A Scottish Executive Review of Speech and Language Therapy, Physiotherapy and Occupational Therapy for Children and Speech and Language Therapy for Adults with Learning Disabilities and Autistic Spectrum Disorder.

A Scottish Executive Review of

Speech and Language Therapy, Physiotherapy and Occupational Therapy for Children

and

Speech and Language Therapy for Adults with Learning Disabilities and Autistic Spectrum Disorder.

contents

Foreword

We are very pleased to announce the publication of this report.

We are grateful to the members of the review working group and the consultancy team from Queen Margaret University College who conducted the research, for producing this important document.

Many of the report's recommendations on children's services build on those contained in recent reports such as *For Scotland's Children*, which highlights the importance of integrated working across education, health and social work, and promotes effective joint working across agencies. This is consistent with the Executive's commitment to supporting an inclusive approach to education and to developing the New Community School approach to joint working. *Community Care: a Joint Future* also emphasises the importance of joint working with the older population relevant to the part of the review that looked at adults.

The report highlights issues of concern to professionals in health, education and social care, as well as to parents and to adults with learning difficulties. Our health White Paper, *Partnership for Care,* has since clarified the mechanisms for joint decisions on community care – involving NHS Boards and local authorities as partners at the heart of integrated local care through new Community Health Partnerships. Working in partnership with these mechanisms, other agencies and bodies like the new National Workforce Committee, emerging regional structures and NHS Education for Scotland will help determine supply of, and demand for, therapists, workforce planning, management and organisation of services and funding. We believe that many of these concerns are being addressed in the substantial progress already made through the national action plan for the Allied Health Professions (AHPs), *Building on Success – Future Directions* – since its publication almost exactly a year ago.

Future Directions stresses the unique nature of each of the nine constituent professions within the AHP community, which includes Speech and Language Therapists, Physiotherapists and Occupational Therapists – but it also addresses common issues affecting all practitioners regardless of speciality. We are providing resources aimed at improving recruitment and retention, and we are providing additional AHP student places. In addition, a number of key groups have been set up to work with existing AHP groups, NHSScotland, the higher education sector and the people of Scotland to ensure progress is made across the board. Specifically, a Ministerial Implementation Group (MIG) will be overseeing the implementation of *Future Directions*. Five short-life working groups covering Research and Development, Clinical Placements, Staff Governance, Careers Information, and Recruitment and Retention will report to the MIG.

Of course, this report is not just about services for children. In May 2000 the Learning Disabilities Review, *The same as you?* reported that adults with learning disabilities requiring speech and language therapy were finding difficulty in accessing services. We therefore agreed to extend the scope of the review to include adult speech and language therapy services. And we expect our main recommendations on these – access to services; involvement of adults with learning disabilities and their families in planning, delivery and evaluation of services – to be taken forward through the Partnership in Practice agreements being developed between local authorities and NHSScotland.

Overall, the report sets out 28 recommendations. Clear, specific actions will be required to ensure these are addressed, within the context set out in this foreword. To ensure publication of the report within a reasonable timescale, a selection of views were sought reflecting the diversity of these services in Scotland. But there is a need to be properly inclusive so that all interests are fully represented. So, in publishing this report, we welcome comments from recipients by **Friday, 31 October 2003**. Thereafter, we will publish a full response to the report.

MALCOLM CHISHOLM, MSP
Minister for Health and Community Care

PETER J PEACOCK, MSP
Minister for Education and Young People

August 2003

The contact for recipients of this Review who wish to comment is

Miss Ella Macneil
Scottish Executive Health Department
GE.19
St Andrew's House
Regent Road
Edinburgh EH1 3DG

Email ella.macneil@scotland.gsi.gov.uk

Tel: 0131-244-2854.

part I

Executive Summary

Introduction

1. This report outlines the work of the Review of Speech and Language Therapy, Occupational Therapy and Physiotherapy for children and Speech and Language Therapy for adults with learning disabilities in Scotland, commissioned by the Scottish Executive in 2002.

2. The review was carried out by researchers from Queen Margaret University College, guided by a steering group made up of representatives from the Scottish Executive Education Department and the Scottish Executive Health Department as well as advisors from a number of stakeholder groups.

3. The terms of reference of the review were:

- An examination of the **supply** of Speech and Language Therapists, Physiotherapists and Occupational Therapists to meet the needs of children requiring these therapies
- An examination of the **management and organisation** of Speech and Language Therapists, Physiotherapists and Occupational Therapists for children with special educational needs
- An examination of how the **current funding mechanisms** for Speech and Language Therapy services for children operate and how these might be improved
- Consideration of whether the funding mechanisms for Speech and Language Therapy, Physiotherapy and Occupational Therapy services for children should be **aligned**
- An examination of the supply, management and organisation of Speech and Language Therapy services for **adults with learning disabilities**.

4. The supply, management and organisation of Speech and Language Therapy services for adults with autistic spectrum disorder who do not have a learning disability was also included in the remit.

5. This report does **not** cover analysis of the roles of therapists of the same profession working in different organisations or those between different professions.

Background to the report

6. The report provides a background to recent initiatives which led to the Scottish Executive commissioning this report. These include research on children's needs by the Joseph Rowntree Foundation and recommendations from the Riddell Advisory Committee on Severe Low Incidence Disability and from the White Paper on learning disability *The same as you?*. It outlines ways in which children requiring therapy, or related interventions, and adults with learning disability and/or autistic spectrum disorder (ASD) are defined. It then summarises the legislative framework within which the therapy needs of children and adults with learning disabilities and/or ASD are identified and met. The development and impact of the current funding mechanisms for Speech and Language Therapy for children who have Records of Needs is then discussed.

part I

7. Theoretical policy and practice frameworks which are of relevance to the review are explored. Attention is drawn to the philosophical concept of inclusive education for children with disabilities and the way this is being put into practice through legislation and policy guidelines. The theme of inclusion is continued in addressing the implementation of *The same as you?* agenda for people with learning disabilities. Finally the current status of joint funding initiatives designed to facilitate seamless provision of services by local authorities, the NHS, the voluntary sector and other interested bodies is considered.

Methodology

8. The investigation was undertaken as two separate, but inter-linked studies, which were carried out in parallel. One study examined Speech and Language Therapy (SLT), Occupational Therapy (OT), and Physiotherapy (PT) input to services for children and the second study examined Speech and Language Therapy input to services for adults with learning disabilities and/or ASD.

9. In each study, information was gathered in two phases. For children's services, phase one involved a series of questionnaires for managers of NHS and Local Authority services as well as voluntary organisations. Questionnaires were also sent to Scottish universities providing pre-registration training for Occupational Therapists, Physiotherapists and Speech and Language Therapists. The review received almost 100% return rate from NHS services. A return rate of 72%, representing less than 50% of the population) was received from Local Authorities. Two NHS Board areas were involved in phase two. Here, group interviews were held with purchasers of Speech and Language Therapy from Local Authority education departments and individual interviews were carried out with managers of selected children's services in which Speech and Language Therapy, Occupational Therapy and Physiotherapy are available.

10. For adults' services, in phase one a questionnaire was sent to NHS managers of Speech and Language Therapy for people with learning disabilities. Information was gathered by telephone from voluntary organisations. Data relating to adults with ASD were also collected through learning disability services. Questionnaires were returned by services from 13 of the 15 NHS Board areas (87%). In phase two, interviews were conducted with a manager of a Speech and Language Therapy service in each of the two NHS Board areas noted above.

11. Data analysis involved quantitative measures for numerical data and a qualitative framework approach to analyse data from interviews and focus groups. Data relating specifically to supply, demand, funding, management and organisational issues were identified.

SERVICES FOR CHILDREN

Supply

12. The data collected through the surveys confirm the Riddell Committee's concern that there are shortages of NHS therapists working with children and unacceptable waiting times for some children.

13. There were varied interpretations of terms such as 'caseload' and different approaches to managing referrals, making it difficult to quantify supply and demand reliably. However, it is clear that there are too few experienced therapists, recruitment difficulties in rural areas and growing numbers of referrals.

14. There are a number of key factors influencing the supply of NHS therapists. First, although actual numbers of vacant posts are low, there are high percentage vacancy rates for therapists in children's services and many of these persist for three months or more. This is particularly an issue in remote and rural areas. Secondly, there is currently too small a pool of therapists to draw upon to fill posts which require some experience and expertise. In addition, there are too few opportunities for therapists to develop paediatric experience. Thirdly, there is evidence that skill mix is being affected by the pressure on services to meet demand. Fourthly, there appears to be inadequate IT infrastructures and administrative support for therapists.

15. The majority of therapists working in specialist paediatric services are female and under 40. Temporary absences in particular for maternity leave are not well covered at the present time. Managers would like to have contingency funds to cover maternity and sick leave, supernumerary staff to cover fluctuations in staffing, and automatic or emergency approval of funding to cover maternity leave. The introduction of family friendly policies is having a positive influence on recruitment and retention. However, this creates new challenges such as maintaining continuity within the service and good communication when so many employees work part time.

Demand

16. Most children are offered an initial assessment appointment within six to eight weeks, however, some children are waiting for 32 weeks or longer to receive an initial appointment from an NHS therapist. Children in rural areas can experience long delays for all disciplines and children who speak minority languages appear to be waiting longer than other children to receive SLT. There are inequities of NHS therapies both within and between NHS Board areas. In addition, some children are waiting for long periods to see an OT working in a Local Authority social work service, particularly in rural areas.

Workforce

17. Within the NHS long waiting lists and increased demand from children with ASD and children with complex health needs, as identified in this review, would indicate that children's services require an increase in numbers of therapists – or alternative methods of practice. Just as the factors affecting supply and demand are multiple, so the strategies needed to tackle the problems will be multiple. Increasing posts alone will not necessarily ease pressure. A long-term strategy for workforce planning based on a comprehensive analysis of multiple factors is needed.

18. The key workforce issue which must be addressed is the need to maintain and increase the pool of therapists who are suitably trained and experienced to meet the needs of children in an inclusive setting.

Funding

19. Most NHS therapy posts are funded from the mainstream health budget. The exception is SLT which receives a significant amount of funding from Education departments. NHS therapists from each of the three professions expressed concerns about the ability of services to meet increasing demand without additional resources, regardless of the source of this funding.

20. The additional funding received by SLT through Education departments was welcomed by managers. The main benefits of the funding identified by SLT managers have been increased staffing and a greater dialogue between NHS therapists and Education services. However, the review has identified a number of difficulties relating to the funding mechanism, including the unhypothecated nature of the funding, the protracted amount of time and energy that is spent on negotiating contracts, erosion of SLT provision and a problematic link between the funding and the Record of Needs system. It is clear that the current mechanism of funding SLT through education contracts is problematic and that the mechanism should not be replicated for OT and PT in its current form.

Management and organisation

21. Close co-operation and good communication between the work of Education, Social Work and Health at all levels is essential if holistic services are to become a reality. While there was no consensus on the best way to achieve a joined-up working approach, however, there was agreement that clear lines of accountability are crucial.

22. Equipment and adaptation services, in which therapists play key roles, are particularly fragmented with each agency having different responsibilities and different areas of expertise. There appears to be a number of specific gaps that need to be investigated further and addressed. The current division of responsibility for the purchasing, assessment and maintenance of equipment used by children in schools is unsatisfactory although it is clear that agencies welcome joint initiatives to improve this situation.

23. The report of the Strategy Forum: Equipment and Adaptations explores these issues in more detail. It recommends that partners across all sectors, involved in implementing the agenda for integrated and accessible children's services, should work together with a proposed Implementation Steering Group to establish a lifelong approach to the implementation and development of their strategy.

Recommendations

24. The report makes 21 recommendations on therapy for children. In particular, it is recommended that:

- Local Authorities and NHS Scotland should develop integrated approaches to the provision of therapy and other related interventions for children
- a systematic approach to workforce analysis and development is adopted for paediatric therapists and other therapists working with children
- steps be taken to expand the pool of suitably experienced and skilled therapists and clinical support workers
- the structure and skill mix within individual therapy professions should be reviewed to ensure effective and efficient use of resources and ability to meet demand. AHP leaders[i] professional bodies, NHS Boards and Local Authorities, where appropriate, should work in partnership in taking this forward
- initiatives should be progressed to tackle recruitment, retention, training, supervision and, in particular, support issues in remote and rural areas
- NHS Boards should take steps to minimise the length of time that children have to wait for therapy
- funding for Speech and Language Therapy to education authorities for provision to pupils with Records of Needs should be integrated with funding for SLT to other children
- strategic planning arrangements are established to ensure the involvement of key stakeholders and effective and efficient delivery of services by therapists.

[i] The term AHP leaders refers to managers from each of the professions who provide professional leadership.

part I

SPEECH AND LANGUAGE THERAPY FOR ADULTS WITH LEARNING DISABILITIES AND/OR AUTISTIC SPECTRUM DISORDER

Supply and demand

25. The majority of services for adults with learning disabilities and/or autistic spectrum disorder are provided by SLTs employed by the NHS, while a small number of SLTs are employed in the voluntary sector. Learning disability has traditionally been seen as one of the 'Cinderella services'. There are few opportunities for new graduates to gain experience of working with people with learning disabilities early in their career and it has been difficult to recruit to this field, although there are likely to be some interesting developments in services as a result of the implementation of *The same as you?*

26. There was some variation in the number of state registered Speech and Language Therapists per 100,000 population in the 12 areas for which there is complete data, suggesting some inequities in the level of service available. Vacancy rates overall are low although there are high vacancy percentage rates in a small number of areas. Rates of maternity and sick leave are also low.

27. There does not currently appear to be excessive demands being placed on SLT adult learning disability services as a whole. These findings contradict the findings of the report *The same as you?* which suggested that adults with learning disabilities found it difficult to access Speech and Language Therapy.

Organisation and management

28. The service for adults with learning disabilities is relatively well defined, but that for adults with ASD but no learning disability, is neither well defined nor identifiable. This may be one reason why so few of this client group are referred to SLT. It may also be the case that adults with ASD but no learning disability do not view themselves as having a 'need' or as having a need that requires health input from the learning disability service. If this client group does have a need that can be met by SLT then the challenge for these services is to be more creative in finding ways to make themselves visible, accessible and acceptable.

Recommendations

29. The report makes seven recommendations for speech and language therapy for adults with learning disability and/or ASD. In particular, it is recommended that:

- NHS Boards should explore why people with learning disabilities and/or ASD experience difficulty in getting a service, when the level of demand on services does not appear to correspond to anticipated levels of need
- NHS Boards should ensure that services in which speech and language therapy is provided encourage and accept appropriate referrals from adults with ASD but without a learning disability
- Opportunities should be created for students and new graduates to experience work in this field
- People with learning disabilities and/or ASD as well as their families are involved in the planning, delivery and evaluation of services.

Conclusion

30. The consultants are grateful to the many respondents to the surveys for giving up their time to contribute to this review and to the steering group for its expertise and advice.

part 2

Introduction

BACKGROUND TO THE REVIEW

1. In early 2002, the Scottish Executive embarked on a national review of Speech and Language Therapy, Physiotherapy and Occupational Therapy for children and Speech and Language Therapy for adults with learning disabilities.

2. The review was called in response to a number of concerns:

- There has been a significant increase in funding for Speech and Language Therapy for children with records of needs in recent years yet children still find it difficult to access services.
- The Riddell Advisory Committee Report' into the Education of Children with Severe and Low Incidence Disabilities (SLID) highlighted the problem of shortages of therapists leading to unacceptable waiting times for children with SLID. It raised questions about the current management and organisation of therapists and reported some dissatisfaction with funding mechanisms.
- The report of the Learning Disabilities Review, *The same as you?*[2] stated that adults with learning disabilities found it difficult to access Speech and Language Therapy. It recommended that the review of children's therapy recommended by the Riddell Committee' should be extended to cover Speech and Language Therapy for adults with learning difficulties.

3. The review, therefore, intended to address issues such as continued shortages of therapists, the management of therapy provision and current funding mechanisms particularly for children's therapy.

4. The review was guided by a steering group made up of representatives from the Scottish Executive Education Department and the Scottish Executive Health Department as well as advisors from a number of stakeholder groups (see Appendix A for membership).

5. Queen Margaret University College provided consultancy to the review team. The University College undertook an investigation of Speech and Language Therapy, Physiotherapy and Occupational Therapy for children and Speech and Language Therapy for adults with learning disabilities as part of the review. The investigation is described in Chapter 4. In addition, a focus group was organised by the Scottish Consortium of Learning Disability to seek the views of adults with learning disabilities who use Speech and Language Therapy. The views of parents were fed into the review by the parent representative on the steering group.

part 2

TERMS OF REFERENCE

6. The terms of reference of the review were:

- An examination of the **supply** of Speech and Language Therapists, Physiotherapists and Occupational Therapists to meet the needs of children requiring these therapies
- An examination of the **management and organisation** of Speech and Language Therapists, Physiotherapists and Occupational Therapists for children with special educational needs
- An examination of how the **current funding mechanisms** for Speech and Language Therapy for children operate and how these might be improved
- Consideration of whether the funding mechanisms for Speech and Language Therapy, Physiotherapy and Occupational Therapy for children should be **aligned**
- An examination of the supply, management and organisation of Speech and Language Therapy for **adults with learning disabilities**.

7. The Group interpreted the terms of the review to include the supply, management and organisation of Speech and Language Therapy for adults with autistic spectrum disorder (ASD) as this group of service users fall within the scope of the *The same as you?*[2]

The review did not aim to evaluate current models of service provision or define 'effective practice'. It also did not seek to ascertain the therapy needs of the children and adults with learning disabilities and/or ASD. While these are important aspects of service delivery, they fell outside the remit of this review. Instead the focus was on organisational and management issues and possible improvements in these within existing service models.

8. In the report we use the terms Occupational Therapist, Physiotherapist and Speech and Language Therapist (OT, PT and SLT) to refer to therapists from these professions who have undertaken a programme of study leading to state registration. We use the term clinical support worker to refer to NHS employees who work under the supervision of state registered therapists including therapy assistants and technical instructors. We use the term OT assistant when referring to Local Authority support staff. The role of each profession when working with children and adults with learning disabilities is described in Appendix B. An examination of the role of therapists was also outside the remit of this review.

DEFINING THE POPULATION IN NEED

Children requiring therapy

9. It has been estimated that there are just under one million children (972,000) under the age of 16 living in Scotland and a further 389,000 16 to 21 year olds.[3] For the purposes of the review the term children includes any person aged 18 or under.

10. A number of Scotland's children will be given a diagnosis, label or administrative category which gives some indication of their need for specialist health, education and/or social work services. These categories include 'disabled children', 'children in need' and 'children with special educational needs'. The review recognises the importance of avoiding unnecessary stigmatisation of children through labelling. However, these categories can provide important information to assist in the appropriate targeting of resources when applied consistently.

11. Children experiencing difficulty accessing the school curriculum are identified as having Special Educational Needs. Many of these pupils are assessed by Educational Psychologists and where appropriate other professionals. Local Authorities are obliged to open a 'Record of Needs' where children have pronounced specific or complex special educational needs requiring ongoing review. The Scottish Executive's education statistics reported that there were a total of 45,701 pupils with Special Educational Needs in Scotland in 2001 and 16,137 pupils with a Record of Needs.[4]

12. A report for Joseph Rowntree Foundation[5] indicated that there were approximately 33,000 disabled children in Scotland. Earlier research by Joseph Rowntree Foundation[6] reported that numbers of children with high levels of support needs, including those with nursing care needs, are increasing. The Riddell Committee estimated that 1.1% of the school population or 8,745 children in Scotland have Severe Low Incidence Disability.[1]

13. It is difficult to predict or estimate how many of the children within each category described above are likely to need therapy. There is evidence that these categories are applied inconsistently.[1,7] Also the nature and extent of therapy needed is difficult to predict from such categorisations. However, it is likely that children with more severe impairments will have a greater need for input from a therapist.

part 2

Adults with learning disabilities

14. The review adopted the definition of a learning disability used in the report of the review of services for people with learning disabilities *The same as you?*.[2] It stated:

15. "People with learning disabilities have a significant, lifelong condition that started before adulthood, that affected their development and which means they need help to:

- Understand information
- Learn skills; and
- Cope independently."

16. The review also stated that people with learning disabilities should have a range of support and services to meet their needs, which may include complexities arising from both learning disability and from other difficulties such as physical and sensory impairment.

17. The report went on to estimate that there were around 100,000 people with mild or moderate learning disabilities and 20,000 people with profound learning disabilities or multiple disabilities in Scotland. Research has indicated that numbers will increase by 1% per year over the next 10 years.[8]

18. Assuming that the same prevalence rates apply to the child population as the adult population, there were approximately 24,000 children and approximately 96,000 adults with learning disabilities in Scotland in 2000.

19. It has been estimated that at least 50% of people with learning disabilities have communication difficulties.[9,10] This suggests that approximately 48,000 adults with learning disabilities experience communication difficulties. It does not indicate how many of these adults require input from a Speech and Language Therapist or the level of input required. However, the Public Health Institute of Scotland is undertaking a health needs assessment for people with learning difficulties which is likely to report in June 2003.

Adults with autistic spectrum disorder

20. A recent publication by the Public Health Institute of Scotland[11] reported that there has been no formal work to identify the prevalence of autistic spectrum disorder amongst adults. However, the report estimates the prevalence rate among children to be 60 per 10,000. It also highlights the trend towards increasing numbers of children and adults being identified as having disorders on the autistic spectrum than in the past.

LEGAL DUTIES OF AUTHORITIES TOWARDS DISABLED ADULTS AND CHILDREN

21. Disabled adults and children requiring therapy are often reliant on a number of agencies and services. Each has different areas of statutory responsibility.

Legislation impacting on community care services

22. Disabled adults are entitled to a community care assessment under the NHS and Community Care Act (1990). Children under 16 do not have the same entitlement. However, if the child is 'chronically sick or disabled' under the Chronically Sick and Disabled Person's Act 1970 and the Disabled Persons (Services, Consultation and Representation) Act 1986, they have the same entitlement as adults to a disabled person's assessment from the Local Authority. The term 'chronically sick or disabled' includes people with mental health problems or learning disabilities. Local Authorities also have a statutory duty to ensure that disabled people receive any necessary household equipment and adaptations to their home. If a child has Record of Needs they are entitled to a Future Needs Assessment before they reach 16 to consider what provision they will require post 16.

Legislation impacting on children's services

23. Local Authorities have a statutory responsibility in relation to 'Children in Need'. They must assess the needs of disabled children and provide day care, after-school care and holiday care if needed. Under Section 19 of the Children (Scotland) Act 1995 they are required to prepare and publish plans for children's services.

Legislation impacting on education services

24. Under the Education (Scotland) Act 1980, Local Authorities have a duty to secure adequate and efficient provision of school education for their area including special education. They must establish which children in their area, who are aged 2 or over but under school leaving age (16) have pronounced, specific or complex education needs which require ongoing review. They must assess the needs of these children and open a Record of Needs. Education authorities are also able, but not obliged, to open records for children under 2. Parents have the right to make representations and submit evidence during the assessment and recording process and can appeal against a decision not to record. They also have the right to request a certain placement. Under Section 2 of the more updated Act,[12] legislation requires that education authorities ensure that education is directed to the development of the personality, talents and mental and physical abilities of the child or young person to their fullest potential. (See also Section 3.2 for description of the DDA (1995) and Education (Disabilities, Strategies and Pupils' Educational Records (Scotland) Act 2002).)

part 2

FUNDING OF SPEECH AND LANGUAGE THERAPY PROVISION IN SCOTLAND FOR CHILDREN WITH RECORDS OF NEEDS

25. Significant changes to the funding of Speech and Language Therapy for children were made in the 1990s. These are described below.

26. In mid 1991, it was identified that the demand for Speech and Language Therapy provision for children with a Record of Needs was rapidly outstripping supply. Many children were not receiving the Speech and Language Therapy specified in their Record. In 1992, following a well-publicised campaign by parents, Ministers announced an additional £2 million per year for speech therapy for recorded pupils. This was additional funding, not a transfer from the health programme, and was included in the local government finance settlement for 1992-93 to allow Local Authorities to contract with Health Boards for the provision of speech and language therapy for recorded pupils.

