them early in their careers. This preparation helps to reduce fear and avoidance of these types of situations.

Post Graduate Level:

Reflecting from a postgraduate perspective, fear and discomfort from SLTs to engage in palliative care work was highlighted as a barrier in all countries, particularly for SLTs when it comes to engaging in conversations around death and advance care planning (ACP). As in my experience, it is still common to see people who are deemed ‘end of life’ or ‘palliative’ to be discharged from SLT services. This is why starting within our own profession is essential to increase knowledge and confidence. In Austria in response to this feedback from SLTs they are planning to run a 2 day course to prepare SLTs to work in palliative care with communication skills (> dysphagia) being the desired focus.

Further training and education is necessary as skills related to communication and the understanding and application of ethics are often seen as softer skills but need to be valued as much as practical competency based SLT skills, if we are to ensure SLTs are confident in using their skills to support ACP conversations. In the U.S.A. ACP processes depend on the setting and the resources and often depend on how comfortable the health care professional is to initiate. Often there is a lack of skills in ACP conversations and referrals will be sent straight to palliative care teams to initiate. But again similarly to the UK there is the push that ACP conversations are the role of everyone, which SLT need to be a part of.

For The Multi-Disciplinary Team (MDT)

There is a huge opportunity for increasing awareness and upskilling other professionals through education and training. This in turn would broaden access and support for people with communication difficulties in partaking in ACP. It is also an easy win and supports the idea of bringing everyone along in supporting people with communication difficulties.

It was reflected that healthcare professionals don’t have great training in how to support people with communication difficulties and often lack knowledge on having useful and simple, resources or strategies available for example suction, tissues for people with head and neck cancer, considering the time of day, ensuring preferred support systems are in place if wanted for example spouses or accessing translators (which it seems are very easily accessible in the U.S.A.). In neuro- palliative care Dr Besbris noted similar, often health care professionals lack the awareness and do not provide the time or communication aid access or know how to frame yes / no questions. However this is seen as a specialist skill of neuro palliative care professionals. In regards to support provided by the team for people with communication difficulties, they may see them more frequently and provide fewer topics per session. Bringing advance directives and other ACP topics up early is really important and the responsibility of the health care professional. They look at pivot points (for example someone having a tracheostomy inserted) in regards to having conversations about the future.

Dr Offeringa also highlighted that MDT members can struggle when there are complex communication difficulties at play for example someone with Frontotemporal Dementia, which can lead to misunderstandings and people not accessing services due to not understanding the processes. SLTs will provide advice, joint sessions for demonstrations to the MDT or families, focusing on a total communication approach (drawing, gesture, implementing low/ high tech AAC devices) to improve their confidence. Communication advice will also be put into someone's medical file for the MDT to see which helps increase awareness.

Thinking about the wider MDT and communication being a basic human right, we need to get everyone on board in being able to support people with communication difficulties. But first the MDT needs to be able to recognise a communication difficulty. This is an easy win when there is so much training already provided around advanced communication skills and ACP. We can incorporate education around recognising communication difficulties, supporting them and ensuring the role that SLTs can provide in specialist assessment and support is known.

People with communication difficulties are at high risk of being treated as not having capacity. SLTs can ensure that people with communication difficulties can request their basic needs, make choices, give informed consent, and have access to spiritual needs and closure. There is an overwhelming feeling of it being an important responsibility of SLTs to share skills and knowledge in communication access and the use of communication aids, to members of the MDT. On the East coast of America technology was used to provide training resources and maintain training and competence of MDT members, whilst balancing limited SLT capacity.

Strengthening awareness within the MDT can only be of wider benefit to progressing the recognition of the value of SLTs in palliative care and hopefully leading to the inclusion of SLTs in MDTs and inter- professional guidance in the future. It also allows for more opportunities for joint working for example with social workers to ensure early initiation of ACP and exposure to communication aids in anticipation for deterioration in communication skills. It also identifies ‘champions’ who will recognise the need and refer.