27. It was further agreed that Local Authorities, jointly with Health Boards and in consultation with The Scottish Office, would carry out an assessment of the needs for Speech and Language Therapy provision in Scotland for both recorded and non-recorded pupils. After research it was estimated by the working group set up to undertake this assessment that there were 5,642 recorded children in Scotland in 1993 requiring Speech and Language Therapy. Taking account of the needs of children for initial assessment, follow-up action and in some cases extended therapy, the group estimated that this would require an establishment of 126 therapists. On the basis of that assessment it was calculated that to provide fully for the Speech and Language Therapy needs of all recorded children in Scotland, including salaries, travel and other costs, would cost £3m in 1993-94.

28. As regards non-recorded children, the group estimated that around 8% of children in Scottish schools would, at one time or another, require some Speech and Language Therapy provision. They estimated the needs of children without records could be adequately provided for through the employment of 304 speech therapists at a cost of £7.5m.

29. In the light of the working group's findings on recorded pupils, Ministers agreed that a further £1m be included within the local government finance settlement to support contracts made between education authorities and Health Boards for children with a Record of Needs. Unlike the original announcement, this additional £1m was funded by a transfer from the health programme. Responsibility for funding provision of Speech and Language Therapy for non-recorded pupils remained with Health Boards.

30. There has been no systematic attempt to assess the precise impact that these new funding arrangements have had. There was a steady rise in the numbers of Speech and Language Therapists in the NHS in Scotland from 1994 to 1997, equivalent to 118.5 whole-time equivalents or 22%. It had been hoped that supply and demand would be broadly in balance by 1998. However, the Department received representations, following its discussion paper on special educational needs in 1998, that there remained localised shortages for specialist skills and in certain geographical areas. In view of this, funding for speech and language therapy provision for recorded pupils was increased from April 1999 to £6.5m per year. This funding is included as part of the Local Authorities grant-aided expenditure settlement from the Scottish Executive.

part 3

Theory, Policy and Practice

Developments

1. The following chapter briefly outlines some key theory, policy and practice developments that are of relevance to the review.

DISABILITY THEORY

2. There have been two key developments in disability theory which have had a significant influence on health and social care practice.[13] The first, the Social Model of Disability, was developed by disabled people and has had the greatest impact on the way services for people with physical and sensory impairment are organised and delivered. The second, normalisation theory has had the greatest impact on services for people with learning disabilities.

3. The Social Model of Disability was developed by disabled people. It challenges the Medical Model of Disability's emphasis on 'fixing' or 'curing' the person and instead directs its efforts towards the identification and removal of social and economic barriers faced by disabled people. The adoption of the Social Model of Disability has gained pace in recent years and has led to a number of practice developments including disability-led services and the purchasing of care services by individual disabled people through Direct Payments.

4. Normalisation[14] is synonymous with the term 'ordinary living' and has been a catalyst for the development of community-based services and the inclusion of people with learning disabilities in mainstream settings. The emphasis has moved from treatment and training to quality of life. Many services now sign up to the framework for achieving quality in services developed by John O'Brien, the 'five service accomplishments'.[15]

5. Both the Social Model of Disability and Normalisation are having an impact on the way disability is defined by therapists, that is, whether the 'problem' is located with the individual or located within society. This, in turn, has an impact on the goals or desired outcomes of interventions. In addition these theories have influenced the settings in which services are delivered.

INCLUSIVE EDUCATION POLICY AND PRACTICE

6. The Scottish Executive is leading the way with a number of initiatives supporting the advancement of inclusive education. Recent legislation has placed new duties on Local Authorities in this respect. Section 15 of the Standards in Scotland's Schools etc. Act 2000[12] requires that the education of all children should be provided in mainstream schools, unless certain specified exceptions apply.

7. Guidance to Local Authorities[16] states that the legislation 'is based on the premise that there is benefit to all children when the inclusion of pupils with special educational needs with their peers is properly prepared, well-supported and takes place in mainstream schools within a positive ethos. Such inclusion helps schools to develop an ethos to the benefit of all children, and of society generally'.

part 3

8. The Scottish Executive has also brought forward new legislation through the Education (Disability Strategies and Pupils' Educational Records)(Scotland) Act,[17] which was passed by the Scottish Parliament in March 2002. This legislation will require Local Authorities and independent, grant-aided and self-governing schools to prepare and implement accessibility strategies to improve over time access to education for pupils with disabilities. In addition, from 1 September 2002 the provisions of the Disability Discrimination Act have been extended making it unlawful for education and training providers and other related services to discriminate against disabled people.[18]

9. A review of the assessment and recording arrangements (the Record of Needs system) for children with special educational needs is also well underway.[19,20] Developments in inclusion have been supported through the Excellence Fund and the SEN Innovations Grants Programme and there have been a number of initiatives funded which aim to improve the transition of young people from school to post school education and training or employment following the recommendations made in the Beattie Committee Report.[21]

10. The increasing emphasis on mainstream education for disabled children has obvious implications for the planning and delivery of therapy. These changes will be challenging for therapists, service planners and managers as well as other key stakeholders such as families and education colleagues. However, they also offer exciting opportunities to develop new models and approaches to support children to be included in schools and in society more generally.

IMPLEMENTATION OF '*THE SAME AS YOU?*'

11. The Scottish Executive published *The same as you?*,[2] the Learning Disability Strategy for Scotland, in 2000, and the following year Valuing People[22] was published in England. The number of people living in long-stay hospitals for people with learning disabilities in Scotland has fallen from 7,000 in 1965[23] to 1,221 in 2002.[24] *The same as you?*[2] states that long-stay hospitals should close by 2005. It also recommends the role of day centres should change, operating increasingly as resource centres offering some in-house activities and support. They should also use community facilities more and support people into education, jobs and sports and leisure activities. This has obvious implications for the delivery of Speech and Language Therapy which is also increasingly likely to be delivered in community settings.

12. *The same as you?*[2] makes a number of additional recommendations. These include:

- The development of 'Partnership in Practice' agreements between Local Authorities and Health Boards
- The establishment of Local Area Co-ordinators
- The widespread availability of Personal Life Plans.

13. These have the potential to provide mechanisms to ensure that the needs of people with learning disabilities, including their communication needs, are more effectively identified and met. In addition, Speech and Language Therapists have a key role to play in ensuring that the commitment made in *The same as you?*[2] to fully involve people with learning disabilities in decisions about their lives is achieved.

JOINT MANAGEMENT AND RESOURCING OF SERVICES

14. A recurring theme in recent policy documents is the Joint Future agenda, the key parts of which are joint resourcing and joint management of services and single shared assessment. *Our National Health* made a commitment to introduce both. Joint resourcing and joint management of community care services starts with older people's services from April 2003. The Joint Future agenda has been strengthened by the provisions in the Community Care and Health (Scotland) Act on delegating functions and pooling budgets. Single Shared Assessment for all community care groups is planned to start in April 2003. Within primary care, joint management and joint working issues are found in the March 2002 report of the Primary Care Modernisation Group 'Making the Connections'.

15. Similar advances are being made on children's services. The Scottish Executive report *For Scotland's Children*[7] highlighted the importance of an integrated approach to service delivery. A Cabinet Sub-Committee on Children's Services, chaired by the First Minister, is driving forward this agenda. The Changing Children's Services Fund has provided Local Authorities, the NHS, the voluntary sector and other interested parties with resources to re-orient their services in a more integrated way and guidance on more integrated planning for children's services has been issued. Other developments include work to try to build up more integrated approaches to assessment, enabling those from different professions to share information and jointly decide upon action, and studies of workforce issues.

part 4

Investigating the Current Picture

1. In order to assist the review, Queen Margaret University College was asked to collect information about the current supply, management, organisation and funding of Speech and Language Therapy, Occupational Therapy and Physiotherapy for children and Speech and Language Therapy for adults with learning disabilities and/or ASD.

METHODOLOGY FOR THE INVESTIGATION

2. The investigation was undertaken as two separate, but inter-linked, studies which were carried out in parallel. One study examined Speech and Language Therapy, Occupational Therapy, and Physiotherapy for children and the second study examined Speech and Language Therapy for adults with learning disabilities and/or ASD. In each study, information was gathered in two phases.[ii]

Investigation of children's therapy

3. In phase one, between April and July 2002, a series of surveys were sent to managers of NHS and Local Authority therapy as well as voluntary organisations. The database of NHS managers was compiled in consultation with professional advisors and networks such as the Therapy Managers Network. Local Authority questionnaires were sent to Local Authority Chief Executives and to members of the Association of Directors of Social Work illness, disability and sensory impairment sub-group. Voluntary sector providers were identified by advertising in professional journals and through professional contacts. Some information was gathered by telephone from voluntary organisations. Questionnaires were also sent to Scottish universities providing pre-registration training for Occupational Therapists, Physiotherapists and Speech and Language Therapists.

4. In phase two, between August and September 2002, the following procedures were carried out in two NHS Board areas:

- group interviews were held with purchasers of Speech and Language Therapy from Local Authority education departments
- individual interviews were held with four managers of Speech and Language Therapy
- two Occupational Therapy managers and two Physiotherapy managers were interviewed.

Investigation of therapy for adults with learning disabilities and/or ASD

5. In phase one, between April and July 2002, a survey was sent to NHS managers of Speech and Language Therapy for people with learning disabilities. QMUC were advised that there are few specialist Speech and Language Therapists for adults with ASD and that these services are typically provided by therapists working with adults with learning disabilities. Data relating to this client group were, therefore, collected through learning disability services. The database of NHS managers was compiled in consultation with professional advisors and a therapy managers' network.

[ii] The research tools are available from Fiona O'May at QMUC at fomay@qmuc,ac,uk.

part 4

6. QMUC identified voluntary sector providers through professional contacts and by advertising the review in professional journals. Information was gathered by telephone from voluntary organisations.

7. In phase two, between August and September 2002, interviews were conducted with a manager of a Speech and Language Therapy service for people with learning disabilities in each of the two NHS Board areas.

DATA ANALYSIS

8. The survey data were analysed using Excel and SPSS software. Interviews and focus groups were recorded by a scribe and an audio-recording was made as a back up resource. A framework approach was used to analyse data from interviews and focus groups.[25] This approach is particularly relevant to policy and practice-orientated investigations. The framework was developed from the objectives of the review. Data relating specifically to supply, demand, funding, management and organisational issues were identified. Further thematic analysis identified additional categories to be included in the framework.

LIMITATIONS OF THE INVESTIGATION

9. One of the strengths of the investigation was that it was undertaken within a short timeframe ensuring its relevance to current policy and practice. However, there were some limitations within the investigation. Resources only allowed a small number of services and Local Authorities to be interviewed in phase two and consultation with people with learning disabilities and disabled children and their parents was limited at this stage.

part 5

Speech and Language Therapy, Physiotherapy and Occupational Therapy for Children

1. In this section of the report, we summarise the information gathered relating to the supply, demand, funding, organisation and management of Speech and Language Therapy, Physiotherapy and Occupational Therapy for children. The data are reported more fully in the appendices.

2. The statistical information reported here was gathered through surveys of NHS and Local Authority services in which therapists work. The review received almost 100% return rate from the NHS. A lower return rate of 72% was received from Local Authorities. As this information is partial it should be treated with some caution.

CURRENT PATTERN OF THERAPY FOR CHILDREN

3. Therapies for children are either delivered by therapists who work solely with children or therapists who work with both children and adults. In the report we refer to these as 'paediatric' and 'generic therapists'[iii] respectively. These therapists are either employed by NHS Boards, Local Authorities, voluntary organisations or grant-aided schools.

4. The majority of Speech and Language Therapists, Physiotherapists and Occupational Therapists working with children are employed by NHS Boards. A diversity of management arrangements are in place within the Trusts. The proportion of services for children provided by paediatric therapists as opposed to generic therapists in the NHS varies from profession to profession and from area to area.

5. There are a significant number of Occupational Therapists employed in Scotland's 32 Local Authorities. However, the majority of assessments and service provision undertaken by Occupational Therapists are provided for adults rather than children. There are only a small number of paediatric specialist posts in Local Authorities in Scotland and services for children are frequently provided by generic therapists. A recent report stated that the main role undertaken by generic Local Authority Occupational Therapists continues to be the assessment and provision of equipment and adaptations for disabled people. This is despite the fact that Occupational Therapists have a wider set of skills in rehabilitation.[26]

6. A small number of paediatric therapists are employed by voluntary organisations or grant-aided schools.

7. As the majority of Speech and Language Therapy, Physiotherapy and Occupational Therapy for children is provided by NHS therapists, more detailed data relating to the supply of and demand for these therapies are reported below than is the case for Local Authorities and voluntary organisations.

[iii] The term 'generic' therapist is often used by practitioners to mean a therapist with an adult only caseload where the caseload contains people with a mix of diagnoses or needs. For the purposes of this review, however, the term is used to describe therapists who work with both children and adults.

part 5

SUPPLY OF SPEECH AND LANGUAGE THERAPY, PHYSIOTHERAPY AND OCCUPATIONAL THERAPY FOR CHILDREN

Numbers of therapy posts established to provide services to children

NHS Therapy Posts

8. The table below shows the number of NHS Speech and Language Therapy, Physiotherapy, Occupational Therapy and clinical support worker posts established to work with children in Scotland. More detailed information about posts can be found in Appendix C. Paediatrics is a relatively small specialist area in Occupational Therapy and Physiotherapy but is the main area of work for Speech and Language Therapists.

9. There are approximately 137 posts established for state registered Occupational Therapists, 165 posts for state registered Physiotherapists and 520 posts for state registered Speech and Language Therapists in NHS Scotland to provide a service to children.

10. We estimate that salary costs for NHS OTs are just under £3.4m, for NHS PTs are just over £4.2m and for NHS SLTs are just under £13.7 million (see Appendix F).

Table 0:1 Numbers of NHS Speech and Language Therapists, Physiotherapists, Occupational Therapists and clinical support workers in Scotland

	Posts for state registered therapists	Posts for clinical support workers	Totals
NHS OT posts	137.22	10.98	**148.2**
NHS PT posts	165.6	20.55	**186.15**
NHS SLT posts	520.84	68.6	**589.44**
Totals	**823.66**	**100.13**	**923.79**

Notes:
All posts are recorded as whole-time equivalents(WTE).
NHS Physiotherapy
Grampian Primary Care Trust generic posts are not included, Tayside Primary Care Trust data were not supplied.
NHS Speech and Language Therapy
Tayside Primary Care Trust data were not supplied.

11. Numbers of NHS therapy posts established per 100,000 population were calculated (see Appendix D). While it would be inappropriate to make any comparison between professional groups, it is noteworthy that variations in numbers of posts per 100,000 population within each profession are substantial. For example, numbers of posts for state registered PTs range from 2.42 posts in Argyll and Clyde to 5.79 in Shetland. It is difficult to make an assessment of the appropriateness of the levels as we are unaware of any benchmarking exercise that has been undertaken in paediatric therapy. However, there is clearly some inequity between NHS Board areas if judged on population figures alone.

Local Authority posts requiring an Occupational Therapy qualification

12. A recent Scottish Executive statistical bulletin reported a total of 39 WTE posts for senior Occupational Therapists and 289 WTE posts for Occupational Therapists in the 32 Scottish Local Authorities. The majority of these will provide a generic service to both adults and children.[27] The same bulletin reported that there were 200 OT assistants in Local Authorities in Scotland.

13. There are also a number of OTs employed under different titles. For example, of 1,833 FTE in 29 local authorities, 164 were OTs, representing 9% of the figure available.[28]

14. It has proved difficult in this review to determine the number of OT posts[iv] established in Local Authorities to work with children. Of 32 questionnaires sent to Local Authority managers, 23 were returned. However, information was not provided by some of the largest Local Authorities in Scotland. The available data, therefore, relate to authorities in which less than 50% of the population of Scotland is located. Data from both rural and urban authorities were not supplied.

15. From the information supplied, it appears that the number of OT posts established in Local Authorities to work specifically with children is low. Only six of the 23 Local Authorities which responded to the survey reported having paediatric posts which require an OT qualification. There are a total of 6.6 paediatric posts in these six authorities. In addition, the survey identified 203.1 WTE posts, in 21 authorities that gave this breakdown, requiring an OT qualification and working with both children and adults. Most authorities were unable to estimate the proportion of time spent by these OTs working with children. Seven authorities made estimates of between 2.2% and 25%. This suggests that the total proportion of these 203.1 generic posts working with children in the 21 authorities could be anywhere between 4 and 51 WTE posts. In addition, a small number of authorities employ assistants who provide services to children.

iv The survey sent to Local Authorities sought information about posts which require the holder to have an OT qualification – job titles other than Occupational Therapist or Senior Occupational Therapist included Community Care Worker, Senior Practitioner, Access Officer, Assistant Manager, Team Manager and Development Manager.

part 5

Therapy posts in the voluntary sector or grant-aided schools

16. There are a small number of therapy posts funded or part-funded by voluntary organisations or grant-aided schools. Some of the therapists occupying these posts are employed directly by the voluntary organisation or school. Others are employed by an NHS Trust and are contracted to provide services to users of the voluntary organisation or pupils at the school.

17. Four of the seven grant-aided schools in Scotland directly employ therapists. Data were available on three of these four schools and they employ a total of 4.8 OTs, 7.9 PTs and 4 SLTs.

18. Two of the schools which directly employ therapists are managed by Capability Scotland. We are aware that Capability Scotland also provides therapy to children in community settings. We were unable to establish the numbers of community therapy posts but believe they are small.

19. There are a number of specialist services in Scotland providing assessment and advice in relation to Alternative and Augmentative Communication aids. These include Scottish Centre of Technology for the Communication Impaired (SCTCI) in the West of Scotland, KeyComm in Lothian, Technological Assessment and Support for Special Children and the Curriculum (TASSCC) in Aberdeen and Fife Assessment Centre for Communication through Technology (FACCT) in Fife. These services all employ a small number of SLTs and we aware of one service that employs a part-time OT. The services are funded either by Local Authorities, Health Boards or they are joint funded.

20. There are a small number of therapists employed by the National Autistic Society in Scotland and The Scottish Society for Autism. There are also individual therapists employed by UK charities to provide a 'regional' service throughout Scotland. The charities include Whiz Kids, a charity providing mobility equipment to disabled children.

21. It proved difficult to find out about therapists working in the voluntary sector. This may be because they are not as closely linked into formal networks as those working in the statutory sector.

Skill Mix in NHS Services for Children

Career structure for NHS therapists working with children

22. Most of the NHS Occupational Therapy and Physiotherapy posts providing a service to children (83%) are graded either at senior I or senior II level. Most NHS Speech and Language Therapy posts are graded at band 2 (75%). These are grades at which therapists would be expected to work independently in a range of community settings. There are few posts established for new graduates, particularly in Physiotherapy (see Appendix E). This appears to be because new graduates usually work under the close supervision of an experienced therapist, for example, on a hospital ward or in a special school that has a high level of therapy input. This on-site supervision is not easily available within community paediatric services because of staffing levels.

Clinical support workers in NHS services for children

23. All three NHS professional groups reported the important role that clinical support workers play in delivering an effective and efficient service. Occupational Therapy traditionally has the highest ratio of clinical support worker posts to state registered therapist posts when compared to other Allied Health Professions (AHPs). The ratio across all clinical areas is 1 clinical support worker for every 4 state registered therapists. The picture in paediatric services is significantly different with a ratio of 1 clinical support worker for every 13 state registered therapists.[29] Physiotherapy also has a slightly lower ratio of clinical support workers to state registered therapists in this speciality. Speech and Language Therapy on the other hand has higher numbers of clinical support workers working with children than in other specialist areas.

24. There is evidence that pressure of work affects skill mix. For example NHS Physiotherapists and Occupational Therapists said that staff shortages make it difficult to supervise and support clinical support workers.

Administrative support to NHS therapists working with children

25. It appears that the level of administrative support for NHS therapists varies from area to area but is often inadequate. Managers were concerned that therapists are tied up with administrative tasks. Many therapists type their own reports and set up their own appointments. Professional advisors on the review steering group estimated that 30% of a therapist's time can be spent undertaking administrative tasks. Frequently, when new therapist posts are funded, no additional clerical support is made available and so administrative support is spread increasingly thinly. In addition, some services have an inadequate Information Technology infrastructure, such as word processing and e-mail facilities, in order to carry out their work efficiently.

Recruitment and Retention Issues

Vacancy rates within NHS posts

26. All three NHS professions have high vacancy rates for NHS paediatric therapists in some areas (see Appendix G). For example, OT vacancy rates were 20% or more in three areas, PT vacancy rates were above 20% in five areas and SLT vacancy rates were above 20% in two areas. These rates are likely to have a significant impact on the level of service that can be provided.

27. That said, the number of posts vacant in some cases is relatively low making the solution more straightforward. For example, the Occupational Therapy service in Borders has a 29% vacancy rate representing a significant reduction in service provision. However, the service needs to recruit only one whole-time equivalent OT to restore a full service to children in the Borders. Similarly, Shetland Physiotherapy service has a 62% vacancy rate and needs to fill 0.8 of a post.

part 5

Factors influencing NHS vacancies

28. Several managers referred to the highly specialised nature of work with children and the extra skills needed by staff when working independently in community settings. Managers from all three professional groups reported that NHS vacancies can persist as there is too small a pool of experienced therapists to draw upon to fill senior I, senior II and band 2 posts. Half of Occupational Therapy vacancies, two-thirds of Physiotherapy vacancies and more than three-quarters of Speech and Language Therapy vacancies had been unfilled for three months or more.

29. In addition, managers stated that there are too few training opportunities available to develop the pool of experienced therapists. Examples given included too few basic grade paediatric posts, a lack of rotational posts, limited numbers of senior II training posts for Physiotherapists in specialities such as paediatrics and neurology, too few paediatric fieldwork education placements for student therapists and too little continuing professional development for therapists wishing to move between specialities.

Recruitment and retention in remote and rural areas

30. Remote and rural areas were particularly affected by high vacancy rates. Rural areas and island communities stated that they tend to have an even smaller pool of therapists to draw upon and it is difficult to attract new therapists into the area. Managers reported that high unemployment rates in some of these areas make it less attractive for therapists to move there, as their partners are unlikely to be able to secure employment. Managers also stated that the cost of living on islands is higher and therapists can feel isolated and lack peer support. Rural areas that are within commuting distance from cities reported that they are able to recruit therapists who choose to live in the city and work in the country. However, high travel costs make retention of these therapists difficult.

The impact of NHS maternity and sick leave rates on supply

31. A major issue across all three professional groups is the additional pressure placed on the service due to maternity leave and sick leave. In paediatric OT, 98% of the workforce is female and more than half of the workforce is under 35. In paediatric PT the picture is similar with more than 95% of the workforce being female and approximately one-third of PTs being under 35. Similarly, in paediatric SLT 98% of employees are female and just over half are aged 40 or under.

32. One OT service with eight WTE posts reported that over the past 12 years there had not been a single year when fewer than two staff took maternity leave at some point. Managers stated that this increases pressure on staff in an already stretched service. In addition, managers stated that many therapists choose to come back to work on a part-time basis following the birth of a child. They pointed out that while the introduction of positive employment policies and practices is to be welcomed, the implications of maternity and sick leave for workforce planning need to be taken into account.

33. Approximately two-thirds of NHS Board areas had at least one instance of long-term sickness in 2001-2. Long-term sickness was defined as an absence of four weeks or more. One PT service had six instances of long-term sickness last year and one OT service had five instances of long-term sickness last year, that is at least five or six months of the year where the service level was reduced due to sickness. These were exceptional cases.

34. All three groups stated that temporary posts to cover absences are unattractive and difficult to fill. Locum posts are both an expensive option and it is often difficult to find a locum with the right level of expertise. These problems are compounded by the fact that there can be delays in releasing money to recruit to temporary posts even when the post is funded under an Education contract.

Tackling supply shortages in the NHS caused by temporary absences

35. Managers called for devolved staffing budgets, contingency funds to cover maternity and sick leave, supernumerary staff to cover fluctuations in staffing, and automatic or emergency approval of funding to cover maternity leave from day one of a maternity leave absence rather than after 18 weeks.

36. Other suggestions to deal with pressures of reduced supply in all three professional groups included allowing overtime or weekend working at enhanced rates for any staff who want additional hours, and developing a bank of therapists to draw on. It was suggested that the NHS boards could co-ordinate setting up a bank system and contact potential bank therapists through professional registers.

Tackling supply shortages in the NHS through the introduction of family friendly policies

37. Many managers reported that they had had some success in retaining existing staff through the introduction of family-friendly policies such as term-time-only contracts, flexible working hours, part-time and job-share opportunities and parental leave policies. While these were seen as positive ways of retaining employees, managers pointed out that they have financial and organisational implications for a service. Managers face the challenge of maintaining continuity within the service and good communication when so many employees work part time. They explained that restructuring the service to accommodate flexible working could result in gaps in service at certain times of the year or week. There is a danger, once several posts have been reduced to part-time hours, that a few hours will be uncovered but that these will be too small to make up an attractive part-time post. This can increase pressure on the staff team as a whole.

part 5

Tackling supply shortages in the NHS through training initiatives

38. There was agreement across the three professional groups that good training programmes, induction programmes and continuing professional development opportunities were necessary to retain staff. Good supervision and support from within the team were also seen as important. Speech and Language Therapy managers in four rural areas highlighted the importance of having good links with universities by offering student placements, teaching on courses and employing students as clinical support workers during holidays.

39. Physiotherapy managers in four areas reported that they had had some success in tackling recruitment and retention problems through the introduction of rotational posts. There are rotational posts for basic grade Physiotherapists in one area in Scotland and rotational posts for senior II Physiotherapists in eight areas in Scotland. Periods of rotation are between six and 12 months. There are far fewer rotational posts in Occupational Therapy, one area having a rotational basic grade post and two having rotational senior II posts. These posts rotate every seven to 18 months. Only one Speech and Language Therapy service reported that it 'sometimes' has rotational posts.

40. Some Speech and Language Therapists also reported that generalist posts that cover several areas such as adult services, paediatrics and learning disabilities are popular and allow therapists to developed a broad set of skills before later specialising. Approximately 13% of SLT provision for children is delivered by generic therapists in Scotland and in some areas the numbers are substantially higher. For example, in Shetland the service is entirely delivered by generic staff and in Highlands 53% of the service is delivered by generic staff. This contrasts with OT and PT which is delivered almost entirely by paediatric therapists.

Recruitment and retention issues relating to Local Authority Occupational Therapy posts

41. From the figures provided by 23 Local Authorities that replied to the survey it appeared that recruitment and retention of Local Authority OTs was less problematic than in the NHS. Only seven authorities reported vacancies in OT posts providing a service to both children and adults. These vacancies represented a 6% vacancy rate. There were no vacant paediatric posts.

42. However, only three authorities stated that they have not experienced recruitment and retention difficulties. The others stated that recruitment and retention is problematic, particularly the recruitment and retention of experienced OTs and part-time employees. Temporary posts are also difficult to fill. They suggested a number of factors contributing to these difficulties including shortages of OTs across all sectors in Scotland, high caseloads, the generic nature of caseloads in Local Authorities and a perception that Local Authority OTs carry a higher level of responsibility. Remote and rural areas stated that they face particular difficulties attracting qualified staff and providing good support and supervision to therapists.

43. The most frequently cited factor contributing to recruitment and retention difficulties was the current unfavourable pay and conditions for OTs in Local Authorities in comparison to NHS employees.

The relationship between supply of therapists and quality of service

44. Managers pointed out that an inadequate supply of therapists affects the quality as well as the quantity of service provision. For example, continuity of care can be negatively affected.

45. Conversely, SLT managers reported that increased supply has affected quality positively. For example, one service explained that increased staffing levels have led to a broader range of skills being available within the team allowing peer support and review arrangements to be implemented.

DEMAND FOR SPEECH AND LANGUAGE THERAPY, PHYSIOTHERAPY AND OCCUPATIONAL THERAPY FOR CHILDREN

46. The table below summarises the numbers of children referred to therapy in 2001-02, discharged from these services in the same year, on the caseload of therapists in Scotland in April 2002 and on a waiting list to see a therapist in April 2002 (see notes in Appendix H).

Table 0:2 Demand for NHS OT, NHS PT, NHS SLT and Local Authority OT for children in Scotland in 2001-02

	NHS OT	NHS PT	NHS SLT	Local Authority OT
Children referred to in 2001-02	4093	10078	16031	1143
Children discharged from in 2001-02	3237	6015	10912	720
Children – current cases of therapists in April 2002	6903	8794	40591	884
Children waiting to see a therapist in April 2002	1809	300	3472	116

NB: LA figures represent less than 50% of the population

part 5

Referral information

47. Rates of children referred to NHS therapists per WTE post and per 1000 population have been calculated. Data on NHS referral rates can be found in Appendix I. These rates varied considerably from area to area. For example, there were 5.5 children referred to PT per 1000 population in Borders and 0.4 children referred to PT per 1000 population in Orkney. It is unclear whether these variations result from different levels of need in certain areas or from different perceptions of what the service can offer.

48. Although the numbers of children referred to Local Authority OTs are lower than those made to NHS colleagues, they are still substantial, especially as the figures are for approximately half of Scotland.

49. Grant-aided schools do not have referrals as such as all of the children attending the school would be considered to be part of the therapists' caseload.

50. The majority of NHS Speech and Language Therapy referrals come from Health Visitors. The majority of NHS Occupational Therapy and Physiotherapy referrals come from Staff Grade/Community Paediatricians or Consultants in hospitals. Small numbers of referrals comes from GPs.

51. Occupational Therapists reported difficulties educating referrers to refer early and to provide appropriate information for prioritisation, e.g. about the functional aspects of the child's impairment.

52. All NHS OT and PT managers stated that they have a procedure in place to prioritise referrals. Only three SLT managers stated that they do not have such a procedure. Managers were asked whether the procedure was devised locally or followed guidance from either a Special Interest Group or professional body. The majority, but not all, said that procedures followed guidance from either a Special Interest Group or professional body.

53. Of the NHS services we interviewed, most, but not all, offer a child an initial assessment within six to eight weeks, the standard set by the waiting list initiative fund. Some services screen referrals by telephone to determine the child's level of priority for an initial assessment. Following an initial assessment a child could:

- immediately receive treatment/direct intervention
- immediately have indirect intervention (e.g. training a classroom assistant in positioning the child)
- go on a waiting list for direct or indirect intervention
- be placed on review for six months – this may be done if the therapist suspects that the problem the child is experiencing is likely to diminish without therapy as the child develops.

54. Some NHS therapists, therefore, operate two waiting lists, one for initial assessment and one for interventions.

Waiting list information

55. Information about waiting lists can be found in Appendix J. In April 2002, there were 1,809 children waiting to see an NHS Occupational Therapist, 300 children waiting to see an NHS Physiotherapist and 3,472 children waiting to see an NHS Speech and Language Therapist across Scotland and 116 children waiting to see an OT in 22 Local Authorities.

56. Managers were asked to state the longest time that a child currently on the waiting list has waited for a service. Some children are experiencing unacceptable waiting times, particularly those waiting to see an NHS OT. Waiting times also varied from service to service within an NHS Board area and even within one service. For example, Lomond & Argyll Primary Care Trust SLT service stated that children are generally seen in six to eight weeks but in rural Argyll it is longer (in Tiree children wait up to 14 weeks and in Tarbet up to 31 weeks).

57. Two areas had children who had been on the waiting list to see an NHS OT for two years. In one of these areas the longest wait resulted from a waiting list being inherited from a service previously contracted out to a voluntary organisation. One local authority and four NHS services had children on a waiting list to see an OT who had waited for at least one year, and one NHS service had a similar experience for a PT. NHS managers reported that children requiring group therapy often wait for longer periods as it takes time to find enough children with similar needs who can be treated together.

58. The SLT service in Greater Glasgow's Yorkhill NHS Trust is the only SLT service in Scotland that employs bi-lingual co-workers. These are clinical support workers who speak a community language and work with SLTs to make the service accessible and appropriate to people from minority ethnic communities. However, the service reported that waiting times can be longer for families whose first language is not English.

59. It should be noted that the longest wait is not the same as the typical wait and many children are seen sooner. In some areas longest waiting times were very low. This was particularly true of PT services where new patients are taken on at the expense of level of input for existing patients.

Current cases and discharges

60. A total of 6903 children were on the caseload of NHS OTs, 8,794 on the caseload of NHS PTs and 40,591 on the caseload of NHS SLTs in Scotland in April 2002. In addition, there were 884 children who were current cases of OTs in 20 Local Authorities, so current cases could be potentially double that figure.

part 5

61. NHS current cases are presented per WTE therapist in Appendix K. These figures do not represent an average caseload per therapist as caseloads may vary between grades of staff. Caseload size might depend on level of management responsibility, level of experience or nature of work undertaken. Some therapists, therefore, will have higher numbers on their caseload than the figures reported and others will have lower numbers. The figures are intended to allow comparison of the relative demands placed on services in each area. In some areas numbers of current cases per WTE are very high. For example, in Borders there were 134 current cases per WTE OT and 168 current cases per WTE PT. In Orkney there were 236 current cases per WTE SLT. These figures raise questions about the scope and level of service that can be offered to children when demand is high.

62. There is evidence that 'current cases' are defined differently by NHS therapists in different areas and even within a single service. The term may include children who are being assessed, children who are receiving intervention and children who are 'under review' or 'passive/dormant cases'. The proportions of each category of child will vary. Therapists in most of the areas we visited are given clinical autonomy to manage their caseload, however, the manager would use supervision to ensure equity of service across the area and fairness of work distribution between the therapy team. Some services have a standard system in place such as SMART objectives (Specific, Measurable, Achievable, Realistic, Time-limited) or 'Care Aims' to set goals, monitor the service's progress with children and evaluate the effectiveness of interventions.

63. It is not clear from our investigations what constitutes a 'passive/dormant case' but we did hear examples of therapists who will keep a child on their caseload as a passive case yet provide no input. In some cases this decision was influenced by parental pressure to keep the child on the therapists caseload. Some services encourage therapists to discharge children and ask for a re-referral if needed. Others do not. Managers reported that some therapists do not discharge children as it is difficult to get back into the system if further therapy is needed.

Management of demand

64. Overall, the pattern of demand for therapy in the NHS appears to be one of rising numbers of referrals, higher numbers of referrals than discharges and even higher numbers of current cases indicating increasing pressure on therapists to meet demand (see table 5:2).

65. Both NHS therapy managers and purchasers of SLT in Education departments described increased need for services for children with complex health needs and children with autism. They highlighted the fact that these developments place growing demands on both education and health services and the need to work together.

66. There were differences evident in the way that demand for therapy is managed by the NHS. For example, Occupational Therapy in NHS Borders had high numbers of referrals, high current cases but low waiting list numbers. Occupational Therapyvice in NHS Glasgow on the other hand, had lower referrals, lower current cases but higher waiting list numbers and times. Where there are limited resources the choice may be between providing a minimum service to as many children as possible or providing intensive services to children in greatest need.

67. Some NHS managers expressed concern about the inadequacy of data collected locally and nationally. They explained that most NHS Trusts collect information on new referrals, re-referrals and face-to-face contacts only.

68. A small number of Local Authority OTs stated that their ability to meet demand from children was hampered by the large volume of adult referrals to what is a primarily adult service.

FUNDING OF CHILDREN'S THERAPY

SOURCES OF FUNDING

Sources of funding for NHS therapy

69. The majority of NHS Occupational Therapy and Physiotherapy posts are funded by NHS Boards (around 97% and 95% respectively). The remaining posts are funded from a range of sources including the Excellence Fund, the Innovation Fund, a Sure Start grant, an Education Department, a Social Work Department, a private special school, a grant-aided school and a voluntary organisation (see Appendix L).

70. The pattern of funding is different for Speech and Language Therapy. Approximately two-thirds of NHS SLT service for children across Scotland are funded by health (64%) and one-third by Education (34%). Only 2% are funded from other sources. However, these figures vary considerably from area to area. In Dumfries and Galloway as little as 11% of the service is funded by Education, whereas as much as 91% is funded from this source in Shetland. A high proportion of the service in Greater Glasgow is funded by Education at 60%.

71. Sources of funding for SLT other than in health and education include grants from Sure Start, the Excellence Fund, the Health Improvement Fund, the Innovation Fund, Changing Children's Services Fund as well as funding from independent schools, community schools, voluntary services and private contracts.

72. There are small but significant numbers of NHS therapy posts being contracted by grant-aided schools in one NHS board area. For example, 3.43 of the 33.4 WTE PT posts in the area are funded through these contracts.

part 5

Sources of funding for OTs in Local Authority services

73. In the 23 Local Authorities which returned the questionnaire, only two indicated that posts are funded from sources other than mainstream Local Authority budgets. In one authority 0.6 WTE post appears to be funded by Capability Scotland and in another 0.6 WTE post is funded by a Sure Start grant.

Pay and conditions

74. There are some differences in pay for each of the three professions.. The situation between OTs employed in the NHS and those employed in LAs has fluctuated over the years, and at times salaries have been higher in LAs. It is current position that NHS salary is higher. It should be noted that the role of the OT may vary both within, and between, Local Authorities.

75. NHS OTs and PTs, but not SLTs, are awarded an additional payment if they provide supervision and support to students undertaking a clinical placement or fieldwork education placement, although this varies across Scotland. In some NHS localities the payments go to departments rather than individuals, and in other areas, are not visible at all. In local authorities, payments are in place for Social Work student practice placements, but not for Occupational Therapists.

Views of NHS managers and Education purchasers about the mechanism of funding Speech and Language Therapy Service through Education Departments

76. Speech and Language Therapy managers across Scotland were surveyed to seek their views about the current mechanism by which therapy for children is funded by education departments. In the majority of areas this applied to SLT only with the exception of Fife where some SLT, OT and PT are funded through this mechanism. This issue was also pursued in interviews with Speech and Language Therapy managers and purchasers from Education.

77. Some important benefits of the funding of therapy for children through Education departments were identified by SLT managers including increased staffing levels and greater dialogue between Health and Education agencies. However, managers in all areas identified some problems with the mechanism, as did the Education Department purchasers.

Level of service funded by Health and Education

78. Education contracts were intended to fund the provision of an 'enhanced' Speech and Language Therapy service, i.e. additional to that provided by NHS Trusts. SLT managers did report an increase in staffing levels when the mechanism was first introduced. However, both managers and purchasers were concerned that this 'enhanced' service is slowly being eroded.

79. Some NHS managers noted that there had been no comparable service developments in therapy funded by health despite increasing demands. This has led to many Speech and Language Therapy posts being funded through external contracts. SLT managers were also concerned that cost of living rises from Education departments are not keeping up with real costs leading to further reductions in the service.

80. Purchasers in Education Departments expressed concern about the lack of clarity about which posts and, therefore, which therapies are being funded from Health or Education sources. They explained that they found it difficult to identify 'additionality', that is, which part of the Speech and Language Therapy service was being provided over and above the baseline service provided by the Trust. Purchasers in one area also expressed concern about an NHS Trust recently reducing the number of therapy posts it funds explaining that this has an impact on the Education Departments' ability to develop therapy to children with special educational needs. The perception of all of the Education department purchasers to whom we spoke was that therapy input is low down on the list of priorities for NHS Trusts. This was also the view of some of the therapists that replied to the surveys. This is surprising as children's services are one of the priorities identified in *Our National Health*.[30]

81. Finally, agencies' responses to the recent Speech and Language Therapy realignment exercise has threatened the level of service. There has been no increase in the grant made to Education departments to meet the cost of regrading and Local Authorities and Trusts are responding to this issue in a variety of ways. Some Trusts are meeting the extra costs. Some Local Authorities are meeting the extra costs. Some services are cutting posts or grades to stay within the existing budget.

Ensuring equity in SLT provision

82. Both NHS managers and Education department purchasers expressed grave concerns about the link between Education department funding for SLT and Records of Needs. They explained that each Local Authority implements Records of Needs differently. This means that there will be cases where two children have very similar needs but one has a Record of Needs while the other does not. There was a general view, therefore, that Records of Needs are not a good indicator of priority.

83. SLT managers also gave examples of education service developments which have resulted in children with similar needs receiving different levels of therapy even within one area. This was seen to raise issues about clinical governance and potential clashes with statutory imperatives.

84. A further concern was raised by SLT managers in relation to the link between funding and the Records of Needs system. Increasingly therapists are prioritising early and preventative work with younger children yet there are few children with a Records of Needs under age 5 and only a handful with Records of Needs at age 2.

part 5

85. Purchasers explained that authorities are reluctant to consider a child for a RON as early as age 2 as a period of development may occur at such an early age and the educational needs of the child may change significantly. However, they suggested that this should not mean that a child's need goes unmet. They also give a high priority to early and preventative work with younger children. Purchasers expressed the view that Records of Needs should not be seen as a passport to services as agencies must meet the needs of children whether recorded or not. In practice, is seems that the requirement to target education funding towards children with Records of Needs or being considered for a Record of Needs is interpreted differently from authority to authority.

Contracts and monitoring arrangements

86. Several NHS managers suggested that the contractual nature of the relationship between health and education has a negative impact on their ability to work in partnership. They suggested that too much of the dialogue between the two agencies is focused on funding and the contract itself and that this does not necessarily lead to mutual understanding. A further disadvantage of the contracts with Education identified by NHS managers was that Heads of Therapy have to negotiate with both Trusts and Education for any developments.

87. Purchasers also described some problems with the contracts. Because they find it difficult to differentiate posts that are additional to those funded by the NHS Trusts this in turn has made monitoring of the education funded service difficult. Education department purchasers in one area also said that they find it difficult to identify one senior manager with overall responsibility for dealing with problems that arise.

Lack of co-terminosity

88. Both NHS managers and Education purchasers described difficulties resulting from the lack of co-terminosity of NHS Trusts and Local Authorities. The main concern of SLT managers was that negotiations are time consuming. Purchasers said that they have particular problems when smaller Local Authorities are dealing with a large NHS Board area. They said that therapies tend to want to adopt a common approach across a whole NHS Board area meaning that the Local Authority has to fit in with this rather than develop a pattern of service that fits with the Local Authority.

The costing of therapy

89. NHS managers highlighted a lack of consistency in the way costs are calculated when drawing up contracts. They explained that local authority contracts often do not cover sick leave, maternity leave, study leave and costs such as clerical support or accommodation and said that some Education departments are only willing to pay for direct contact time. This has led to some employees in the same SLT service having different terms and conditions and different holidays in term time dependent on the contract under which their post is covered.

90. Some NHS managers suggested that there should be a national format for calculating costs and negotiating details of the contract and that the Scottish Executive should have a role in giving guidance about this and the subsequent auditing of any system introduced. The lack of clear ring-fencing of monies was raised as an issue by both managers and purchasers.

The link between funding arrangements and accountability

91. Both NHS managers and Education department purchasers were concerned that there are some ambiguities about responsibility and accountability for SLT for children with special educational needs and that this is key to any discussion about funding arrangements.

92. NHS managers thought that there was a potential conflict between being accountable for the deployment of the staffing resource but lacking control over finances that come from Education departments. They suggested that the present funding mechanism causes confusion about accountability and can allow for complaints to be by-passed by education.

93. Equally, Education purchasers expressed concern that they have a legal responsibility towards children with special educational needs but have to rely on good will and negotiation with health colleagues to ensure that this responsibility is met. Purchasers suggested that the NHS either has to have equal legal accountability with Education departments or that any legislation directed at education needs to be backed up with clear guidance to health services.

Alternative funding arrangements

94. Managers and purchasers were asked to consider alternative models of funding therapy. Many NHS managers were very interested in the idea of aligned budgets for health and education. However, they said that this would raise many questions about how it would work in practice, for example, who would be the employer and would therapists lose Whitley Council pay and conditions. It was felt that there are lessons to be drawn from the Joint Future initiative and that the same protective policy framework is needed if aligned budgets are to be implemented in children's services.

95. There was a consensus among purchasers that there has been too much 'tinkering at the edges' of services. They explained that obtaining small amounts of additional time-limited grant funding takes up a disproportionate amount of energy. There was not a consensus, however, about the best way to fund therapy for children with special educational needs.

96. One group of purchasers suggested that there needs to be a more long-term strategic approach to funding and joint resourcing and a policy framework to support joint work. They would like to see a Framework for Children's Services developed in which health, education and social work all have shared accountability. They felt that 'For Scotland's Children'[7] promotes working together and Children's Service Plans are a vehicle for joint planning but there also needs to be joint accountability along with joint resourcing of services. They said that if it is not possible to have joint accountability then accountability should be with one agency.

part 5

97. The second group of purchasers were less optimistic about joint resourcing expecting it to be 'a long and painful a process'. One purchaser would like to purchase SLT from a private agency or directly employ therapists. Others thought that it would be difficult to recruit therapists. They said that recruitment is difficult enough for the NHS even though they have a support structure, training and pay structure in place.

Views of NHS managers about the funding for therapy through mechanisms other than Education contracts

Inadequacy of current funding levels

98. The major issue raised by managers from all three professional groups when asked to comment on funding was the inadequacy of the central funding currently available. Several managers highlighted the problem, as they saw it, of static health resources trying to meet increasing demand from education. They called for permanent funding for core work and service developments.

Problems associated with time-limited funding

99. While managers welcomed new initiatives such as Sure Start, many expressed considerable concern about this mechanism of funding service developments. First, the short-term nature of the funding was a concern. It was stated that this causes extra pressure on a service and difficulties for managers. For example, it requires that people are appointed on short-term contracts but it is difficult to recruit to these posts.

100. Secondly, the process of applying for grants was a concern. Some mentioned that it is very time consuming to prepare a bid for funding with no guarantee of a successful outcome. A small number of managers from all three professional groups reported that paediatric therapy is not necessarily seen as a high priority within a Local Health Care Co-operative or NHS Trust. This makes it difficult to get grant funding bids accepted at this level and also means that therapy for children is competing with therapy for adults for resources. One manager stated that her Trust was reticent about embarking on funding which is non-recurring. There was a call for grant funding to be simplified and for information to be made more accessible to therapy managers.

Alternative funding arrangements

101. There was a call for agencies to have shared financial responsibility to meet the needs of disabled children. Some NHS managers from all three professional groups said they would welcome increased joint funding of services. This was described variously as 'pooled budgets', 'matched funding' and 'joint funding'. NHS managers felt that Social Work Departments should be included as well as health and education in this joint approach to managing and funding children's therapy.

102. However, some concerns were expressed about therapists' ability to make their own professional judgements if Education departments are given a budget to purchase OT and PT or if joint resourcing arrangements are put in place.

103. Concern was also expressed that much of the current funding designated for interagency work (such as Sure Start) is, in fact, controlled by Local Authorities. These concerns, whether real or perceived, highlight the need for jointly agreed objectives and outcomes.

The importance of integrated therapy provision

104. Finally, managers stressed the importance of having integration of all therapy provision for children in localities. In some areas the current structure of therapy service was seen as restrictive. For example, where therapists are located within several Local Health Care Co-operatives this was seen to reduce flexibility in service provision. There were fears that services may become more fragmented if funded through Education departments.

105. It is important for different therapies to link together (be integrated) as well as to maintain good links (good integration) with other services/professionals. For this to be achieved, flexibility is required. For example, for geographical reasons, in remote and rural areas there may not be sufficient staff numbers to have a WTE in each locality. There may, therefore, be merit in having a more centralised therapy service to respond to fluctuating demand at local level. However, in more populated areas, there is much to be gained from deployment of staff in multidisciplinary teams at locality level, whilst retaining professional links and governance in a virtual way.

MANAGEMENT AND ORGANISATIONAL ISSUES

Joint working between health and education

106. Many Speech and Language Therapy managers were very positive about the relationship between their service and Education Departments, describing the relationship as a 'partnership'. They reported increased joint working at both a practice level and a strategic level, a better understanding of respective roles and better communication resulting from education funding.

107. However, others gave examples of collaboration working less well. For example, they felt that some education service developments had been implemented without the implications for the Speech and Language Therapy service being fully appreciated. They suggested that health priorities and philosophies are not always the same as those in education and called for more joint decision making and planning.

part 5

108. Education purchasers' views about joint working were mixed. In one area purchasers from Education departments reported that there is a will on the ground to work together. However, agencies' ability to provide a holistic service can be hindered by disputes over resources and domains of responsibility. The example was given of a bench used by a PT in a school to undertake a PT programme. There was some ambiguity about whether this was an item of health equipment or education equipment.

109. In the second area there were a number of tensions between Education Departments and some Speech and Language Therapy provision. Purchasers believed that good co-operation often relies on individual personalities and there was also the perception that therapists sometimes get involved inappropriately in education matters. However, in the same area, there was an example of good co-operation with the head of service working at a strategic level with Education colleagues to redesign services for children.