In the UK and the Netherlands SLTs in the hospice are very rare however people may be able to have SLTs visit them in the hospice setting. Arjan the Care Manager at Hospice Kuria reflected that the doctors will often struggle with ACP conversations with people with communication difficulties or primary languages other than Dutch or English. They do try to use different materials to support someone’s communication and there are virtual translating apps on the nurse’s tablets, however sometimes this is not always successful.

One area of outstanding practice I observed was in the care of people with Huntington’s disease in the Netherlands. I learnt that more and more ACP is happening and starts at diagnosis and is reviewed often. A big difference in the Netherlands is that assisted dying is available for people with Huntington’s disease. If this is chosen this influences the type of ACP conversations for example around tube feeding, as it is not in keeping with the overarching choice someone has made for their care. People may stipulate a time they would want to consider it but sometimes they may no longer meet the criteria of being able to repeat their request for assisted dying. However information on their wishes in the past are taken into account for future care to inform decisions. SPC professionals tend not to get involved in ACP conversations as the familiar staff are the ones who possess the specialist knowledge and experience with Huntington’s disease. Palliative care is a part of all their roles, even if they don’t always recognise it.

Use of Resources and Foundational Learning

Advance care planning (ACP) is a process and not a one off conversation. Foundational learning to support conversations and decision making is essential. This can be a challenge particularly in hospital settings due to time limitations. Resources however are universally underutilised and there is not enough done to ensure that resources and materials used are accessible and inclusive. Decisions need to be revisited as people may change their mind. I liked the idea of 'people's magazine rounds' from Dr Leuthner, where one day there may not be significant medical conversations happening (instead a conversation about what is in people's magazine) but it is building the groundwork for these conversations in the future.

Conversations with staff from Compassion and Choices (a non-profit organisation) provided a real reminder of focusing on understanding as much as expression when it comes to ACP. Simple tools like providing and using written and pictorial resources to strengthen understanding and retention of information are equally as important as supporting someone with their expression. Having physical resources which can be left are beneficial, combined with allowing time for follow up, questions and confirmation of understanding. At Boston Children's Hospital there is a big focus on supporting receptive skills and explaining things to children. They use tools like social stories which are seen as low demand but high support. Thinking about discharge from hospital at Boston Children's Hospital I heard the phrase 'having a tool box', where they try to send children home with as many options for communication and access as possible. This made me reflect on my practice as an SLT and the importance of providing multiple access options, to anticipate factors such as fatigue.

I really took away the idea of ACP as a journey. Similar barriers around documentation in the U.S.A. came up as are present in the UK. If we put this aside and think about our documentation as storytelling, of someone's thoughts and wishes along their journey which can contribute to their views being documented and respected in the future, which reduces distress. These conversations are often felt to be more important than the documentation and make it more likely that someone's wishes are followed.

Barriers such as time in a hospital setting can render the community a better setting for ACP conversations. Time is needed to really explore someone’s goals and values as quality of life can look so different from person to person.

Speech and Language Therapists (SLTs) as Gatekeepers

Alternative and Augmentative Communication (AAC)

Communication supports are a communication based right that everyone who needs should have. As SLTs we have the power to withhold this provision, alongside the MDT, whether that be through not providing a communication service or not having the skills and knowledge to do so. The same goes for end of life conversations and advance care planning (ACP), with fear often being a barrier for SLTs. In the MND AAC service in Boston, they agree that initiating EoLC conversations fits within our scope of practice and see it as a fundamental communication based right for quality of life, autonomy and personality. But for individual SLTs this view has often developed and progressed with experience. Experience allows SLTs to be able to pick up on cues that people provide that they want to have these conversations, at the right time for them.