110. Purchasers in both areas pointed out that just as education developments can impact heavily on health, health initiatives and medical advances can impact on education. For example, more children with complex needs are now living longer and are no longer living in hospital settings. As a result schools are increasingly meeting the needs of these children. The purchasers welcome these medical advances but also point out that these place greater demand on education. In addition, the more children being diagnosed with ASD in the health sector, the more the education sector has to respond to this newly identified need.

111. Both NHS managers and Education purchasers want to see more co-operation between agencies. At the same time NHS therapists placed great emphasis on the importance of being able to exercise professional autonomy and clinical judgement as health professionals. Some concern was expressed that this could be threatened if therapists were part of the education system.

Joint working between Local Authority and NHS OTs

112. The review was unable to look in detail at issues relating to the roles of Local Authority and NHS OTs. However, there are some issues described below which were highlighted.

113. Local Authority OTs described a number of arrangements that were in place to ensure good joint working and effective communication with NHS colleagues. These included formal and informal meetings, joint home or school visits, joint assessments, joint working on adaptations and joint reviews of individual children and their needs. These were said to reduce the possibility of duplication of work with children.

114. However, there still appears to be considerable scope for overlap of roles and it was not always clear where the responsibility lies for providing certain aspects of an OT service to children. Therapists drew attention to the confusion that can exist. Nine authorities gave examples of services provided to children in schools. These were mainly in relation to equipment and adaptations. However, some examples given suggested that a wider rehabilitation role was being undertaken. There is a danger that there will be a duplication of effort in areas where there are both Local Authority and NHS OTs and the role demarcation is not clearly defined.

Equipment and adaptation provision

115. The assessment, provision, funding and maintenance of equipment and adaptations for disabled children are the responsibility of several agencies. Health are responsible for assessing for and providing health equipment. Local Authority social work services are responsible for assessing and ensuring the provision of equipment and (temporary) adaptations for daily living – for children at home. Provision of permanent adaptations is organised according to tenure of the property. Education departments have a responsibility to provide any aids, equipment or adaptations needed by a child to access the curriculum. Assessments for equipment and adaptations needed by children in schools are typically undertaken by an NHS or Local Authority therapist and recommendations are made to the Education department who then purchase the equipment.

116. In a small number of areas some NHS therapists have access to a Local Authority equipment store or there is a joint equipment service in operation. An even smaller number have a joint funding protocol or pooled budget arrangements in place. Other areas are in the process of developing joint arrangements as part of the implementation of 'Community Care: A Joint Future'.[24] New regulations on pooled budgets came in on 1 January 2003. We heard of one area at least that is developing a joint health, education and social work equipment service with money from the Changing Children's Services Fund and others where discussions are taking place. Where these joint arrangements are in place, they were welcomed by therapists and Education colleagues. In some areas, Speech and Language Therapists have access to a central resource which offers assessment and advice in relation to communication technology as well as systems for ordering, monitoring and repairing items. These resources were valued by those who can access them.

117. Both the surveys and the interviews undertaken highlighted two key concerns in relation to equipment for children with special educational needs.

118. First, there appears to be some ambiguities about the responsibilities of each agency in relation to various aspects of the process such as the assessment, funding, provision, maintenance, cleaning, storage and reissuing of equipment. In some instances it appears that agreements about, for example, responsibilities for funding equipment, have been in place in the past but have now become obsolete. In other cases these agreements have never existed. There were also some areas of equipment provision, such as advice regarding, and supply of, car seats, that were described as 'black holes' i.e. no-one appears to take responsibility. There was some evidence that agencies are not always able to meet their responsibilities in relation to equipment provision due to budget constraints. There appears to be particular issues around the funding of Alternative and Augmentative Communication aids and items of equipment used by children in respite or 'share the care' arrangements. It was also the perception of some Education departments and Social Work departments that some NHS OTs have recommended equipment which is a higher specification or newer model and therefore more expensive than is necessary to meet the child's need.

part 5

119. Secondly, the systems to deal with equipment are often inadequate, inefficient and uncoordinated. NHS therapists often reported delays in provision by Social Work departments or Education departments following assessment. Also, there was some evidence of wastage where equipment, which could potentially be reused, is lost or even discarded despite only needing to be cleaned or to receive a low level of maintenance, due to poor storage, stock management and cleaning facilities. One group of purchasers said that this has become more difficult since disaggregation. They also explained that are some legal issues about the recycling of equipment.

120. Some areas have access officers based in Education departments who deal specifically with equipment and adaptation issues. These posts were seen as valuable by Education and NHS staff members.

Shared accountability

121. As stated earlier the question of accountability was seen as a key issue both in relation to contracts between Education departments and SLT provision and in relation to joint working more generally. Education departments felt that accountability needs to be with either one agency or to be joint. Some Education departments would like to see a Framework for Children's Services developed in which health, education and social work all have shared accountability.

Linking resource allocation and clinical effectiveness

122. Purchasers expressed uncertainty about the assessment criteria used by therapists when making recommendations about the allocation of Education resources. Their perception is that decisions about particular pieces of equipment or interventions can appear to be based on individual subjective opinion or unduly influenced by parental pressure.

123. Purchasers were also concerned that it can be confusing for parents when different services in neighbouring localities adopt different 'methodologies' such as a mainly 'hands-on' approach or a mainly 'hands-off' approach. They explained that parents tend to see a hands-off approach as less valid and need to be convinced of its value. Purchasers called for therapists to be more explicit about the available clinical evidence when making recommendations or adopting certain approaches in order to foster good relationships with parents and enable Local Authorities to demonstrate that best value is being secured.

The impact of inclusive education and new models of service delivery

124. NHS managers are aware of the increased pace of change towards inclusive education for disabled children. The move towards 'mainstreaming' has already affected roles and service delivery models. Managers expressed the view that the policy has put increased pressure on therapy provision, as the placement of 'special needs children' in a number of mainstream schools, sometimes spread over a wide geographical area and without any increase in therapy provision has resulted in services being stretched ever thinner. They have major concerns regarding the ability of the service to deliver an equitable service within an inclusive schooling system.

125. Purchasers suggested that there should be joint training around inclusion. They were concerned that some people in both health and education "still think that special is best". They thought that Higher Education institutions which train therapists and teachers should work together on such a training programme.

126. It was not within the remit of this review to evaluate service models. However, it is clear that the model of service delivery has an impact on the way demand is managed. Speech and Language Therapists reported that they provide indirect work and direct one-to-one interventions equally. This does not appear to be the case for Occupational Therapy and Physiotherapy who provide mainly direct interventions in the areas we visited. The most striking example of a new model of working was in Lomond and Argyll's Speech and Language Therapy service for adults with learning disabilities where they use an approach called Total Communication. This service model is delivered almost entirely through indirect training and support allowing the service to reach a large number of people. This approach is described further in Part 6.

Facilities in schools

127. Both NHS managers and Education department purchasers highlighted the problem of shortages of suitable accommodation for therapy provision in health centres and schools. Sometimes therapists use the school medical room, the gym or any other room that is free. Purchasers admitted that therapists sometimes end up with the worst room in the school due to a shortage of space and a lack of resources to enable schools to extend. There did not appear to be clarity about what was acceptable or desirable. Purchasers suggested that there should be clear guidance given to Local Authorities about the facilities that therapists should expect in school – size, design, temperature, and quality standards.

part 5

SUMMARY AND CONCLUSIONS

SUPPLY AND DEMAND ISSUES

Analysis of workforce factors

128. The data collected through the surveys confirm the Riddell Committee's concern that there are shortages of NHS therapists working with children and unacceptable waiting times for some children.

129. It is difficult to reliably quantify supply and demand due to the varied interpretations of terms such as 'caseload' and different approaches to managing referrals. However, the investigations have allowed a deeper understanding of the multiple factors affecting supply and demand to be developed. Factors include too few experienced therapists, recruitment difficulties in rural areas and growing numbers of referrals. Overall the picture is of resources that are stretched and are put under greater pressure due to high rates of maternity leave and sick leave.

130. It is important to note the potential impact of analysis of roles within and between professions not covered by this report.

Supply factors currently affecting the workforce

131. There are a number of key factors influencing the supply of NHS therapists. First, although actual numbers of vacant posts are low, there are high vacancy rates in children's therapy and many of these persist for three months or more. This is particularly an issue in remote and rural areas.

132. Secondly, there is currently too small a pool of therapists to draw upon to fill senior I, senior II and band 2 posts. In addition, there are too few opportunities for therapists to develop paediatric experience. Problems highlighted include too few basic grade paediatric posts; a lack of rotational posts; limited numbers of senior II training posts for therapists in specialities such as paediatrics and neurology; too few paediatric fieldwork education placements for student therapists and too little continuing professional development for therapists wishing to move between specialities. All of the above were seen as useful ways to support recruitment and retention.

133. Thirdly, there is evidence that skill mix is being affected by the pressure to meet demand. As well as very few Basic Grade or grade 1 posts established in OT, PT and SLT, there are also fewer clinical support worker posts established in OT and PT than in other clinical areas. The long-term sustainability of the workforce relies on having a good career structure for therapists and clinical support workers to move through.

134. Fourthly, inadequate administrative support for therapists and IT infrastructures also appear to be having a negative impact on ability to meet demand for therapy. Data were not specifically

collected on this activity but there is evidence from managers and steering group advisors that time spent may be significant, perhaps as high as 30%.

135. Also, temporary absences such as maternity leave and sick leave are not well managed at present and posts may not be covered. Managers would like to have ring-fenced staffing budgets, contingency funds to cover maternity and sick leave, supernumerary staff to cover fluctuations in staffing, and automatic or emergency approval of funding to cover maternity leave from the first day of a maternity leave absence rather than after 18 weeks.

136. Finally, the introduction of family-friendly policies is having a positive influence on recruitment and retention. However, this creates new challenges such as maintaining continuity within the service and good communication when so many employees work part time.

137. In addition, some Local Authorities are experiencing difficulties with recruitment and retention of experienced OTs and part-time employees and are finding that temporary posts are also difficult to fill.

138. Both NHS managers and Local Authorities described difficulties providing good support and supervision to therapists working in remote and rural areas.

Current demands on services in which therapists work

139. Some children are waiting for long periods to receive therapy from the NHS. The longest waiting time in several areas is more than six months and it can be up to two years in some cases.

140. Children in rural areas appear to be experiencing longer delays. There is also evidence that children who speak minority languages are waiting longer than children from English-speaking families to receive an effective SLT service, because of a lack of bilingual therapy.

141. There were differences evident in the way that demand is managed by NHS services. Some NHS services operate two waiting lists, one for assessment and one for treatment. There can be potential problems if a child waits too long for treatment as they will need to be reassessed. Some services have a formal system in place such as 'SMART' goals or 'Care Aims' to review progress and make decisions about discharging children. Others do not.

142. Where there are limited resources the choice may be between providing minimal interventions to as many children as possible or in-depth interventions to those children considered to be in greatest need. There appears to be inequities of service both within and between NHS Board areas.

143. Some children are also waiting for long periods to see a Local Authority OT, particularly in rural areas.

part 5

Addressing workforce issues effectively

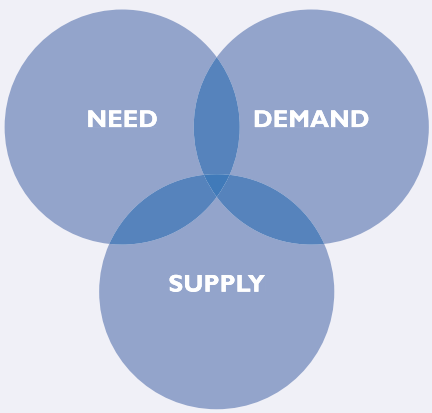
144. *Our National Health*[30] states the government's expectation that the numbers of Allied Health Professionals will rise. Long waiting lists and increased demand from children with ASD and children with complex health needs, as identified in this review, would indicate that children's services require an increase in numbers of therapists. Because of the gaps in data it is not possible to come to any firm conclusions about the absolute numbers of therapists needed to meet any shortfall.

145. Just as the factors affecting supply and demand are multiple, so the strategies needed to tackle the problems will be multiple. Increasing posts alone will not necessarily ease pressure. A long-term strategy for workforce planning based on a comprehensive analysis of multiple factors is needed.

146. The investigation has highlighted gaps in information that exist in relation to supply, demand and outcomes of interventions and a need to develop more sophisticated models to examine the relationship between supply, demand and outcomes.

147. For example, demand is typically measured in terms of numbers of referrals, waiting lists and current cases. However, our investigations have shown that currently these terms are interpreted and measured in different ways by different services. In addition, it is clear that these measures give only a partial picture of demand.

148. Ritchie *et al.*[31] suggest that an analysis of supply and demand alone is problematic. They point out that any demands made on a service are likely to be influenced by existing service models and patterns of delivery. Demands, therefore, should be differentiated from needs. Instead they suggest a model which incorporates not only supply and demand but also need. They make a distinction between 'expressed need', 'normative need' and 'felt need'. 'Expressed need' is analogous with demand, 'normative need' is determined by experts and 'felt need' is influenced by an individual's expectations and experiences.



Source: Ritchie *et al.* 1996[31]

149. The task of related processes such as population needs assessment, service design and workforce planning is, therefore, to ensure that any divergence of supply, demand and need is minimised. The report from the Scottish Integrated Workforce Planning Group[32] also stressed the need to look at workforce issues alongside models of change, models of effective practice and service delivery.

150. In the case of paediatric therapy, workforce planning must link intimately with the current agenda of Inclusive Education. Inclusive Education is already having an impact and will continue to have an impact on the way children's 'needs' are conceptualised, desirable outcomes are defined, the competencies required by therapists to meet children's needs are understood, new models of service provision are developed and new approaches to management and supervision are initiated. The Royal College of SLTs have identified competencies needed to work with certain client groups; other professions have not.

151. Both *Building on Success*[33] and *Working for Health*[34] identify the development of good information systems as a priority for good workforce planning. In order to have a positive impact, any new information systems developed need to contribute to a wider process of population needs assessment and service (re)design.

152. There will also be a need to pay particular attention to remote and rural issues. There is evidence that children are waiting longer for a service in some remote and rural areas than children in urban settings. There are higher vacancy rates in these areas and it is difficult to attract therapists to move into the area and peer support and supervision are more difficult to arrange.

153. Finally, the views of children and families should be central to any developments and efforts should be made to involve families in a meaningful way.

Maintaining and increasing the pool of experienced therapists and clinical support workers

154. The key workforce issue which must be addressed is the need to maintain and increase the pool of therapists who are suitably trained and experienced to meet the needs of children in an inclusive school system. Retention of experienced therapists relies on a well-planned and structured programme of Continuing Professional Development to maintain the currency of therapists' skills as services develop.

part 5

155. A number of strategies could be used to increase the supply of experienced therapists, some requiring longer-term planning than others. Options include:

a) increasing the numbers of OTs, PTs and SLTs that are trained
b) establishing more basic grade rotational posts or senior II training posts in paediatric services and putting in place a training programme co-ordinated by an external organisation
c) providing intensive training courses for new graduates and therapists working in other clinical areas to enable them to work with children
d) providing a structured programme of training for clinical support workers and increasing opportunities for access onto courses leading to state registration
e) investing in return to work initiatives
f) recruiting therapists from outside the UK.

a) Increasing the numbers of OTs, PTs and SLTs that are trained

156. Four Higher Education Institutions in Scotland provide pre-registration education and training for those wishing to train as Speech and Language Therapists, Occupational Therapists and Physiotherapists. Institutions offer three-year ordinary degree and four-year honours courses to undergraduates and some offer two-year post-graduate courses. All lead to eligibility for state registration.

157. The Scottish Executive and Scottish Higher Education Council (SHEFC) have increased funding for two years running to increase the number of places for students on under-graduate courses, although there is no guarantee that such students will work with children.

158. The two-year post-graduate courses offer the quickest route to increasing numbers of therapists. However, the number of students taking up places on these courses is lower than the number of available places as each student has to fund the course him/herself. Because students have already undertaken at least three years education at under-graduate level they are not entitled to further financial support.

159. As well as increasing the number of therapists trained, it will be important that students have positive experiences of working in the field of paediatrics through fieldwork education to encourage them to choose this specialism. At present, one of the factors limiting student placements is the availability of the clinical supervisor allowance. This is covered under Whitley Council pay and conditions and is paid by NHS Trusts to therapists who supervise students for a minimum number of weeks in the year. Students may be refused a placement because there is no money available from the Trust to cover this allowance rather than the supervisor's ability to offer time and expertise.

160. Students should also be given the opportunity to experience working in a remote or rural setting through fieldwork education to challenge some of the preconceptions about work in rural areas. There may be some barriers to rural placements such as the high demand for services faced by rural practitioners, the problem of transport and travel expenses and the issue of placement type, that is, day placements versus block placements.

161. Finally, OT, PT and SLT education is generic and cannot cover every specialist area in depth. However, a few specific paediatric modules are offered during pre-registration education. It will be important that these modules are developed as inclusive education progresses in order to offer students an insight into the changing role of OTs, PTs or SLTs in children's services.

b) Establishing more basic grade rotational posts or senior II training posts in paediatric services and putting in place a training programme co-ordinated by an external organisation

162. There appears to be differing views regarding the ability of new graduates to work in paediatric services, particularly in community services and mainstream schools. There appears to be two related concerns; first, the new graduates' lack of skills or experience in this environment and secondly, the service's lack of ability to deliver the right level of support, training and supervision when experiencing high demand for therapy. There is a need to find new ways to support and train new graduates. It may be helpful for educational institutions to work in partnership with practitioners to develop support and training mechanisms for new graduates working in paediatric services. The input of practitioners to any programme of training or support would be essential as would continuing education back in the clinical field. However, the educational institution could take on the role of co-ordinating at a regional or national level practitioner input, mentorship or peer support arrangements, web-based learning and specialist courses.

c) Providing intensive training courses for new graduates and therapists working in other clinical areas to enable them to work with children

163. The same process of education and support described above could be used with therapists wishing to move from one specialism to another.

d) Providing a structured programme of training for clinical support workers and increasing opportunities for access onto courses leading to state registration

164. It is important to provide robust support and training to clinical support workers. The current training available for clinical support workers working in each profession is variable. A Higher National Certificate in Occupational Therapy Support is run in some areas. The HNC provides a generic training but allows participants to tailor projects or assignments to the clinical specialism in which they are based. There is no equivalent course for Speech and Language Therapy or Physiotherapy clinical support workers.

part 5

165. Clinical support workers may undertake Scottish Vocational Qualifications (SVQs), which have a generic focus. In at least one area, a paediatric SVQ module is being developed with support from the Changing Children's Services Fund.

166. The HNC in OT Support is usually taken up by Occupational Therapy clinical support workers who are already employed rather than those who are looking for future employment as an OT or OT clinical support worker. The qualification allows accelerated entry onto the Occupational Therapy degree course. There would be value in developing an equivalent course to the HNC in OT Support for Speech and Language Therapy or Physiotherapy clinical support workers. There may also be value in providing a similar course for people employed in different fields who want to change career. The development of specific paediatric SVQ modules is also to be welcomed[35].

e) Investing in return-to-work initiatives

167. There are now examples of training and support programmes available for health professionals wishing to return to an NHS post after a career break. *Building on Success*[33] recommended that the Scottish Executive develops these further.

f) Recruiting therapists from outside the UK

168. There has been little research into the scope for international recruitment of AHPs. However, evidence presented to the Review Body for Nursing Staff, Midwives and Professions Allied to Medicine[36] suggested that approximately one-third of physiotherapists joining the Health Professional Council register each year were from overseas.

FUNDING ISSUES

Sources of funding

169. Most NHS therapy posts are funded from the mainstream health budget. The exception is SLT which receives a significant amount of funding from Education departments. There is not the same mechanism for the purchase of OT and PT for children by Education departments.

170. The proportion of funding for SLT coming from Education departments is relatively high in some areas such as Shetland at 91% and Glasgow at 60%. This funding is intended to provide an enhanced service targeted at children with Records of Needs or being considered for a Record of Needs. In areas where the proportion of education funding is high and the proportion of health funding is comparatively low, questions are raised about the ability of the service to meet the needs of non-recorded children.

171. The purchasing of therapy by grant-aided schools also has the potential to create inequities over and above those that already exist.

172. The majority of Local Authority OT posts in the areas for which we have data are funded from the Authority's mainstream budget. There has been little uptake of time-limited grant funding such as Sure Start, New Community Schools and Innovations grants by NHS or LA therapists.

173. There appears to be a number of potential barriers to further take-up by NHS therapy. First, NHS therapists' perception was that therapy are considered a low priority by NHS Trusts when applications are being prepared and so are not included in project designs. Also the NHS managers themselves consider the preparation of applications for time-limited funding to require disproportionate amounts of effort and time to secure relatively small amounts of additional resources. Finally, the grants tend to lead to the creation of temporary posts which they perceive as unattractive.

174. These grants could offer good opportunities to therapy to work collaboratively with education and other agencies. Although these are time-limited funds, they lend themselves well to supporting the sort of innovation that will be needed as inclusive education progresses. Both NHS managers and Education purchasers called for less piecemeal development and more strategic funding structures.

Pay and conditions

175. There is a growing pay differential between NHS SLTs and other NHS Allied Health Professionals, and between NHS therapists and Local Authority personnel. Education contracts are also leading to anomalies in pay and conditions. These could potentially impact on recruitment to certain professions and certain agencies and should be addressed. This will become an even more pressing issue as the Joint Future agenda progresses, as there will be more joint health and social work services creating potential for therapists to be based together but on very different terms and conditions.

part 5

Improving funding arrangements

176. NHS Therapists from each of the three professions expressed concerns about the ability to meet increasing demand without additional resources.

177. The additional funding received by SLT through Education departments was welcomed by managers. The main benefits of the funding identified by SLT managers have been increased staffing and a greater dialogue between NHS therapists and Education services.

178. However, the review has identified a number of difficulties relating to the funding mechanism that are similar to those outlines in a paper produced in 1999 by Speech and Language Therapists in Scotland.[37] These include the 'unhypothecated' nature of the funding, the perceived lack of an equitable distribution of the money across Scotland, and the protracted amount of time and energy that is spent on negotiating contracts.

179. There is also evidence that SLT is being eroded on a number of fronts. First, health developments are not keeping pace with education developments. Secondly, Local Authority cost-of-living rises are not reaching actual cost increases. Finally, the additional costs resulting from the SLTs' realignment exercise are being met, in some cases through service cuts, despite this being discouraged by the Scottish Executive.

180. The link between the funding and the Record of Needs system was seen as particularly problematic. There was agreement across agencies that these records are not a good indicator of degree or urgency of need. Agencies also saw early intervention and preventative work with younger children as a priority that falls outside the Record of Needs system.

181. Another key issue was the lack of transparency about who is paying for what. Purchasers have experienced difficulty differentiating Health and Education funded posts and this has caused difficulties when monitoring contracts.

182. It is clear that the current mechanism of funding SLT through education contracts is problematic and that the mechanism should not be replicated for OT and PT in its current form. However, there is not a clear consensus about the most appropriate mechanism for the funding of therapy for children with Special Educational Needs in the future. Some purchasers and NHS managers favour joint resourcing while others would like to see a single agency taking responsibility for therapy for children with Special Educational Needs.

MANAGEMENT AND ORGANISATION ISSUES

Joint working

183. The work of Education, Social Work and Health is very closely related. Developments introduced by one agency have a direct impact on the other agencies' work. At present there is some ambiguity about the responsibilities of each agency and this can lead to conflict and disputes about resource allocation. Close co-operation and good communication at all levels is crucial if agencies' vision of an holistic service is to be achieved.

184. There was not a consensus about the best way to achieve a joined-up approach, however, there was agreement that clear lines of accountability are crucial. Some respondents were in favour of joint resourcing and management arrangements but also stressed that these would need to be supported by a robust policy framework.

185. It is hoped that any current duplication of effort in areas, where there are both Local Authority and NHS OTs and the role demarcation is not clearly defined, will be resolved by joint resourcing.

Equipment and adaptation services

186. Equipment and adaptation services are fragmented with each agency having different responsibilities and different areas of expertise. Responsibilities are not always clear and the systems to support the service are either inadequate or in some cases non-existent. There appears to be a number of specific gaps that need to be investigated further and addressed such as the funding of Alternative and Augmentative Communication aids and equipment for children using respite or 'share the care' arrangements. The current division of responsibility for the purchasing, assessment and maintenance of equipment used by children in schools and home is unsatisfactory.

187. Agencies welcomed joint initiatives where they exist. Equipment and adaptation services is one area that was highlighted as a priority for action in 'Community Care: A Joint Future'. Joint equipment and adaptation services are currently being developed. A similar model would be equally applicable to children's equipment and adaptation services. Developments need to take account of the specific need of children and of the Education departments' role. From 1 April 2003, all Local Authorities will be required by the Accessibility Strategies Act to have in place a strategy for making education more accessible for pupils with disabilities. National funding has been made available to Local Authorities to help them prepare and implement their accessibility strategies.

part 5

Working within an inclusive education model

188. Any developments in the management, organisation and provision of therapy to disabled children need to be considered in the context of Inclusive Education. The increasing emphasis on mainstream education for disabled children will bring both opportunities and challenges to stakeholders. It will be important to maintain a dialogue between all agencies as well as parents and children as new models of working are developed to meet the needs of children in inclusive educational settings. There will be a requirement to develop shared understandings and expectations of therapy and its likely outcomes.

189. It appears, at present, that Education staff and parents are sometimes unclear about the basis on which clinical decisions are made by therapists. Education colleagues believe that greater explanation about the rationale for clinical decisions will reduce conflict and increase joint understanding between all parties.

190. There was also a call for more joint training initiatives aimed at therapists and education staff and specifically addressing the inclusive education agenda. Such joint training initiatives should be made easier with the introduction of the McCrone report[38] which guarantees all teachers 35 hours in-service training per year. It will be important to include parents and, where appropriate, children in any joint training initiatives to ensure that they are able to take an active part in the development of inclusive education.

191. Finally, the need for a more strategic approach to the provision of facilities in schools to accommodate children's therapy needs has also been highlighted.

RECOMMENDATIONS

192. The working group proposes a number of recommendations relating to issues of strategic planning which take account of recent reports and current Scottish Executive initiatives in Education, Health and Social Services. These include *For Scotland's Children; Building on Success: Future Directions for the Allied Health Professions in Scotland;* and *Community Care: A Joint Future.*

193. Other recommendations are grouped within the terms of the remit for the review under supply and demand, management and organisation and funding. Others are listed under workforce or other issues.

Strategic Planning

a) The Scottish Executive should encourage providers to develop new models of NHS therapy provision in non-traditional and inclusive settings, such as mainstream schools and nurseries and other community settings; and multi-agency training initiatives to support the delivery of therapy to children in inclusive educational settings. [Part 3, paras 6-10; Part 5, paras 124-126; 188-190]

b) Local authorities and NHSScotland should develop integrated approaches to the provision of therapy and other related interventions for children. These approaches should be planned and resourced within the statutory framework of local planning for children's services. Inter-agency Children's Services Plans should describe assessed levels of need and the provision made to meet these. [Part 3, paras 14-15; Part 5, paras 106-111]

c) NHS and Local Authorities should apply lessons learned from implementation of the *Joint Future* agenda in community care services, to their implementation of *For Scotland's Children*, the Executive's initiative on better integrated services for children. [Part 3, paras 14-15]

d) The Scottish Executive Health Department, NHS Boards and Local Authorities should ensure that the national, regional and local structures established through *Working for Health* involve AHP leaders and that a systematic approach to workforce analysis and development is adopted for NHS paediatric therapy. This should be an integrated approach involving key stakeholders, e.g. professional bodies, HEIs and NES, and LA partners. [Part 5, paras 144-153]

Supply and Demand

e) NHS Boards and Local Authorities should review the structure and skill mix of therapy staff in services to children, to ensure effective and efficient use of resources, ability to meet demand and the provision of training opportunities for junior grades of staff and assistants. [Part 5, paras 22-24;133]

f) The Scottish Executive, the Scottish Higher Education Funding Council, NHS Boards and Local Authorities should together take steps to expand the pool of suitably experienced and skilled therapists and clinical support workers. They should take into account opportunities to develop alternative routes into state registration in partnership with the Health Professional Council (HPC), universities, NHS Education for Scotland, Scottish Qualifications Authority and professional bodies. [Part 5, paras 26-29;132; 154-155]

g) NHS Boards should progress initiatives to tackle recruitment, retention, training, supervision and support issues in remote and rural areas through the Remote and Rural Areas Resource Initiative (RARARI) in NHS Scotland. [Part 5, paras 30; 131; 138]

h) NHS Boards should take steps to minmise the length of time that children have to wait for therapy required to support their educational needs. [Part 5, paras 55-57; 139-143]

Management and Organisation

i) NHS Boards, Local Authorities and other employers of AHPs, in determining their therapy staffing complements for children's services, should take into account the impact of planned leave, including projected maternity leave, and changing workforce patterns, so that there is continuity and comprehensiveness of service as outlined in *Building on Success – Future Directions for the Allied Health Professions in Scotland.* In addition, they should use Partnership Implementation Network guidelines to develop and implement flexible employment policies to support the recruitment and retention of staff. [Part 5, paras 8-24; 31-37; 135-136]

j) NHS Boards through AHP leaders should audit the time spent by therapists on non-clinical tasks, such as routine administration, and seek to maximise AHP time on direct service delivery. [Part 5, paras 25; 134]

k) NHS Boards should fully utilise the enabling agreement and other mechanisms which exist to recognise and reward clinical expertise in order to promote job retention in paediatric services. These include developing opportunities for new ways of working and improving clinical care such as 'extended scope practitioners', clinical specialist or AHP consultant posts. [Part 5, paras 37-40; 154-168]

l) NHS Boards and AHP leaders from each therapy profession should ensure that each therapy profession has a clear rationale for caseload management decisions which is developed in consultation with key stakeholders such as parents, education colleagues and where appropriate children. [Part 5, paras 60-68]

m) AHP employers and leaders should support the development of multidisciplinary and multi-agency networks to underpin practice development. These should review and share clinical effectiveness information developed by each profession in partnership with families using services. [Part 5, paras 188-190]

Funding

n) Allocation of funding for Speech and Language Therapy to education authorities for provision to pupils with Records of Needs should be integrated with funding for SLT to other children. Provision of therapy should be made according to clinical need and be outcome-focused rather than led by diagnosis, label or administrative category. [Part 5, paras 82-85; 176-182]

o) The Scottish Executive should, with Local Authorities and NHSScotland, develop joint resourcing and management for children's services, including the therapy professions' contribution. [Part 5, paras 94-105]

Workforce

p) Competencies required to deliver and manage a high quality children's service should be established by OT and PT leaders in line with similar work in SALT. This should be undertaken in partnership with professional and regulatory bodies, and HEIs and used to inform the work of NES in developing education and training and continuing professional development. [Part 5, para 150]

q) NHS Boards and Local Authorities should create opportunities for students and new graduates to gain experience of working with children. In the NHS they should consider arrangements for the payment of clinical supervision allowances, within the timeframe for the implementation of the UK *Agenda for Change* initiative. [Part 5, para 159]

Other Issues

r) NHS Boards, Local Authorities and AHP leaders should develop strategies for involving children, young people and their families in service evaluation and development in line with the *Involving People* agenda,[39] [Part 5, para 153].

s) NHSScotland commissioners with NHS Boards and SLT leaders should review the current level of bilingual SLT available to families from minority ethnic communities in their area and should take steps to address service gaps. [Part 5, para 58; 140]

t) NHS Boards and Local Authorities should put in place strategic planning arrangements to ensure that effective and efficient joint systems and protocols are developed to meet the equipment and adaptation needs of disabled children. These arrangements should cover assessment, funding, provision, monitoring, maintenance and recycling of equipment. Developments should link with activities under 'A Joint Future' and Education Departments' 'Accessibility Strategies'. [Part 5, paras 186-187; 115-123]

u) As part of local implementation of Accessibility Strategies, education authorities, in consultation with NHS Boardss and Head Teachers, should agree appropriate accommodation and facilities for the provision of therapy in educational settings. [Part 5, paras 127; 191]

part 6

Speech and Language Therapy for Adults with Learning Disabilities and/or Autistic Spectrum Disorder

1. In this section we report the information gathered about the organisation, supply and demand of Speech and Language Therapy for adults with learning disabilities and/or autistic spectrum disorder (ASD). Questionnaires were returned by 13 of the 15 NHS Board areas (87%).

Introduction

2. As stated earlier, the Scottish Executive extended the terms of the review to include the supply, management and organisation of Speech and Language Therapy (SLT) for adults with autistic spectrum disorder (ASD) as well as adults with learning disabilities. This was because this group of service users fall within the scope of the The same as you?[2]. In this section of the report, therefore, we refer to three distinct client groups, namely:

adults with learning disabilities but no ASD
adults with learning disabilities and ASD
adults with ASD but no learning disability.

3. Speech and Language Therapy for adults with learning disabilities and/or ASD are either delivered by therapists who work solely with this client group or therapists who work with multiple client groups. In the report we refer to these as specialist and generic therapists respectively.

4. The majority of services are provided by Speech and Language Therapists employed by the NHS. A small number of therapists are employed in the voluntary sector.

SUPPLY OF SPEECH AND LANGUAGE THERAPY TO PEOPLE WITH LEARNING DISABILITIES AND/OR ASD

Numbers of NHS SLT posts established to provide services to people with learning disabilities and/or ASD

5. There are a total of 53.55 posts for state registered SLTs and four posts for clinical support workers established in Scotland to provide a service to adults with learning disabilities. Some of these adults with learning disabilities will have ASD. A small number of these posts also provide a service to adults with ASD but no learning disability. It was not possible to determine the proportion of services provided to adults with ASD, however, the extremely low referrals for adults with ASD in 2001-02 is an indication that the proportion is small.

Skill mix in NHS SLT therapy

6. The majority of SLT posts for state registered therapists are graded at band 2 (56%) and a substantial number are graded at band 3 (25%) (see appendix M). There are the equivalent of only 2.7 WTE posts for band 1 SLTs, all situated in NHS Lothian.

part 6

7. Clinical support workers are employed in only five NHS Board areas. Only 7% of the total posts are support posts. This gives a qualified to unqualified staff ratio of just over 13 state registered therapists to every one clinical support worker. This is marginally higher than the Scottish average for SLT across all clinical areas of 12:1.[23]

8. The numbers of state registered Speech and Language Therapists per 100,000 population were calculated (see Appendix N). In the 12 areas for which we have complete data, these range from 0.22 in Shetland to 1.71 in Lanarkshire.

Recruitment and Retention Issues

Vacancy rates

9. Overall, vacancy rates reported for posts delivering a service solely to adults with learning disabilities and/or ASD across Scotland were low (see Appendix O). Several areas had no vacancies for posts working solely with adults with learning disabilities and/or ASD. However, three services had significantly higher rates than others, namely Renfrewshire and Inverclyde Primary Care Trust at 41%, Ayrshire and Arran at 38% and Tayside at 37%. An additional four areas reported experiencing difficulties recruiting qualified SLTs to work with adults with learning disabilities and/or ASD despite having very low vacancy rates at the time of the survey. In areas with high vacancy rates it should be noted that the actual number of posts vacant is relatively low, ranging from 1.2 to 2 WTE posts.

10. 3.8 of the 5.8 WTE vacant posts across Scotland had been unfilled for three months or more. There were 0.7 vacancies for clinical support workers. These included a newly created 0.5 WTE post funded by a Local Authority. Rates of maternity leave among SLTs working solely with adults with learning disabilities and/or ASD and instances of sick leave were also low.

Factors influencing vacancies

11. Managers were asked to comment on any factors that contribute to recruitment difficulties and any strategies they have tried to recruit or retain staff. The factors reported were diverse. Three areas stated that this clinical area is highly specialised and recruitment of appropriately experienced therapists is difficult. Three areas reported that it is difficult to attract therapists, particularly new graduates, to work in this specialism as it is perceived as a less attractive option. Some reported that generic posts which cover both children and adults can change this perception. Four areas in total stated that mixed posts ease recruitment difficulties. However, the manager of an island-based service also expressed the view that recruitment difficulties can result from therapists having to manage complex caseloads.

12. NHS Lothian, the only area with band 1 posts, reported that it is easier to attract new graduates than more experienced staff. Along with a second area, they stressed the importance of student placements to develop the next generation of therapists.

13. The most frequently reported factor leading to the successful recruitment and retention of staff was the implementation of family-friendly policies and flexible working. Support and professional development opportunities were also perceived as highly important factors influencing staff retention. Managers referred to induction programmes, shadowing, in-house training, mentoring, secondment opportunities, peer review, project work and opportunities to work outwith the clinical area from time to time to maintain generic skills.

14. Finally, the structure of services was seen as influential. Two managers expressed concerns about SLTs being spread thinly over several community learning disability teams or LHCCs. Another manager had reviewed the service's skill mix as a way of tackling staffing issues. One manager was concerned that a lack of career structure means that therapists are trained in this specialist area and then move to a new area to take up a higher-grade post. One manager expressed the view that recruitment had become easier since the recent realignment exercise as this had led to improved salaries.

DEMAND FOR SPEECH AND LANGUAGE THERAPY FOR PEOPLE WITH LEARNING DISABILITIES AND/OR ASD

A summary of demand for NHS SLT for adults with learning disabilities and/or ASD across Scotland

15. The table below summarises the numbers of adults with learning disabilities and/or ASD referred to SLT in 2001/2, discharged from these services in the same year, on the caseload of Speech and Language Therapists in Scotland in April 2002 and on a waiting list to see a SLT in April 2002. Only partial data were available for several areas and so these figures are likely to be underestimated.

part 6

Table 6:1 – SLT referrals, discharges, caseloads and waiting lists

	Numbers of adults with learning disabilities and/or ASD
Adults with learning disabilities and/or ASD referred to SLT in 2001-02	**917**
Adults with learning disabilities and/or ASD discharged from SLT in 2001-02	**692**
Adults with learning disabilities and/or ASD who were current cases of SLTs in April 2002	**2174**
Adults with learning disabilities and/or ASD who were on a waiting list to see a SLT in April 2002	**284**

Notes
All figures
Figures for Grampian and Highland were unavailable
Argyll and Clyde – Lomond & Argyll PCT do not operate a referral-based system for these groups, so no figures provided
Referrals
Argyll and Clyde – no figures for Renfrewshire and Inverclyde PCT as well as Lomond & Argyll PCT
Current cases
Argyll and Clyde – current cases are for Renfrewshire and Inverclyde PCT only and these are estimated
Discharges
No figures available for Renfrewshire and Inverclyde PCT, Borders, Dumfries and Galloway, Fife, Lanarkshire, Lothian, or Tayside.

Referral information

16. Referral rates per WTE qualified post ranged from 10 referrals in Ayrshire and Arran, Lanarkshire and Orkney, to 100 referrals in Shetland (see appendix P). These rates give some indication of differences between NHS Board areas in terms of demands placed on services. However, further research is needed to explain the differences between some areas.

17. The referral rate per 1000 population varied considerably from area to area (see Appendix Q). The mean rate was 0.2 referrals per 1000 population. The range was from 0.06 referrals per 1000 population in Dumfries and Galloway to 0.5 in Borders. Again, further investigation is needed to understand these differences.

18. Managers from nine of the 13 areas stated that they have a procedure in place to prioritise referrals. Two of the services with no procedure also had the highest numbers of people referred per WTE, although the actual numbers of referrals in one of these areas were relatively small.

One area did not respond to this question. Of the nine areas with a procedure, three said that the procedure was devised locally. The remaining six stated that the procedure was locally devised and follows guidance from professional bodies or special interest groups.

Numbers of adults with learning disabilities and/or ASD who are current cases of qualified NHS SLTs

19. As stated earlier, a total of 2126 adults with learning disabilities/ASD were on the caseload of a SLT in April 2002. These cases are presented per WTE SLT in Appendix R. The figures do not represent an average caseload per therapist as caseload may vary between grades of staff. Caseload size might depend on level of management responsibility, level of experience or nature of work undertaken. Some therapists, therefore, will have higher numbers on their caseload than the figures reported below. Others will have lower numbers. The figures are intended to allow comparison of the relative demands placed on services in each area.

20. The mean number of cases per WTE qualified SLT was 66. The rates ranged from 29 cases per WTE SLT in Lothian to 180 in Shetland. The areas with higher numbers of cases per WTE SLT were all largely rural areas or island authorities.

Waiting list information

21. Waiting list information is presented in Appendix S. There was a total of 284 'adults with learning disabilities but no ASD' and 'adults with learning disabilities and ASD' waiting to see a SLT in Scotland in April 2002. There were no 'adults with ASD but no learning disability' waiting for a service.

22. The mean number of people with learning disabilities and/or ASD waiting per WTE was 6.2. Five areas had no adults with learning disabilities/ASD waiting to be seen. Many others had relatively low numbers waiting per WTE therapist, ranging from 1.6 to 7.8. Borders, however, had a very much higher number waiting per WTE therapist than other areas at 42.3.

23. Managers were asked to give the longest time that an adult with learning disabilities and/or ASD currently on the waiting list had waited for a service. The longest wait was reported by Renfrewshire and Inverclyde PCT at more than one year. In another four areas the longest wait was between eight and nine months.

MEETING THE NEEDS OF ADULTS WITH ASD BUT NO LEARNING DISABILITY

24. All of the services indicated that they work with 'adults with learning disabilities but no ASD' and 'adults with learning disabilities and ASD'. In addition, six services stated that they also provide a service to 'adults with ASD but no learning disability'. However, there are indications that services for the last client group are poorly defined and there are gaps in service provision.

25. For example, managers were asked to estimate the proportion of posts providing a service to the three categories of client. Two services that stated that they provide a service to 'adults with ASD but no learning disability' reported that no posts were allocated to provide this service. The remaining four services were unable to allocate proportions.

26. In addition, four of the services that stated that they provide a service to 'adults with ASD but no learning disability' had not had any referrals for adults with ASD in 2001-02 and the other two were unable to give this information. From the figures provided, it appears that only one service, namely Greater Glasgow, received referrals for adults with ASD but no learning disability in 2001-02 even though they stated that they do not provide a service to this group. A second area appeared to group together adults with learning disabilities and adults with ASD and it was not possible to differentiate numbers within these client groups.

27. Nine services indicated that they do not work with 'adults with ASD but no learning disability'. In two areas the managers stated that clients with Asperger's Syndrome were occasionally referred to 'adult acquired' or 'adult mental health' services. However, in five areas where a service is not provided to adults with ASD by a learning disability service or generic service, managers were not able to identify who does provide this service.

MODELS OF SERVICE DELIVERY

28. As part of the investigation, managers of SLT in two areas were interviewed. In one of these areas, the service had adopted a particular service delivery model called Total Communication[v] (TC). The model used is described below.

29. TC differs from traditional therapy. It is not based on a medical model which aims to 'fix' individual impairment but instead adopts a social model approach and recognises the need for society to adapt to accommodate individuals' different communicate styles and needs. Instead of individuals being referred for therapy by an SLT, training is delivered to the people with whom the person spends most time, that is, parents, carers and support staff, to enable them to create supportive communication environments for people.

30. A number of training modules are provided as part of the model. These are attended by mixed groups of stakeholders such as parents and staff from health, social care and voluntary agencies. Integral to the TC approach is the use of Communication Link Workers (CLW). The role of the CLW is to promote the creation of a TC environment by liaising with service managers, colleagues and the SLT.

31. The manager of the service gave the example of one man who had received individual therapy for 25 years. Through TC training it was identified that the man had developed a repertoire of signs at school that he was not using as no-one in his current service knew about them. These signs were reintroduced, along with new communication methods which were less confrontational, for example, using fewer questions. His parent noticed such a difference in the

v Please note that the approach described as Total Communication here differs from that used in the education of people who are deaf.

man's communication following the training that she now champions this as a more effective approach than individual therapy.

32. The Total Communication model is noteworthy in that one WTE SLT has provided a TC service to a large number of people over a very large rural geographical area. In the two-and-a-half years since introducing TC, the service has provided 379 training courses. There are a further 238 people waiting for training.

Case studies

33. The working group commissioned the Scottish Consortium for Learning Disability to discuss with adults with learning difficulties their experiences of speech and language therapy. Two case studies illustrating some of the difficulties of securing therapy, and the benefits to adults with learning difficulties, are provided at Appendix T.

CONCLUSIONS

Supply and demand

34. There are few opportunities for new graduates to gain experience of working with people with learning disabilities early in their career. This has traditionally been seen as one of the 'Cinderella services' and it has been difficult to recruit to this field. There are likely to be some interesting developments in services as a result of the implementation of *The same as you?*[2]. This should make the specialism a more attractive and challenging career option for SLTs.

35. There was some variation in the numbers of state registered Speech and Language Therapists per 100,000 population in the 12 areas for which we have complete data. This suggests some inequities in the level of service available in NHS Board areas when judged on population alone.

36. Vacancy rates overall are low although there are higher rates in a small number of areas. Rates of maternity and sick leave are also low.

37. There does not appear to be excessive demands being placed on SLT adult learning disability services. Several areas had no people waiting for a service and many others had relatively low numbers of people waiting. However, these findings contradict the findings of the report *The same as you?*[2] which suggested that adults with learning disabilities found it difficult to access Speech and Language Therapy. There are several possible explanations for this. These include:

- people are not being referred because they, their carers or professionals mistakenly think that they would not benefit from an SLT service
- people who perceive themselves as having a need are not referring themselves or being referred because they don't expect to get a service
- people are unsure about what an SLT service can offer
- people do not know how to access the service
- people do not find the service acceptable or suitable for them.

part 6

Organisation and management

38. The service for adults with ASD but no learning disability is not well defined or identifiable. This may be one reason why so few of this client group are referred to SLT. It may also be the case that adults with ASD but no learning disability do not view themselves as having a 'need' or as having a need that requires health input.

39. If this client group does have a need that can be met by SLT then the challenge for these services is to be more creative in finding ways to make themselves visible, accessible and acceptable to adults with ASD but no learning disability. People's needs may be identified through their contact with education, employment and other mainstream services, rather than through health and social care services.

40. Finally, the model of service delivery adopted can have a significant impact on the service's ability to meet the needs of people with learning disabilities and/or ASD. New models, such as Total Communication, require closer investigation.