AAC users can only use language they have made available to them by SLTs. Adding terminology related to health care decisions allows people to be familiar with it and have the opportunity to use it. Barriers for SLTs include fear of upsetting someone and only using tools they are most familiar and comfortable with. I took a huge amount away from my visit to Boston Children's Hospital where the SLT role in communication is equally prioritised alongside dysphagia. Their aims of (1) communication access (2) control (3) connection, are clear to see. This might include providing children with access to negative language or swear words that they might normally have used. This is allowing them authorship and the opportunity to express frustrations and big emotions. Not doing so isn't trauma-informed care and people are more likely to reject AAC if the language is not appropriate for them.

If we're not providing the language and access to it, we're missing out on opportunities for people to initiate ACP conversations. It was reflected how powerful ACP conversations can be for a person with a life limiting condition, in removing some of the burden that comes with nobody knowing their wishes and this also in turn removes guilt for families in knowing they are following someone's wishes and not making decisions independently.

It was highlighted that AAC is something that will change due to necessity as different generations experience aging and dying. High tech AAC may progress now with someone the whole way through their life. With Dr Offeringa we spoke a lot about low vs high tech AAC, with low tech being the hardest for people to get on board with (especially younger people) despite it often being the simplest. Due to this they have less of a focus on low tech and instead focus on getting text to speech apps for people’s phones as it is something they already have and use.

When trying to integrate AAC, it needs to be a team approach. If it is not this can impact environmental use, for example someone being able to use their AAC at medical appointments. In the Amsterdam University Medical Centre MND MDT some areas of really good practice I heard about were, people being asked to bring AAC devices to outpatient appointments and prepare in advance questions and information for the doctors and having a SLT as part of the MND MDT in outpatient clinics. Given virtually all people with MND will have speech changes at some stage this makes sense.

We also feed into the MDT and have a responsibility to ‘bring everyone along’ and ensure we are sharing and educating on strategies and supports. The aim is always to reinforce use of AAC and ease transition when people’s communication deteriorates.

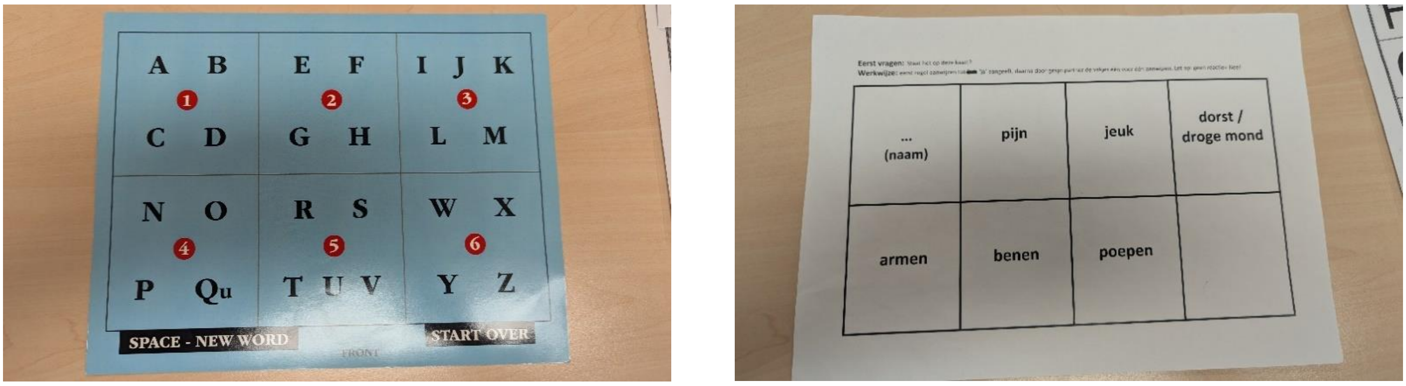
Timing

As professionals we also need to consider the timing of ACP. Professor Stead suggested as professionals we need to ask, not wait for people to tell us. This is especially important as dignity can look different for everyone, so we have to ask to know. This is referred to as ‘the bid’ and reminds us that what you don’t do is as meaningful as what you do**.** We need to be making an offer, to have these conversations, as well as providing people with the language to engage in these conversations.