RECOMMENDATIONS

SPEECH AND LANGUAGE THERAPY FOR ADULTS WITH LEARNING DISABILITIES AND/OR AUTISTIC SPECTRUM DISORDERS

Strategic Planning

a) NHS Boards should review access to therapy for adults with learning disabilities and/or ASD, their families and professionals so that their needs can be better met and unmet needs identified. In doing so they should explore why people with learning disabilities and/or ASD experience difficulty in getting a service, when the level of demand on services does not appear to correspond to anticipated levels of need. [Part 6, paras 21; 35]

b) NHS Boards should ensure that services in which SLT is provided encourage and accept appropriate referrals from adults with ASD but without a learning disability. [Part 6, paras 24-27; 37]

c) NHS Boards and Local Authorities should involve adults with learning disabilities and/or ASD and their families in the planning, delivery and evaluation of services. They should also make sure that the communication needs of adults with learning disabilities and/or ASD are taken account of in Partnership in Practice agreements. Local databases of people with learning disabilities should include information about the communication needs of adults with learning disabilities and/or ASD. [Part 6, para 37]

Supply and Demand

d) NHS Boards should develop and implement flexible employment policies to support the recruitment and retention of relevant staff. [Part 6, paras 11-14]

Service Provision

e) SLT services should review and disseminate information about new developments and innovative practice in therapy for adults with learning disabilities and/or ASD. Particular efforts should be made to provide accessible information to adults with learning disabilities and/or ASD and their families. [Part 6, paras 28-32]

Workforce

f) NHS Boards and other employers in conjunction with HEIs should create opportunities for SLT students and new graduates to gain experience of working with adults with learning disabilities and/or ASD in community settings and in remote and rural areas. [Part 6, para 34]

Research

g) The Scottish Executive should fund comparative research on what models of practice produce good outcomes for adults with learning disabilities and/or ASD. [Part 6, para 40]


Logic Puzzles
Logic Puzzles
Games
Illustration
Puzzles
Listening
Writing
Computer

References

1 Scottish Executive (1999) *The Riddell Advisory Committee Report on Education of Children with Severe Low Incidence Disabilities*. Edinburgh: Scottish Executive.
2 Scottish Executive (2000) *The same as you? A review of services for people with learning disabilities*. Edinburgh: Scottish Executive.
3 General Register for Scotland (GROS) (2002) *2001 Population Report*. Edinburgh: GROS.
4 Scottish Executive Education Department (2002) *Statistical Bulletin Edn/B1/2002/3*. Edinburgh: Scottish Executive.
5 Stalker K (2000) *Supporting Disabled Children and their Families in Scotland: A Review of Policy and Research. Foundations Series N90*. York: Joseph Rowntree Foundation.
6 Joseph Rowntree Foundation (1999) *Supporting Disabled Children and their Families. Foundations Series N79*. York: Joseph Rowntree Foundation.
7 Scottish Executive (2001) *For Scotland's Children: Better Integrated Children's Services*. Edinburgh: Scottish Executive.
8 McGrother, CW and Thorp, CF (1999) *Planning and Research Information to improve services for people with learning disabilities,* Annual Scientific Meeting of the Faculty of Public Health Medicine, Glasgow.
9 Mansell J (1993) *Services for people with learning disability and challenging behaviour and mental health needs: Report of a Project Group*. London: HMSO.
10 Van der Gaag A. (1998) Communication Skills and Adults with Learning Disabilities: Eliminating Professional Myopia. BILD Keynote Reviews, *British Journal of Learning Disabilities,* 26(3), 88-93.
11 Public Health Institute of Scotland (2001) *Autistic Spectrum Disorder. Needs Assessment Report*. Glasgow: PHIS.
12 Scottish Executive (2000) *Standards in Scotland's Schools Etc. Act* Edinburgh: Scottish Executive Education Department.
13 Stalker K and Jones C (1998) Normalisation and critical disability theory. In: Jones D, Blair SEE, Hartery T and Jones RK (eds.) *Sociology and Occupational Therapy. An Integrated Approach*. Edinburgh: Churchill Livingstone.
14 Wolfensberger W (1972) *The principle of normalisation in human services*. Toronto, National Institute on Mental Retardation.
15 O'Brien J (1987) A guide to lifestyle planning: suing the activities catalogue to integrate services and natural support systems. In: Wilcox BW and Bellamy GT (eds.) *The activities catalogue: an alternative curriculum for youth and adults with severe disabilities*. Baltimore, MD: Brookes.
16 Scottish Executive (2001) *Making inclusion in the classroom a reality for Scottish pupils. Press Release SE0029/2001*. Edinburgh: Scottish Executive.
17 *Education (Disability Strategies and Pupils' Educational Records) (Scotland) Act 2002 asp 12*. Edinburgh: HMSO.
18 *Special Needs and Disability Act (2001)* London: HMSO.
19 Scottish Executive (2001) *Assessing our children's educational needs. The Way Forward*. Edinburgh: Scottish Executive.
20 Scottish Executive (2001) *Assessing our children's educational needs. The Way Forward. Scottish Executive Response to the Consultation*. Edinburgh: Scottish Executive.
21 Scottish Executive (1999) *Implementing Inclusiveness: Realising Potential*. Report of the Beattie Committee. Edinburgh: Scottish Executive.
22 Department of Health (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century*. CM 5086. London: HMSO.
23 Information and Statistics Division, NHSiS (1981) *Scottish Health Statistics 1979*, Edinburgh: ISD.
24 Information and Statistics Division, NHSiS (2002) *Scottish Health Statistics 2000*, Edinburgh: ISD.
25 Pope C, Ziebland S and Mays N (2000) *Qualitative research in health care: analysing qualitative data. British Medical Journal* 320: 114-116.
26 Hall E and Social Work Services Inspectorate (2001) *Equipment and Adaptation Services in Scotland: A Survey of Waiting Times for Social Work Provision*. Edinburgh: Scottish Executive Central Research Unit.
27 Scottish Executive (2001) *Staff of Scottish Local Authority Social Work Services, 2000*. Scottish Executive National Statistics Publication. Statistical Bulletin: Social Work Series, SWK/S/2001/23. Edinburgh: Scottish Executive.
28 *Review of Care Management in Scotland,* Scottish Executive Central Research Unit, 2002.
29 ISD (2000) *Professions Allied to Medicine employed by the NHS in Scotland 1990-1999: a Health Briefing*. No. 00/07. Edinburgh: ISD.
30 Scottish Executive (2000) *Our National Health: A Plan for Action, A Plan for Change*. Edinburgh: Scottish Executive.
31 Ritchie P, Christie S and Wilson E (1996) *Population Needs Assessment in Community Care. A Handbook for Planners and Practitioners*. Edinburgh: Social Work Services Inspectorate for Scotland.

32 Scottish Executive (2002) *Planning Together. Final Report of the Scottish Integrated Workforce Planning Group and Response by Scottish Executive Health Department.* Edinburgh: Scottish Executive.
33 Scottish Executive (2002) *Building on Success: Future Directions for the Allied Health Professions in Scotland.* Edinburgh: Scottish Executive.
34 Scottish Executive (2002) *Working for health: the workforce development action plan for NHS Scotland.* Edinburgh: Scottish Executive.
35 Department of Health (2000) *Meeting the Challenge: a strategy for the Allied Health Professions*. London: DoH.
36 Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine (2002) *Nineteenth report on professions allied to medicine CM5346.*
37 Speech and Language Therapy Working Party (1999) *Speech and Language Therapy For Children – Whose Responsibility? A perspective from Speech and Therapists Across Scotland.*
38 Scottish Executive (2000) *A teaching profession for the 21st Century. The McCrone Report.* Edinburgh: Scottish Executive.
39 Scottish Executive (2001) *Patient Focus and Public Involvement.* Edinburgh, Scottish Executive.

appendix A

STEERING GROUP MEMBERS

Mo Grant	Chartered Society of Physiotherapists
Carolyn McDonald	College of Occupational Therapists
Jeanette Cochrane Kim Hartley (attended for 2 meetings)	Royal College of Speech and Language Therapists
Claire Edwards	SNIP (Special Needs Information Point) – parents group
Jim McGregor (until 9/02) David McKenzie	Fife Council (Support Services)
Stephen Iliffe	Highland Council Psychological Service

Scottish Executive:

Mike Gibson, Chair	Additional Support Needs Division
John Bissett	Additional Support Needs Division
Marilyn Barrett	Directorate of Nursing, Health Department
Jackie Mcrae	Women and Children's Unit, Health Department
Ian Kerr	Community Care, Social Work Services Inspectorate

QMUC Consultancy Team:

Professor William Hardcastle	Dean of Research
Dr. Jois Stansfield	Head of Speech and Language Sciences
Chris Jones	Project Manager
Fiona O'May	Researcher

Consultancy team also supported by QMUC internal team including occupational therapy and physiotherapy colleagues

appendix B

Role of Occupational Therapists, Physiotherapists and Speech and Language Therapists with children and people with learning disabilities and/or autistic spectrum disorder

Role of the Occupational Therapist when working with children

1. Within the NHS Paediatric Occupational Therapists are specialists within their field and are trained to work with children with special needs including those with a physical disability, co-ordination and specific learning difficulties, emotional and/or behavioural difficulties, learning disabilities and acute or chronic illness.

2. They can work in a variety of settings: child development centres, nurseries, schools (mainstream and special schools); at home or in hospitals.

3. They may provide assessment and intervention in the following areas:

Motor Abilities: both in gross and fine motor skills, with particular emphasis to developing purposeful hand function, perceptuo-motor abilities and general levels of motor function to aid in daily life skills.

Sensory Skills: how the child processes, interprets and modulates sensory information from the environment (e.g. noise, touch, smells).

Cognitive Skills: perception, concept formation, sequencing, problem solving, memory, attention and motor planning.

Visual Perceptual Skills: figure ground, spatial relations, visual motor integration, form constancy, etc.

Play Skills: exploration and encouragement of specific movement and other skills through play.

Social Skills: inter-personal relationships and practice of social skills in everyday situations.

Home and School: visits – to assess, advise and liaise re: equipment, adaptations, provision of small, personal aids and discussion of progress. Therapy can take place in the home or school setting, dependent on age and needs of the child.

Technology: to aid access to curriculum and communication through technology via liaison with education – either at home or school.

Seating: to promote an optimal seating position to aid function, management and access to environment.

appendix B

Splinting:	hand splinting – both functional and resting to reduce pain and risk of deformity.
Emotional/ Behavioural Skills:	interpersonal relationships, response to illness, development of self esteem/ concept through increased success and increased control of function; liaison and, on occasion, referral to other agencies, e.g. child and adolescent mental health, clinical psychology, educational psychology, etc.
ADL	dressing/undressing, eating, drinking, bathing, toileting, etc. – both in relation to access to, and for, independence skills.

4. Within social work services (and housing) Occupational Therapists work with children with special needs living in the community. They specialise in the assessment and management of problems at home, providing assessment, advice and assistance to carers and families and assessing for and arranging provision of, equipment and adaptations within the home and immediate environment. They also play a key role in terms of housing options and in sourcing specialist and alternative housing when required.

5. In addition they provide a specialist assessment service to Children and Families teams within Social Work Services in terms of the management of 'cared for' children who have special needs including within a fostering and/or adoption setting.

6. They accept direct referrals from a wide range of sources for children with physical disabilities, learning difficulties and, increasingly, behavioural problems. They also deal with children with very profound multiple disabilities.

7. Work with children and families will usually, but not exclusively, take place in the home environment. They may also be asked to advise on environmental adaptation of school and residential environments.

Grading of Occupational Therapy Staff

8. Within the NHS paediatric occupational therapists are employed on a range of grades, but predominantly senior I.

9. The different responsibilities of different grades of staff are dependent largely upon where that therapist works, how they are supported/supervised and a range of competencies within the area of Paediatric Occupational Therapy for example, for clinical skills. A basic grade Occupational Therapist would be able to carry out the occupational therapy process with an appropriate level of guidance and within agreed parameters of practice. A Senior II would be able to practice independently within agreed parameters of practice. A Senior I would be able to select from an extensive range of assessments, implement intervention and reliably predict outcomes.

10. Deciding upon grades of staff may also depend on how the service is delivered for example a hospital-based service may have more flexibility to adopt a wider skill mix in comparison to a community-based (primary care) service in a rural area.

11. Within social work services occupational therapists are employed on local government pay and conditions, as a community occupational therapist or care manager. Although they may work as part of a multidisciplinary social work team, where they are not managed by an occupational therapist they will receive professional support and supervision from a more senior member of the profession.

12. Salary levels between the NHS and social care tend to fluctuate. At the present time these are more favourable to those working in the NHS, although pay and conditions are not the only factors that influence decisions on where to practice.

Role of Occupational Therapy Assistants

13. Within the NHS Paediatric Occupational Therapists increasingly have Occupational Therapy Assistants working alongside them. With the appropriate levels of induction, training and guidance, they can demonstrate sufficient knowledge and competence to implement programmes, particularly in schools, and can contribute to reviewing the child with the Occupational Therapist.

14. Assistants are also used for organising and planning treatment sessions and managing, with supervision, their own time. Assistant posts attract a wide amount of interest from a variety of people with varying skills and knowledge. Most have no formal qualifications relating to working with children but can acquire these as they are in post, if required.

15. Assistants require extensive induction and in-service training programmes which can be run in conjunction with other professions. Employing a broad skill mix, including assistants, depends on there being a sufficient ratio of trained staff to provide adequate training and supervision. Many third-level education facilities offer courses on child development or special educational needs, which would also be of relevance to assistants working in paediatric settings.

16. Although within social work services assistants are employed to work extensively across a range of service areas, the intervention required from an occupational therapist would usually require their specialist expertise, and opportunities to delegate to an assistant may be limited.

17. In Edinburgh and Glasgow HNC course in Occupational Therapy Support are available, usually through a 2-year day release programme. However, securing finance to fund these courses can be difficult.

appendix B

Role of the Physiotherapist when working with children

18. The Paediatric Physiotherapist is concerned with the assessment, treatment and management of children who have a general developmental delay, disorder of movement, disability or illness which will be improved, controlled or alleviated by physiotherapeutic skills and/or the use of specialised equipment.

19. Paediatric Physiotherapists offer treatment for children with problems, caused by neuro-muscular, musculo-skeletal and cardio-vascular/respiratory conditions. Paediatric Physiotherapy covers most of the multiple pathologies which benefit from physiotherapeutic intervention, e.g. cerebral palsy and developmental delay, progressive neuro-muscular disorders, elective and acute orthopaedics, burns and plastic surgery, haematology and oncology, and a wide range or respiratory conditions including intensive care and neonatal care. The Paediatric Physiotherapist requires specialist paediatric core skills and in addition requires to develop skills particular to the different specialities encountered.

20. The Paediatric Physiotherapist has a key role in helping to facilitate a child's maximum attainment. An in-depth knowledge of the physical, emotional, behavioural and social variables of child development is essential. The child is seen in the context of the family who has a key role in the team involved with the child and the Paediatric Physiotherapist is required to balance the child's needs and those of the family and offers support and teaching to the families involved in the child's care.

21. Access to education is important for the children and Paediatric Physiotherapists must be able to participate in this process and distinguish between a child's physiotherapy needs for home and the physiotherapeutic intervention required to enable a child to gain maximum benefit from education. The Paediatric Physiotherapist rarely works in isolation and must be able to work together with other professionals as part of a multidisciplinary and multiagency team. All children referred for physiotherapy are assessed to identify problems which may indicate that physiotherapy is appropriate. Following assessment a treatment plan is drawn up in conjunction with parents and other carers (this may include school staff). This treatment plan should contain goals, which are agreed and understood by the family and other carers. Individual treatment by the physiotherapist is a very small part of a physiotherapy programme and the management plan should reflect the need to incorporate the skills into normal daily activities carried out by carers in all environments.

22. Paediatric Physiotherapists work in a variety of environments including hospitals, clinics, children's homes, nurseries, children's centres and schools. Equipment may be a fundamental part of a child's treatment and management programme. The Paediatric Physiotherapist ensures that any equipment supplied is suitable for the child and the purpose for which it has been supplied. The Paediatric Physiotherapist has a role as an adviser and educator to families, other carers and education staff who are involved in the supply and use of specialised equipment.

23. Physiotherapy can be reactive and proactive. The Paediatric Physiotherapist may be required to respond to an emergency or urgent situation within the hospital setting, the treatment duration being relatively short or there may be referred children who are likely to require treatment over many months or years. Paediatric physiotherapy is offered for as long as the child is at school at which point they are transferred to adult services irrespective of age.

appendix B

Grading of Physiotherapy Staff

24. The majority of paediatric services employ Senior II Physiotherapists upwards. It is considered preferable that Senior II staff should have 1-2 years in the general adult setting in order to consolidate their core skills.

25. Some Senior II staff join the service with little or no paediatric experience and may be taken on in a training role. In multi-speciality settings they will have the opportunity to gain experience on a rotational basis. Senior II staff are responsible for the management of their own caseload but should have an identified Senior I Physiotherapist who provides clinical supervision and training.

26. Senior I physiotherapists have paediatric experience and skills in paediatrics or a paediatric speciality. They are responsible for managing their own caseloads, monitoring other staff's caseloads, taking responsibility for supervising staff within their area of work and teaching and training other physiotherapy staff, students and other health professionals.

27. They offer expert physiotherapy opinion and advice to other health care professionals and families, lecturing in their field of expertise. They are responsible for facilitating the clinical effectiveness agenda within their area of work and undertake managerial support roles.

28. Senior I staff may also undertake a team leader role although in some areas these posts are graded as Superintendent III – this needs to be addressed. This can cause a significant increase in responsibility as their role is to co-ordinate a team within an area, e.g. Acute services, Community services, Special schools or on a geographical or specialty basis.

29. General comment: There is a clear sliding scale of skills, expertise and expected responsibilities from a Senior II upwards. It is advisable that staff working single-handed or without supervision should be in Senior I posts and have the necessary skills to support families and other carers. Equally it is important that there are posts for Senior II staff for succession planning.

Role of Physiotherapy Clinical Support Workers

30. Physiotherapists are ultimately responsible for the physiotherapeutic management of their patients and must take control and responsibility for the proper and appropriate use of assistance within physiotherapy.

31. Physiotherapists will delegate tasks to Physiotherapy clinical support workers depending on their assessed level of competence and evidence of ongoing training. Having achieved an acceptable level of competence Physiotherapy Assistants and Technical Instructors will continue to deliver treatment management programmes specifically detailed and taught by the Physiotherapist responsible for that individual child and family, e.g. repetitive developmental programmes, positioning, respiratory treatment and the provision of equipment. They work closely with the named Physiotherapist and only change treatment programmes under close supervision. They also work in and around hydrotherapy pools and with groups of patients.

appendix B

32. There are four career bands – Physiotherapy Assistant and Technical Instructor 1, 2 and 3. Presently Physiotherapy Assistants require no training/qualifications when they apply or are appointed and this is provided in-house but there is no standard approach.

Role of the Speech and Language Therapist when working with children

33. The ethos of SLT is that it is the right of every child to be able to communicate to the best of their ability. The aims/principles of service delivery are to promote the child's communication and/or eating and drinking skills in order that s/he may achieve optimally:

- in satisfying the child's/other's needs and desires
- in exchanging information
- in using language creatively
- in initiating and maintaining social interaction
- in learning and in participating in education.

34. Children can access SLT from many different routes. Most services operate an open referral system. Following referral, the child will receive a period of assessment. Assessment should lead to a differential diagnosis of the child's difficulties and form the basis for any plan of intervention. Intervention may be carried out by the therapist directly or indirectly, it may also be facilitated by the therapist and carried out by, e.g. a parent. Intervention is the joint responsibility of therapist, child, parent and/or other professionals.

35. Where intervention is carried out by a multi-disciplinary team the programme will be drawn up in conjunction with the other team members and have clearly defined aims and objectives for therapy.

36. Intervention with a child at school or nursery should be planned jointly with education staff to fit in with the child's overall educational programme and address educational issues, including access to the curriculum. Intervention should also include the provision of in-service training to others involved with the child.

37. The child may be discharged from therapy at any point following referral, subsequent to a case management decision to do so. Normally the decision to discharge will be taken by the therapist responsible for the child's care in the light of progress and/or change in performance. Discharge will always be discussed with parent and with child where appropriate.

38. Children can access therapy from birth, e.g. cleft palate, eating/drinking difficulties, Down's syndrome and at any time throughout their school life. The nature of intervention will change with the child's changing needs.

39. Therapy is provided for children who have a difficulty with communication and/or eating and drinking. The list includes:

- developmental speech and language disorders
- dysfluency
- developmental dysthnia
- dyspraxia
- eating and drinking difficulties
- communication impairment relating to an aetiology
- learning difficulty
- physical impairment
- visual impairment
- hearing impairment
- mental health
- autistic spectrum disorder
- traumatic brain injury.

40. Children may be seen in their home, at a clinic, nursery, child development centre or school.

41. Within any group of children, there will exist a continuum of need and an optimum time to deliver therapy. Therapists will use the evidence base to ensure they deliver therapy when it can be most effective.

Grading of Speech and Language Therapy Staff

Band 1: Spine points 18-22 (3-point scale within range)	Qualified SLT practitioner who carries own caseload. Normally has access to a mentor for professional advice and guidance.
Band 2: Spine points 23-33 (3-point scale within range)	Experienced specialist or generalist practitioner who provides training for other professionals. May supervise less experienced staff and mentor newly qualified SLTs. Points 34-35 are available for exceptionally demanding posts.
Band 3: Spine points 36-41 (3-point scale within range)	Systematic and autonomous management of a delegated part of the whole service and/or expert practitioner in a specialty. The major difference for these bands of therapists is their level of skill and expertise in carrying out the job. Band 3 expert practitioners would be expected to have advanced professional qualifications and be a recognised expert within the profession.

appendix B

Band 4: Spine points 40-48 (9-point scale within range)	Head of a whole service or a major part of a service of equivalent size. Substantial relevant experience in the profession and/or required to provide a service of an exceptional high level of expertise and may also be expected to be a significant resource to the wider health care system. Or A SLT who has made, and is continuing to make, a recognised distinguished contribution to the furtherance and practice of SLT.
Band 5: Spine points 41-53 (8-point scale within range)	Consultant Head of Service. Combines both management of a service plus a clinical excellence status.

Role of Speech and Language Therapy Clinical Support Workers

42. SLT clinical support workers work under the direction of a qualified clinician. Clinical support workers are routinely engaged in a wide range of clinical settings with a range of client groups, activities and duties. They carry out individual and group therapy, contribute to assessments, prepare materials and assist in case history taking. As with all members of staff they are required to carry out administrative tasks such as photocopying and arranging clinics.

43. Clinical support workers are not required to complete a qualification before they take up employment. However, they may bring a variety of existing skills or qualifications which can be of direct benefit to the service, e.g. nursery nurse qualifications. Training varies form health and safety courses to more therapy oriented packages, e.g. types of disorders, stages of development. National occupational standards have now been defined. These are the basis of a formal qualification which has been developed within the Scottish Vocational Qualifications Award at level 3.

appendix B

Role of the Speech and Language Therapist when working with adults with learning disabilities and/or autistic spectrum disorder

Principles

44. The key principles that underpin good practice for Speech and Language Therapy provision for adults with learning disabilities are:

- Speech and Language Therapy service delivery needs to be committed to the promotion of independence, choice, inclusion and civil rights.
- Speech and Language Therapy service delivery should consider communication needs in the context of a social model of disability.
- The practical delivery of Speech and Language Therapy services to adults with learning disabilities should be in line and in partnership with local policies, resources and priorities.
- All modalities of communication should be valued, respected and promoted by Speech and Language Therapists. An inclusive communication environment should be facilitated which will allow for the client's specific needs in terms of the format and style of presentation of visual and auditory information.
- The Speech and Language Therapist will recognise the need for respecting quality of life whilst maintaining optimum nutrition and safety during eating, drinking and swallowing.
- Speech and Language Therapy service delivery should maximise service user involvement at all levels, e.g. with regard to Person Centred Planning, consent and advocacy.
- A collaborative approach to service delivery across agencies, professional groups and also across the lifespan of people with learning disabilities is recognised as essential.
- All Speech and Language Therapy intervention must be linked to the life aims of the individual in agreement with identified priorities.
- Speech and Language Therapists need to be committed to contributing to the growing evidence base through reflective practice, research, clinical supervision and clinical networking.

Process for Working with Adults with Learning Disabilities

45. In order for Speech and Language Therapists to maximise the communication and/or eating drinking and swallowing skills of people with learning disabilities, they must deliver their services within the client's wider environment, and work closely with other health and social care professions. Adults with learning disabilities can access Speech and Language Therapy services from many routes. Many people with learning disabilities will require support with their communication or eating, drinking and swallowing skills throughout their lives. Most services operate an open referral system. Therapy will often be provided as episodes of care with clearly identified aims and measurable goals.

appendix B

46. A variety of approaches are likely to be used, and these may include one or more of the following:

- **Assessment and evaluation.** The assessment will take into account the individual's life experience, their communication ability and understanding, their environmental constraints and opportunities and the potential for change. The Speech and Language Therapist will explore communication within the context of different life opportunities for people with learning disabilities and their carers.
- **Intervention** may be direct (individually or in a group), working with the client, and/or indirect, working with the communicative environment. Following a period of intervention, when the identified aims have been achieved, the client will be discharged from therapy but may require further involvement with Speech and Language Therapy throughout his/her life.
- **Providing advice, consultation and co-working with others.** The Speech and Language Therapist may act as a specific resource for issues concerning communication, through involvement with health, education, private and voluntary sectors, the work place, housing, community facilities and involvement with inter-agency initiatives. The purpose of this is to overcome communication barriers, which impact on people's choices, social inclusion, civil rights or independence.
- **Training and teaching.** Speech and Language Therapists play a pivotal role in communication training for other professional and carers.
- **Service development.** Speech and Language Therapists can take a proactive role in highlighting the communication issues inherent in delivering high quality services for people with learning disabilities.

Service level

47. In order to be effective the Speech and Language Therapist working in the field of adult learning disability will be involved in providing a service at three levels. The level of the:

- **Person –** intervention is based on addressing communication skills through individual work.
- **Environment –** where there are changes in people, processes or settings within a person's (or group of people's) environment, which will increase the individual's inclusion in social networks.
- **Community –** where the level of communication activity for adults with learning disabilities can be increased through attitudinal or cultural changes within the local community.

appendix B

Role of Further and Higher Education in the supply of therapists and clinical support workers into the workforce

48. Four Higher Education Institutions in Scotland provide pre-registration education and training to those wishing to train as Speech and Language Therapists, Occupational Therapists and Physiotherapists. The following routes to professional registration are available:

Occupational Therapy

49. Under-graduate pre-registration education in OT is available at Glasgow Caledonian University, Queen Margaret University College and Robert Gordon University. All offer a 4-year BSc honours route and GCU and QMUC offer a 3-year BSc route.