When asked about involvement and support in ACP Meghan who works with people with MND in Boston said there is still an uncomfortableness around discussing EoLC planning, as well as time barriers. SLTs may be trying to have an ACP conversation in a 20 minute session. To combat this they are looking to come up with a page set so that people can prepare and edit their responses to the questions in advance of appointments. The lack of input when someone switches to hospice care is a real issue though in the U.S.A. as this is when a lot of these conversations will come up more frequently.

Changes since the pandemic

I had numerous conversations reflecting the challenging times in healthcare during the Covid 19 Pandemic where there was a big focus on communication and the barriers that were in place. There have been some positive changes to come from this and I particularly noticed that multiple times provision for SLT support for communication and decision making was present in intensive care settings in the U.S.A. and Europe. But challenges were highlighted such as getting the MDT to initiate using communication aids. Surveying highlighted a preference for nurses to use yes/ no questions and lip reading as opposed to communication aids. This goes back to the need for MDT education and training.



A B ① C D	E F ② G H	I J K ③ L M
N O ④ P Qu	R S ⑤ T U V	W X ⑥ Y Z

SPACE - NEW WORD

START OVER

FRONT

Eerst vragen:

Werkwijze:

... (naam)	pijn	jeuk	dorst / droge mond
armen	benen	poepen	

Figures 4 Low tech AAC charts used at University Medical Centre Amsterdam.

Defining the Role

My findings highlight that we are at a point where globally SLTs have accepted that palliative and EoLC is part of our scope of practice including advance care planning (ACP) conversations. As Professor Stead said ‘the dying process should trigger the need for SLT support’ and our role is to provide access and opportunity. Doors are often opened for dysphagia, we can take this opening and address the other issues in our scope such as communication. Just because cognition and communication have been unaddressed it doesn’t mean they should remain unaddressed. In home settings and transition to EoLC services, in the U.S.A. due to insurance there is barriers to the provisions of ongoing SLT, but this is something we do not have to contend with in the same way in the UK. In Austria, scarce community SLT and long waiting lists result in people seeking private palliative care SLT input, which is uncommon in the UK.

Globally SLTs working with adults have become predominantly recognised for working with swallowing difficulties. Although this is an equally important part of our role in palliative and EoLC, we need to raise the awareness and recognition of what we can offer in terms of supporting communication. A rebranding so to speak. Suggestions of having a more globally recognised definition of what the SLT offer in palliative and EoLC is another consideration. Dr Chang reported often SLTs are known for support with swallow and often not consulted towards the end of life. This may also be related to the fact SLTs are traditionally seen as a rehabilitation service as opposed to a supportive one. Dr Chang says that in his experience in California 1% of patients receiving hospice and palliative care receive SLT input. He wonders if this is may be due to the role being ill defined.

One thing for sure is that we are still needing to infiltrate palliative care MDTs and self-identify suitable patients. This in itself can only help establish and bring recognition of our role. SLT support can be the most timely, holistic and thorough when SLTs are integrated as part of a MDT, for example with progressive neurological diseases such as MND and Huntington’s disease. Austria have recently published a service brochure on what services palliative care SLTs can offer which includes guidance around nutrition, communication, respiratory, secretions, tracheostomy, counselling for caregivers and the SLT role within the MDT. Similar documents exist in the UK and Ireland.

Dr Javorszky shared that she uses the concept of total pain (as a concept the palliative care MDT understand) and how SLTs are needed to be able to establish and facilitate communication to address this in people with communication difficulties.

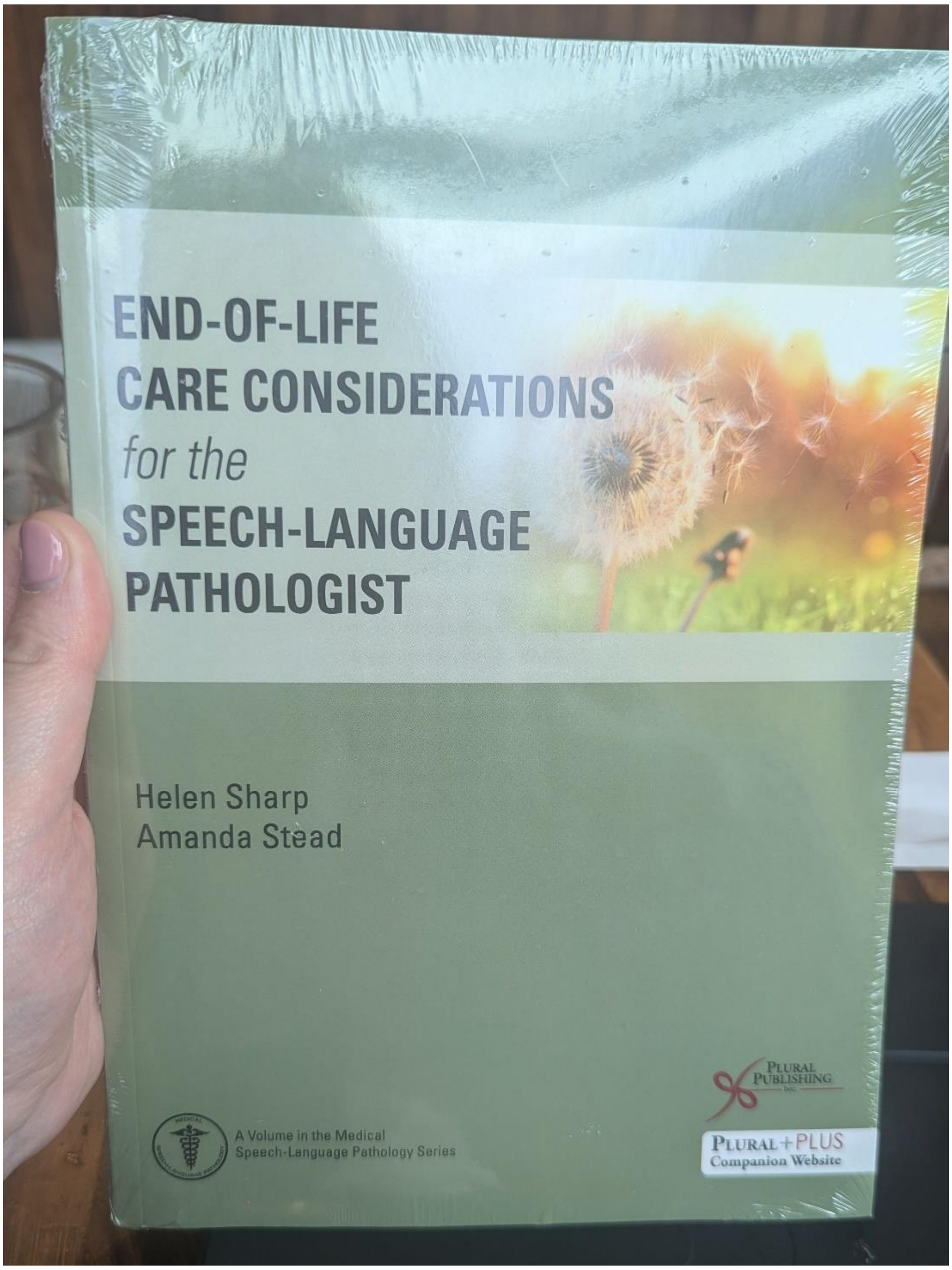


Figure 5 End of Life Considerations for the Speech - Language Pathologist book.

Conclusion

SLTs can contribute a unique role of supporting people with communication difficulties in advance care planning (ACP). This is a belief held by SLTs working within specialist and generalist palliative care and evolving within the wider palliative care MDT.

As it stands people with communication difficulties do not consistently receive the right support they require to engage in ACP. This is due to a lack of SLT provisions and also lack of training and education for SLTs and the MDT. Pockets of good practice exist globally, often reliant on individual's passion and drive to provide and progress a service.