50. GCU and QMUC also offer pre-registration education to people who already have a first degree. These post-graduate courses last between 2 years and 27 months when full-time or 3½ years when part time.

Physiotherapy

51. Under-graduate pre-registration education in PT is available at Glasgow Caledonian University, Queen Margaret University College and Robert Gordon University. All offer a 4-year BSc honours route.

52. All three institutions also offer pre-registration education to people who already have a first degree. These post-graduate courses all take 2 years to complete on a full-time basis.

Speech and Language Therapy

53. Under-graduate pre-registration education in SLT is available at Queen Margaret University College and Strathclyde University. Both offer a 4-year BSc honours route and Strathclyde University offer a 3-year BSc route.

54. There is no post-graduate education of SLTs in Scotland.

Funding of post-graduate education

55. In Scotland, unlike England, a post-graduate student is not eligible to have course fees paid and has to fund the course him/herself.

appendix C

Establishment of NHS Occupational Therapy, Physiotherapy and Speech and Language Therapy posts providing a service to children in Scotland

Table 1: NHS paediatric and generic OT posts providing a service to children in Scotland

	WTE paediatric OT posts	WTE generic OT posts	TOTAL
State registered therapists	136.92	0.30	**137.22**
Clinical support workers	10.29	0.69	**10.98**
TOTAL	**147.21**	**0.99**	**148.2**

Table 2: NHS paediatric and generic PT posts providing a service to children in Scotland

	WTE paediatric PT posts	WTE generic PT posts	TOTAL
State-registered therapists	161.56	4.04	**165.60**
Clinical support workers	20.35	0.2	**20.55**
TOTAL	**181.91**	**4.24**	**186.15**

Notes:
Borders Acute NHS Trust figures exclude staff members who provide 'on call' service to adults and generic post figures are approximate.
Grampian – PCT were unable to estimate time generic staff dedicate to children and so generic post data is for Acute Trust only.
Tayside – Data for Child Health services and service at Ninewells. PCT figures not supplied.

Table 3: NHS paediatric and generic SLT posts providing a service to children in Scotland

	WTE paediatric SLT posts	WTE generic SLT posts	TOTAL
State-registered therapists	452.10	68.74	**520.84**
Clinical support workers	61.45	7.15	**68.60**
TOTAL	**513.55**	**75.89**	**589.44**

Notes:
Tayside – Figures for acute trust only including Ninewells Hospital and Centre for Child Health. Data for PCT missing.

appendix D

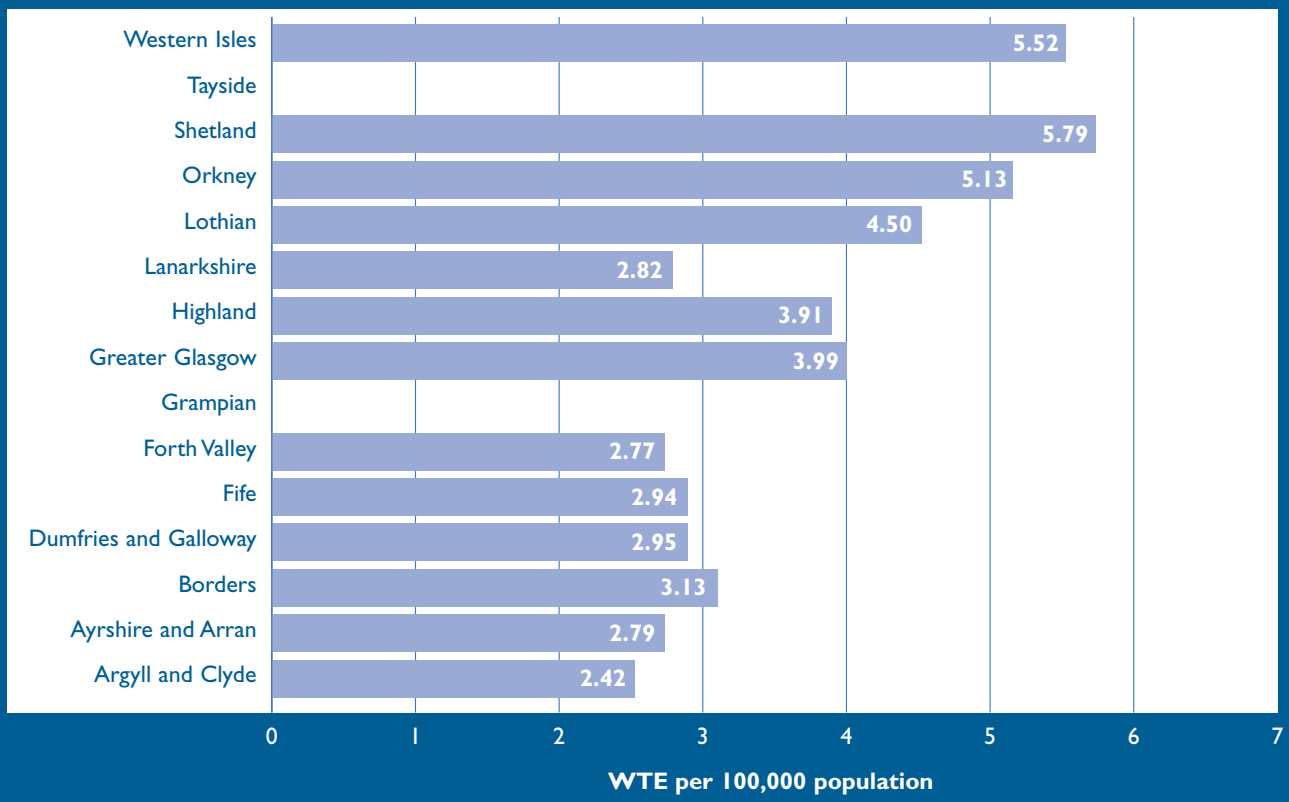
Establishment of NHS OT, PT and SLT posts providing a service to children in each NHS Board area per 100,000 population

Table 1: Numbers of NHS posts for state registered OTs providing a service to children per 100,000 population

Notes:
Population figures based on GROS mid-year estimates for 2000.
Mean = 3.11 posts per 100,000 population.

appendix D

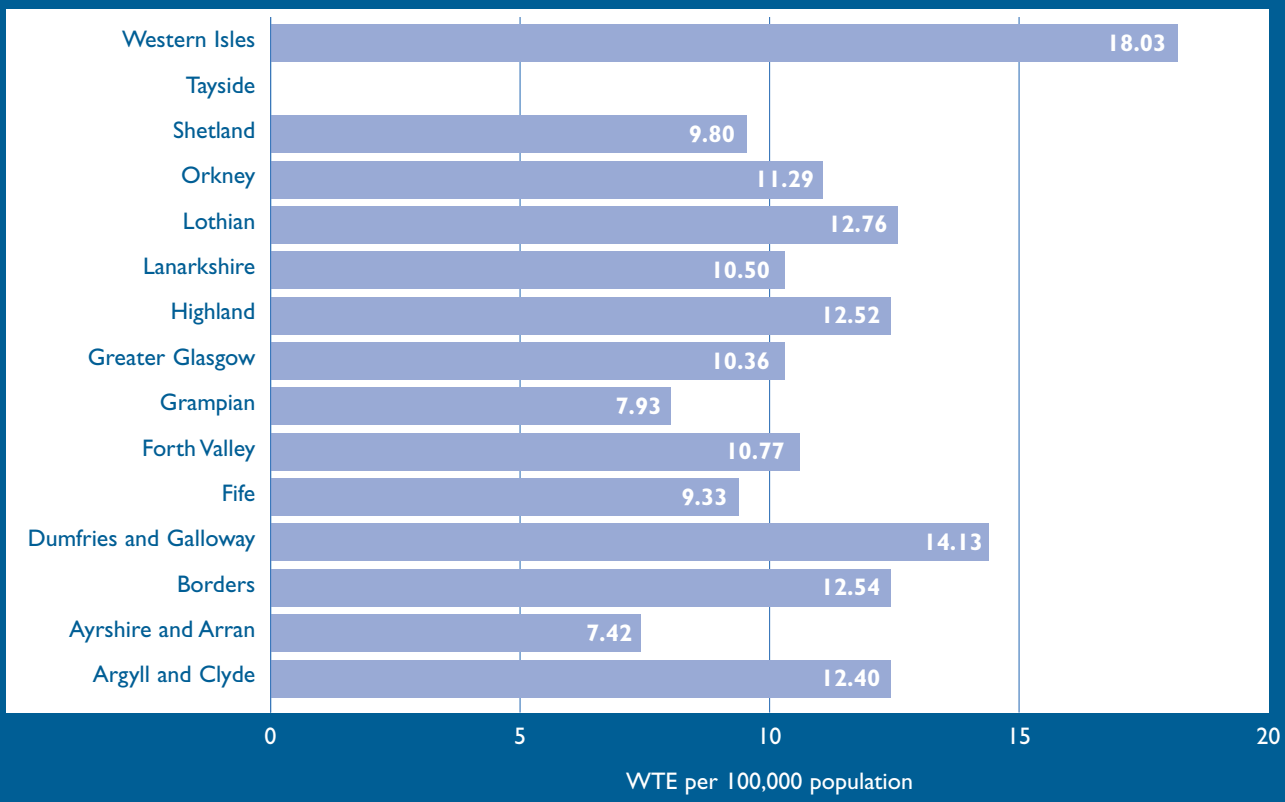
Table 2: Numbers of NHS posts for state registered PTs providing a service to children per 100,000 population



Notes:
Population figures based on GROS mid-year estimates for 2000.
Grampian – PCT were unable to estimate time generic staff dedicate to children and so generic post data are for Acute Trust only.
Tayside – Data for Child Health services and service at Ninewells available only. PCT figures not supplied.
Mean = 3.74 posts per 100,000 population.

appendix D

Table 3: Numbers of NHS posts for state registered SLTs providing a service to children per 100,000 population

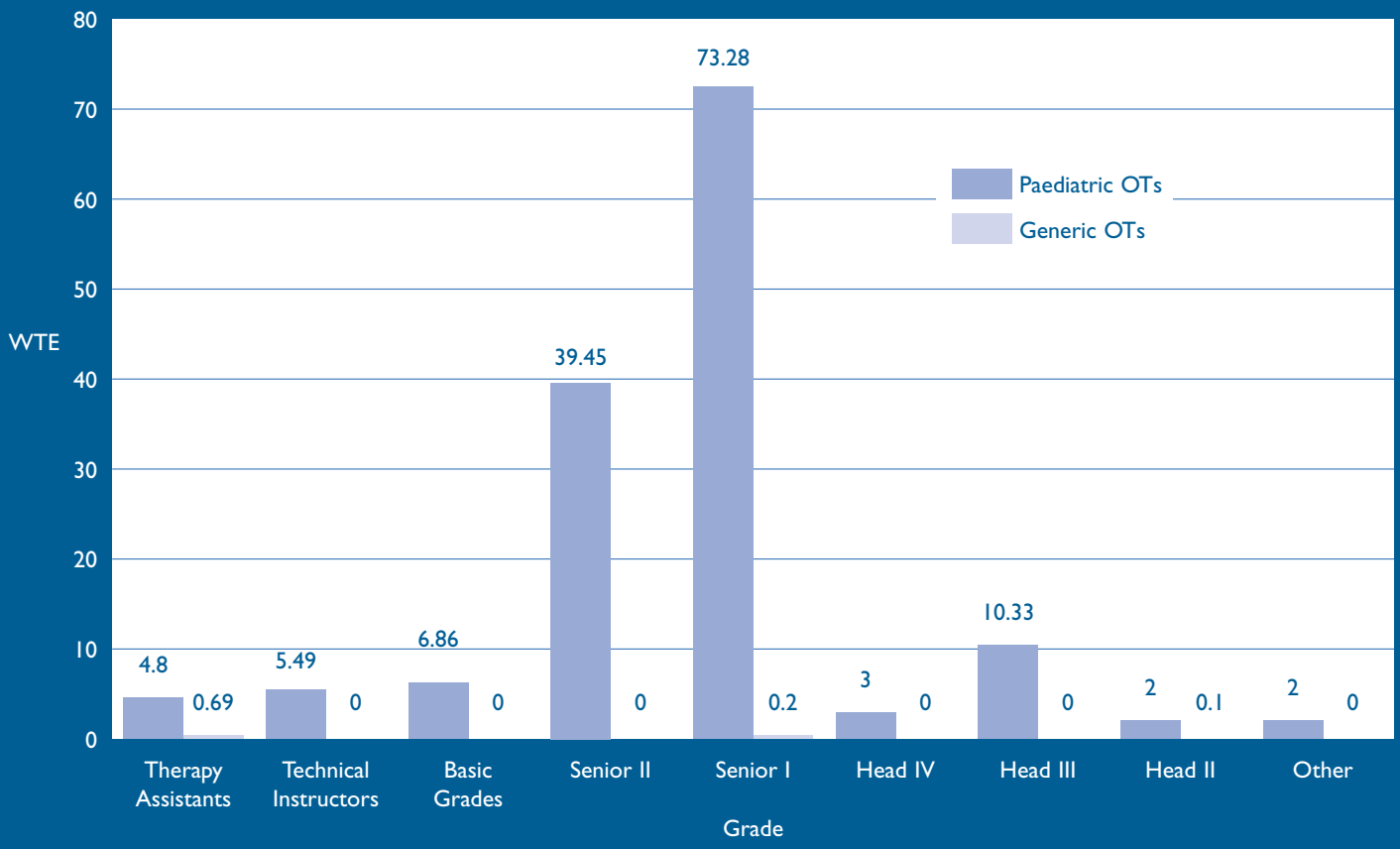


Notes:
Population figures based on GROS mid-year estimates for 2000.
Tayside – Data for Child Health services and service at Ninewells only available. PCT figures not supplied.
Mean = 10.5 posts per 100,000 population.

appendix E

Grades of NHS OT, PT and SLT posts providing a service to children and salary costs

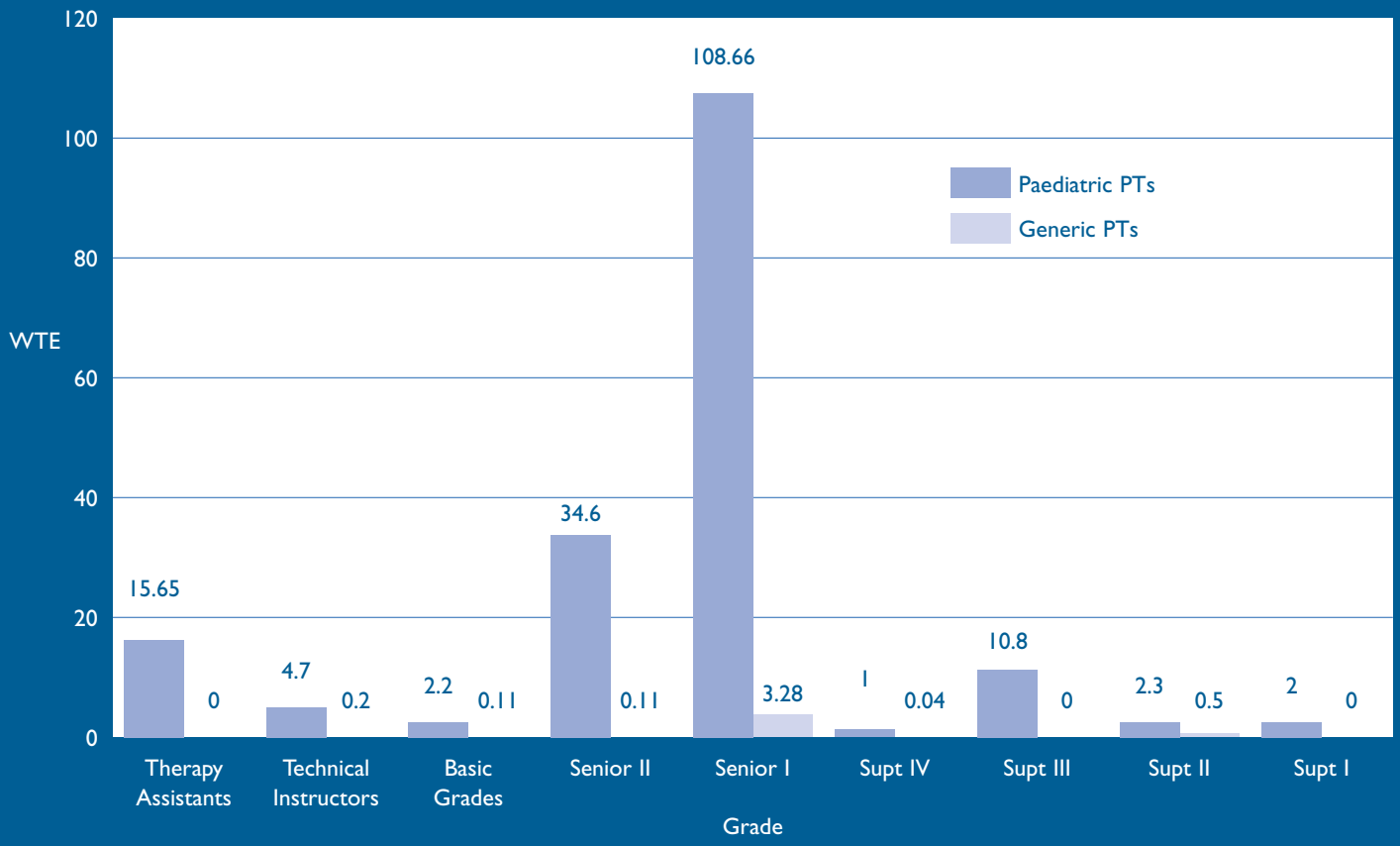
Table 1: Grades of paediatric and generic NHS OT posts established to provide a service to children in Scotland



Notes:
Head III is clinical specialist post in Fife, the first in Scotland in paediatric OT.
Other = Professional Head OT in Greater Glasgow and Head I in Lothian University Hospitals Trust.

See Appendix B for description of grades, bands and responsibilities.

Table 2: Grades of paediatric and generic NHS PT posts established to provide a service to children in Scotland

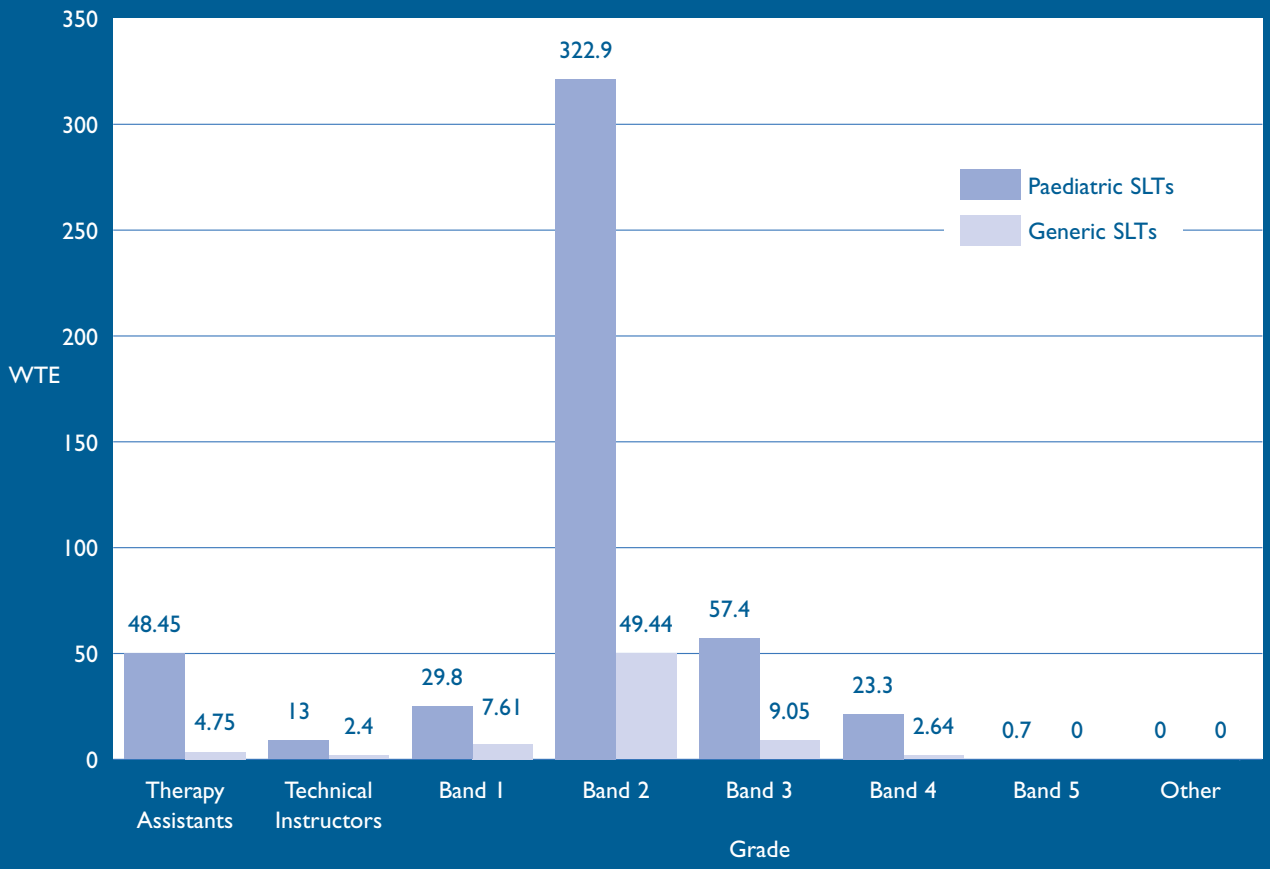


Notes:
These figures are likely to be slightly underestimated as:
Borders Acute NHS Trust figures exclude staff members who provide 'on call' service to adults and children proportional figures are approximate.
Grampian – PCT were unable to estimate time generic staff dedicate to children and so generic post data are for Acute Trust only.
Tayside – Data for Child Health services and service at Ninewells. PCT figures missing.

See Appendix B for description of grades, bands and responsibilities.

appendix E

Table 3: Grades of paediatric and generic NHS SLT posts established to provide a service to children in Scotland



Notes:
These figures are likely to be slightly underestimated as:
Lothian – figures for Lothian University Hospitals Trust only as a breakdown on West Lothian figures by grade was unavailable.
Tayside – Figures for acute trust only including Ninewells Hospital and Centre for Child Health. Data for PCT missing.
Three of the technical instructors are grade 3 bilingual co-workers in Greater Glasgow.

See Appendix B for description of grades, bands and responsibilities.

appendix F

Estimated cost of salaries for NHS OTs, PTs and SLTs working with children

Table: 1 Grades of therapy staff and associated salary costs

Grades of OT staff	Total generic and paediatric posts	Salary costs
Helper	5.49	£62,529
TI	5.49	£84,162
Basic Grade	6.86	£123,892
Senior II	39.65	£830,073
Senior I	73.28	£1,792,612
Head IV	3.00	£73,388
Head III	10.33	£272,815
Head II	2.10	£59,924
Head I	2.00	£62,960
Total cost	**148.20**	**£3,362,353**

Grades of PT staff	Total generic and paediatric posts	Salary costs
Helper	15.65	£178,410
TI	4.90	£75,117
Basic Grade	2.31	£41,719
Senior II	34.71	£726,654
Senior I	111.94	£2,738,332
Head IV	1.04	£25,441
Head III	10.80	£285,228
Head II	2.80	£79,898
Head I	2.00	£62,960
Total cost	**186.15**	**£4,213,759**

Grades of SLT staff	Total generic and paediatric posts	Salary costs
TA	53.20	£596,000
TI	15.40	£236,082
Band 1	37.41	£638,888
Band 2	372.34	£8,703,075
Band 3	66.45	£2,345,054
Band 4	25.94	£1,135,653
Band 5	0.70	£34,472
Total cost	**571.44**	**£13,689,223**

Notes:
Salary scales are at April 2002.
Median calculations for state registered grades do not include discretionary points.
SLT posts exclude 18 posts in West Lothian – no breakdown of grades available.

appendix G

Vacancy rates in NHS OT, PT and SLT posts providing a service to children

Table 1: WTE vacant posts for paediatric OTs

NHS Board Area	Establishment of state-registered paediatric OT posts	Vacancies state-registered paediatric OT posts	Vacancy Rate
Argyll and Clyde	7.6	1.5	20%
Ayrshire and Arran	7.9	0.5	6%
Borders Area	3.5	1	29%
Dumfries and Galloway	4.37	0.86	20%
Fife	12.2	0	0
Forth Valley	6	1	17%
Grampian	13.45	1	7%
Greater Glasgow	16.4	1.5	9%
Highland	5	0	0
Lanarkshire	12.7	0.5	4%
Lothian	31.4	1	3%
Orkney	1	0	0
Shetland	1	0	0
Tayside	13.4	1.5	11%
Western Isles	1	0	0
Totals	**136.92**	**10.36**	

Notes :
NB – These figures are vacancies in dedicated paediatric posts only. There are no figures available for vacancies in generic posts.
Mean vacancy rate = 8%.