Raising awareness of the unique contribution of SLTs in palliative and EoLC particularly in supporting individuals with communication difficulties in ACP is essential. Addressing the training and awareness needs of the wider MDT will optimise existing staffing resources. Strategic use of resources can achieve significant impact with minimal additional demand.

Knowledge and skills in palliative and EoLC are essential across the career span of a SLT, starting with students through to qualified SLTs. Our own fears and skill mix should not impact on someone's access to language and communication support required to engage in ACP.

Recommendations

(1) All people with a palliative diagnosis and communication difficulties, should have access to a SLT, to provide specialist assessment and provision of AAC that can be used in ACP and assist in facilitating ACP conversations as required.

(2) All health care professionals should receive awareness training on communication difficulties and how to support those individuals in ACP, and when to refer on for specialist input from SLT.

(3) SLTs should receive training and education in palliative and EoLC, from an undergraduate level onwards. Advanced skills and training in palliative and EoLC should be available at postgraduate level.

(4) Resources should be utilised to support understanding in ACP conversations.

(5) People with communication difficulties should be given access to the language they need to initiate and make decisions about their future care.

(6) SLT needs to be a recognised role in palliative and EoLC. SLTs need to continue to define this role, provide evidence, promote and raise awareness, in a bid to influence MDT members, funders and policy makers.

Next Steps

- Dissemination of learning – at local, regional and national forums, article for the RCSLT magazine, sharing my report nationally (RCSLT, Hospice UK, Macmillan, Marie Curie, Sue Ryder), conference presentations / posters (RCSLT, Hospice UK, Palliative Care Congress, Association of Palliative Medicine, European Association of Palliative Medicine).

- Review local trust training offer and ensure communication difficulties are included.

- Consideration of regional and national training provision for SLTs around our role in palliative and EoLC.

- Utilise post Fellowship grant to continue to develop this vision.

Figure 6 Pictures from the Netherlands and Austria.

Thank Yous

- The Churchill Fellowship, Marie Curie and the Burdett Trust for Nursing, for this amazing opportunity.
- Professor Amanda Stead - SLT, Coordinator of Simulation Education at Pacific University + Team at Pacific University especially Jordan and Kerry
- Oregon Speech –Language Hearing Association
- Sanora Yonan- SLT at City of Hope Hospital + Team + the West Hollywood VA Hospital SLT Team
- Alyssa Kenton- SLT at Huntington Health + Team
- Emily Downing-Mahli - Nurse Practitioner Supportive Care Medicine (Neuro Palliative care) at Cedars-Sinai
- Dr Jessica Besbris - Assistant Professor of Neurology and Medicine/ Director of Neuro Palliative Care / Lead Consultant, Supportive Medicine at Cedars- Sinai
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- Lauren Cramer Finnerty - Paediatric Advanced Care Team Social Worker at Boston Children's / Dana-Farber Cancer Institute
- Meghan O'Brien - SLT, Clinical Coordinator Augmentative Communication Programme, MND Programme at Boston Children's
- Dr Steven Leuthner - Professor of Paediatrics and Bioethics at Medical College of Wisconsin/ Medical Director of Palliative Care at Children's Wisconsin
- Meagan Williams - Manager, Clinical Education / Clinical Engagement Team at Compassion and Choices
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- Arjan van Binsbergen- Care Manager at Hospice Kuria
- Dr A.F.Offeringa- SLT at University Medical Centre Amsterdam
- Dr Dorine Boersema- Wijma and Kim Geerlings- Grootscholten - Research Coordinator Topaz Overduin Huntington Expertisecentrum

+ Stella Physio, Evelyn Psychology student, Charlotte and Caroline SLTs.

- Rainer Simader- Education and Diversity Director Hospice Austria
- Professor Susanne Javorszky, SLT / researcher FH Campus Wien and colleague Laura.

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