Table 2: WTE vacant posts for paediatric PTs

NHS Board Area	Establishment of state-registered paediatric PT posts	Vacancies state-registered paediatric PT posts	Vacancy Rate
Argyll and Clyde	9.2	2	22%
Ayrshire and Arran	10.4	0	0
Borders Area	2.8	0	0
Dumfries and Galloway	4	1	25%
Fife	9.6	0	0
Forth Valley	7.7	0	0
Grampian	11.3	0	0
Greater Glasgow	36.1	9.5	26%
Highland	7.3	1	14%
Lanarkshire	15.76	1.58	10%
Lothian	35.3	1.6	5%
Orkney	1	0	0
Shetland	1.3	0.8	62%
Tayside	8.8	0.4	5%
Western Isles	1	1	100%
Totals	**161.56**	**18.88**	

Notes:
NB – These figures are vacancies in dedicated paediatric posts only. There are no figures available for vacancies in generic posts.
Greater Glasgow – 5 vacancies are for temporary Superintendent III posts.
NHS Tayside – Data for Child Health services and service at Ninewells in Acute Trust only. PCT figures missing.
Mean vacancy rate = 18%.

appendix G

Table 3: WTE vacant posts for paediatric SLTs

NHS Board Area	Establishment of state-registered paediatric SLT posts	Vacancies state-registered paediatric SLT posts	Vacancy Rate
Argyll and Clyde	43.6	12.3	28%
Ayrshire and Arran	10.8	1	9%
Borders Area	9.9	3.0	30%
Dumfries and Galloway	18	2	11%
Fife	32.2	0	0
Forth Valley	23.7	2	8%
Grampian	40.8	6	15%
Greater Glasgow	90.7	8	9%
Highland	12.2	2	16%
Lanarkshire	51.2	4.4	9%
Lothian	99	5.6	6%
Orkney	0.4	0	0
Shetland	0	0	0
Tayside	17.4	0.5	3%
Western Isles	2.2	0	0
Totals	**452.1**	**46.8**	

Notes:
NB – These figures are vacancies in dedicated paediatric posts only. There are no figures available for vacancies in generic posts.
Tayside – Figures for acute trust only including Ninewells Hospital and Centre for Child Health. Data for PCT missing.
Mean vacancy rate = 10%.

appendix H

Demand for Occupational Therapy, Physiotherapy and Speech and Language Therapy for children

Table 1: Demand for OTs employed in NHS for children in 2001/2

	Numbers of children
Children referred to OT in Scotland 2001/2	4093
Children discharged from OT in Scotland in 2001/2	3237
Children who were current cases of OTs in Scotland in April 2002	6903
Children who were waiting to see an OT in Scotland in April 2002	1809

Notes:
Highland, Lanarkshire and Shetland – all figures are estimated.
Argyll and Clyde – Lomond and Argyll PCT discharge figures are estimated.
Borders – discharge figures are estimated.
Grampian – Grampian University Hospitals Trust referrals are for Children's Hospital only and do not include child development teams. Grampian University Hospitals Trust current cases are estimated.
Grampian discharge figures are for Moray only.
Highland – discharge figures were unavailable.
Tayside – discharge figures are for Perth and Kinross LHCC only.

Table 2: Demand for NHS PT for children in 2001/2

	Numbers of children
Children referred to PT in 2001/2	10,078
Children discharged from PT in 2001/2	6015
Children who were current cases of PTs in April 2002	8794
Children who were waiting to see a PT in April 2002	300

Notes:
Argyll and Clyde – Acute Trust waiting list figures for in-patients at Royal Alexandria Hospital not included.
Borders – Acute Trust waiting list figures were unavailable.
Grampian – all figures provided by the Primary Care Trust are not compehensive.
Greater Glasgow – referrals from schools have not been provided, numbers of current acute cases have not been provided, figures for waiting list refer to CDC team only.
Highland – all figures are for Acute Trust only – figures from Primary Care Trust unavailable.
Lanarkshire – all figures provided by the Primary Care Trust are not compehensive. The Primary Care Trust discharge figures are incomplete. Acute Trust waiting list figures were unavailable.
Shetland – all figures were unavailable.
Tayside – Data for Child Health services and Ninewells service in Acute Trust only. Primary Care Trust data were unavailable.

appendix H

Table 3: Demand for NHS SLT for children in 2001/2

	Numbers of children
Children referred to SLT in 2001/2	16,031
Children discharged from SLT in 2001/2	10,912
Children who were current cases of SLTs in April 2002	40,591
Children who were waiting to see a SLT in April 2002	3472

Notes:
Argyll and Clyde – Renfrewshire and Inverclyde PCT referral figures are for 2000/1.
Highland – Referral, current case and discharge information unavailable.
Lothian – Lothian University Hospitals Trust waiting list figures are for Edinburgh only and so exclude East Lothian and Midlothian.
Orkney – all children on the waiting list are awaiting therapy.
Shetland current cases figures are estimated.
Tayside – All figures for acute trust only including Ninewells Hospital and Centre for Child Health. Data for Primary CareTrust were unavailable.
Western Isles – All figures are all estimated.

Table 4: Demand for OTs in Local Authority services for children in 2001/2

	Numbers of children
Children referred to LA OT in 2001/2	1143
Children discharged from LA OT in 2001/2	720
Children who were current cases of LA OTs in April 2002	884
Children who were waiting to see a LA OT in April 2002	116

Notes:
Referral figures are for 18 Local Authorities.
Discharge figures are for 15 Local Authorities.
Current cases are in 20 Local Authorities.
Waiting list figures are for 22 Local Authorities.

Numbers of children referred to NHS OT, PT and SLTs in 2001/2

Table 1: Numbers of children referred to NHS OT in 2001/2 and rate per WTE state registered OT post

NHS Board Area	Referrals in 2001/02	WTE OT posts for state registered staff	Referral rate per WTE state registered OT
Shetland	65	1	**65**
Borders Area	192	3.5	**55**
Dumfries and Galloway	160	4.37	**37**
Lothian	1148	31.4	**37**
Argyll and Clyde	270	7.6	**36**
Forth Valley	200	6	**33**
Highland	150	5	**30**
Fife	357	12.2	**29**
Tayside	382	13.4	**29**
Lanarkshire	350	12.7	**28**
Greater Glasgow	430	16.4	**26**
Western Isles	31	1.3	**24**
Ayrshire and Arran	185	7.9	**23**
Orkney	14	1	**14**
Grampian	159	13.45	**12***

Notes:
* denotes missing figures – these data should be treated with caution.
Grampian – Grampian University Hospitals Trust referrals are for Children's Hospital only and do not include child development teams.
Highland, Lanarkshire and Shetland referral figures are estimated.

Table 2: Numbers of children referred to NHS PT in 2001/2 and rate per WTE state registered PT post

NHS Board Area	Referrals in 2001/02	WTE PT posts for state registered staff	Referral rate per WTE state registered PT
Borders	593	3.35	177
Grampian	1228	11.30	109*
Forth Valley	645	7.70	84
Argyll & Clyde	839	10.24	82
Lothian	2534	35.30	72
Ayrshire and Arran	682	10.40	66
Dumfries and Galloway	274	4.30	64
Fife	640	10.30	62
Tayside	461	8.80	52*
Greater Glasgow	1760	36.10	49*
Highland	199	8.15	24*
Western Isles	26	1.50	17
Lanarkshire	189	15.86	12*
Orkney	8	1.00	8
Shetland	-	1.30	-

Notes:
* denotes missing figures – these data should be treated with caution.
Grampian – referral figures provided by the Primary Care Trust are not comprehensive.
Greater Glasgow – referral figures are for CDC and acute service only – referrals from schools have not been provided.
Highland – referral figures are for Acute Trust only – figures from Primary CareTrust were unavailable.
Lanarkshire – referral figures provided by the Primary Care Trust are not comprehensive.
Shetland referral figures were unavailable.
Tayside – Data for Child Health services and Ninewells service in Acute Trust only. Primary Care Trust data were unavailable.

There were some differences between the referral patterns in acute settings and community settings. In acute services, a relatively small number of posts provide a service to a relatively large number of children. For example, in Fife, the acute service received 40 child referrals in 2001/2 and have the equivalent of 0.2 posts to provide this service. This gives a referral rate of 200 children per WTE post. The community paediatric service received 600 referrals in 2001/2 and have 10.1 posts to provide this service. This gives a referral rate of 59 children per WTE post. However, the nature of the work undertaken by therapists in acute settings and community settings is very different, community work being more long term. This is just one factor affecting referral rates per WTE.

Table 3: Numbers of children referred to NHS SLT in 2001/2 and rate per WTE state registered SLT post

NHS Board Area	Referrals in 2001/02	WTE SLT posts for state registered staff	Referral rate per WTE state registered SLT
Orkney	230	2.2	**105**
Grampian	2505	41.5	**60**
Borders Area	527	13.4	**39**
Lanarkshire	2285	59	**39**
Tayside	671	17.4	**39**
Ayrshire and Arran	1000	27.7	**36**
Lothian	3559	100	**36**
Argyll and Clyde	1719	52.5	**33**
Shetland	72	2.2	**33**
Dumfries and Galloway	597	20.6	**29**
Forth Valley	851	29.9	**28**
Greater Glasgow	1475	90.7	**16**
Fife	499	32.7	**15**
Western Isles	41	4.9	**8**
Highland	-	-	**-**

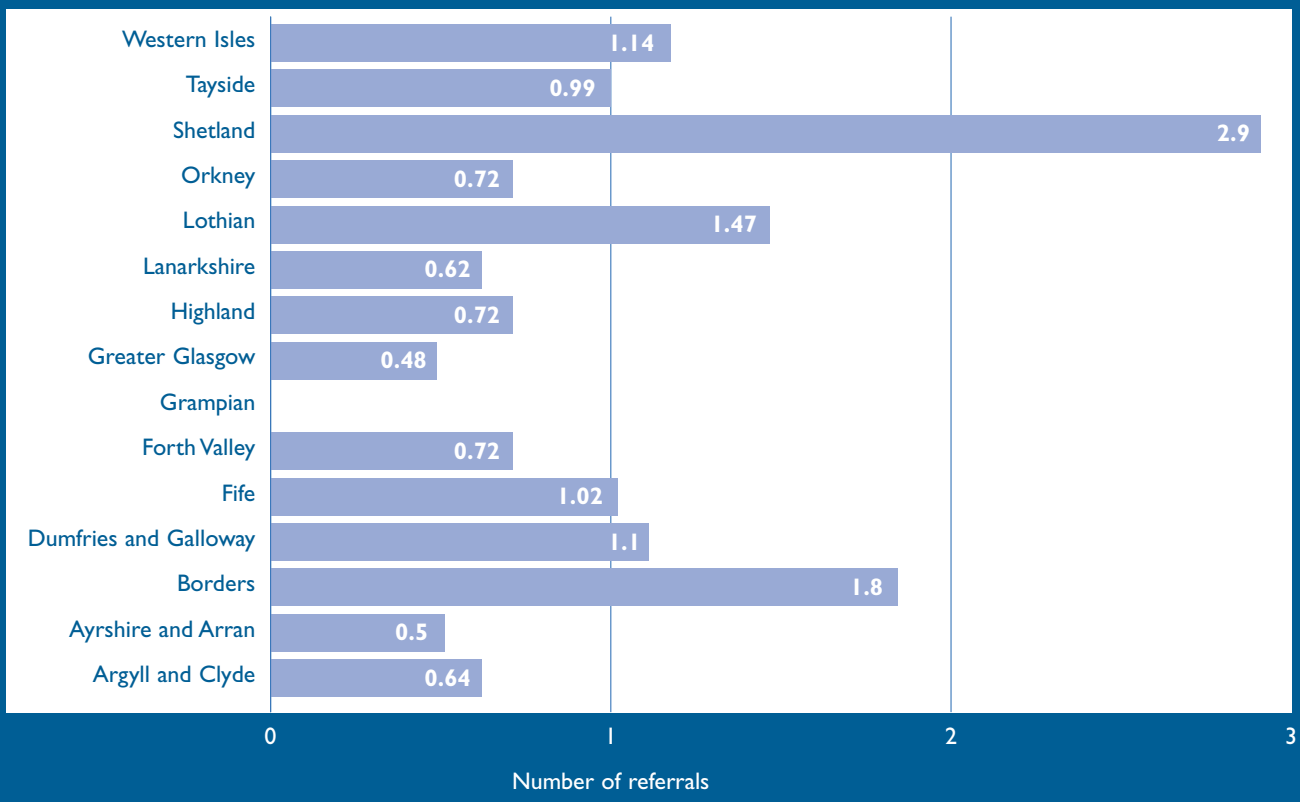
Notes:
Argyll and Clyde – Renfrewshire and Inverclyde PCT figures are for 2000/1.
Highland – Information was unavailable.
Tayside – Figures for acute trust only including Ninewells Hospital and Centre for Child Health. Data for Primary Care Trust were unavailable.
Western Isles figures are all estimated.

Table 4: Numbers of children referred to Local Authority services in which OTs work in 2001/2

Local Authority	Referrals in 2001/2
City of Aberdeen	68
Aberdeenshire	22
Angus	32
Argyll & Bute	122
Borders	-
Clackmannan	37
Dumfries & Galloway	-
City of Dundee	-
East Ayrshire	73
East Dunbartonshire	29
East Lothian	-
East Renfrewshire	71
Edinburgh (City of)	-
Falkirk	34
Fife	112
Glasgow (City of)	-

Local Authority	Referrals in 2001/2
Highland	30
Inverclyde	127
Midlothian	58
Moray	28
North Ayrshire	20
North Lanarkshire	-
Orkney Islands	0
Perthshire & Kinross	-
Renfrewshire	-
Shetland Isles	-
South Ayrshire	-
South Lanarkshire	159
Stirling	28
West Dunbartonshire	-
West Lothian	93
Western Isles	-
Total	**1143**

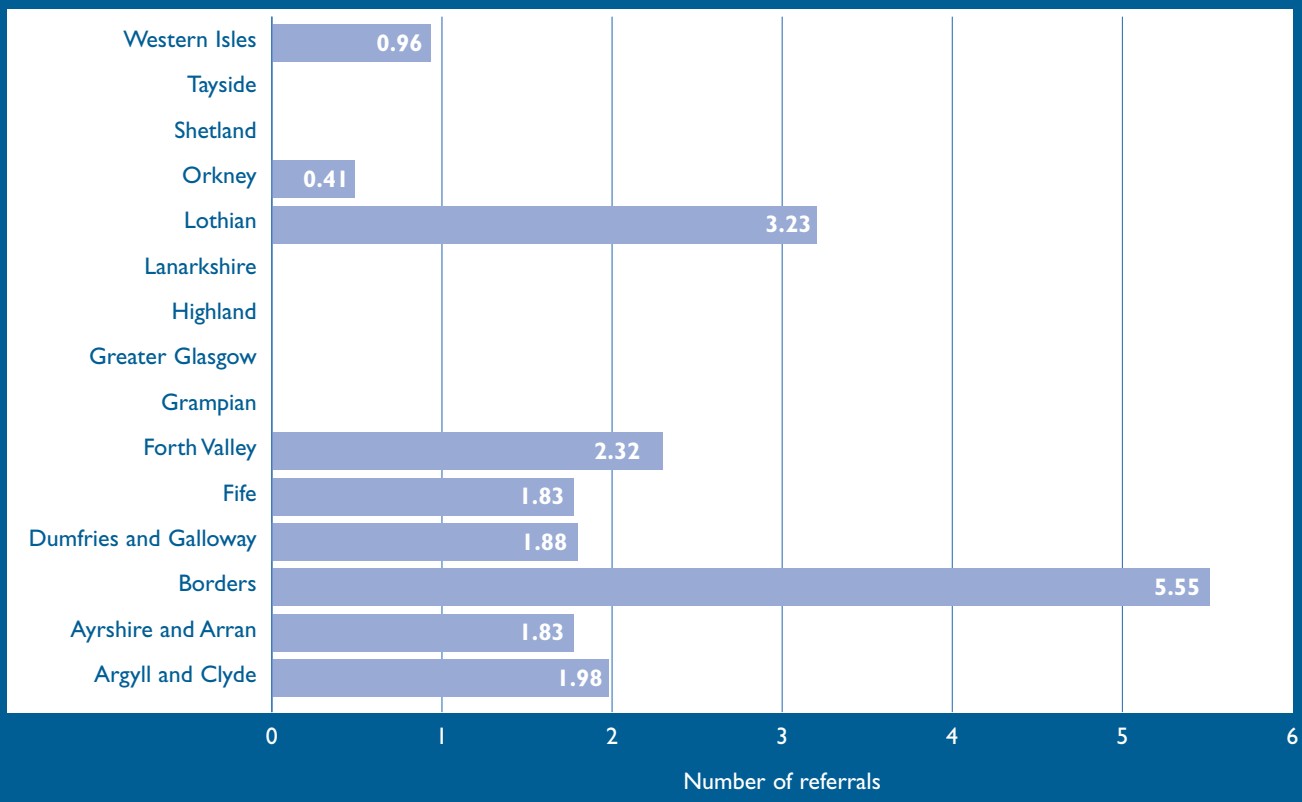
Table 5: Numbers of children referred to NHS OT per 1000 population



Notes:
Population figures based on GROS mid-year estimates for 2000.
Highland, Lanarkshire and Shetland referral figures are estimated.
Grampian has not been included in this graph as Grampian University Hospitals Trust referrals were for Children's Hospital only and did not include child development teams.
Mean = 1.01 referrals per 1000 population.

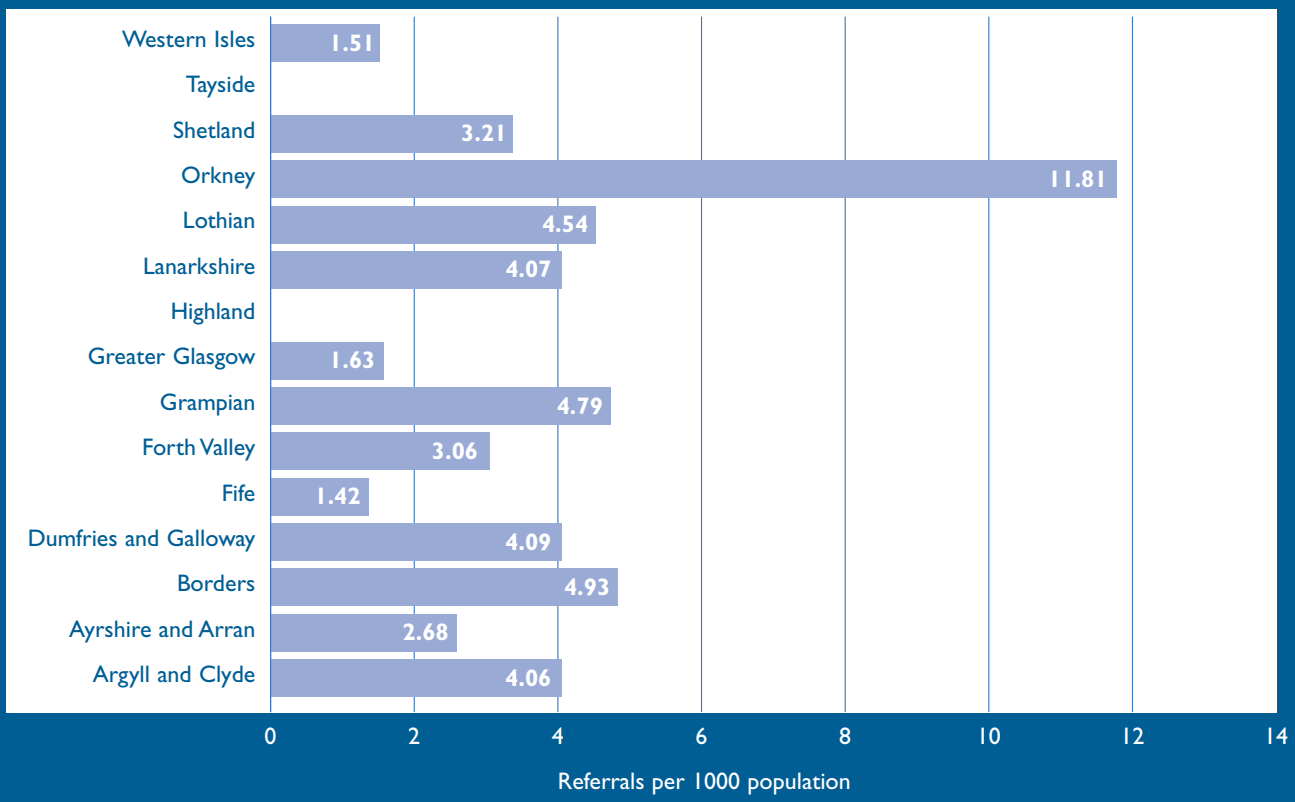
appendix

Table 6: Numbers of children referred to NHS PT per 1000 population



Notes:
Population figures based on GROS mid-year estimates for 2000.
Figures have not been included when data are missing or incomplete.
Grampian – referral figures provided by the Primary Care Trust are not comprehensive.
Greater Glasgow – referral figures are for CDC and acute service only – referrals from schools have not been provided.
Highland – referral figures are for Acute Trust only – figures from Primary Care Trust were unavailable.
Lanarkshire – referral figures provided by the Primary Care Trust are not comprehensive.
Shetland referral figures were unavailable.
Tayside – Data for Child Health services and Ninewells service in Acute Trust only. PCT data were unavailable.
Mean = 2.22 referrals per 1000 population.

Table 7: Numbers of children referred to NHS SLT per 1000 population



Notes:
Population figures GROS mid year estimates for 2000.
Argyll and Clyde – Renfrewshire and Inverclyde PCT figures are for 2000/1.
Highland – Information unavailable.
Tayside have not been included as figures available are for acute trust only including Ninewells Hospital and Centre for Child Health. Data for Primary Care Trust were unavailable.
Western Isles figures are estimated.
Mean = 4.05 referrals per 1000 population.

appendix J

Numbers of children on NHS OT, PT and SLT waiting lists in April 2002.

Table 1: Numbers of children on NHS OT waiting lists in April 2002.

NHS Board Area	No. of children currently waiting	No. waiting per WTE	Longest current wait in weeks
Argyll and Clyde	123	16.2	104
Ayrshire and Arran	81	10.3	52
Borders	34	9.7	3
Dumfries and Galloway	63	14.4	28
Fife	190	15.6	64
Forth Valley	240	40	2.5
Grampian	165	12.3	36
Greater Glasgow	327	19.9	83
Highland	176	35.2	104
Lanarkshire	200	15.7	50
Lothian	53	1.7	15
Orkney	8	8	24
Shetland	3	3	4
Tayside	118	8.8	56
Western Isles	28	21.5	33
Totals	**1809**		

Notes:
NHS Argyll and Clyde – Longest wait in Renfrewshire and Inverclyde PCT is 52 weeks. Longest wait in Lomond and Argyll PCT is 104 weeks. The latter results from a waiting list inherited from a previously contracted out service.
Grampian – Grampian University Hospitals Trust longest wait is 32 weeks. Moray longest wait is 36 weeks.
Lothian – Lothian University Hospitals Trust longest wait is 11 weeks. West Lothian NHS Trust longest wait is 15 weeks.
Tayside – Perth and Kinross LHCC longest wait is 40 weeks. Tayside University Hospitals Trust longest wait is 56 weeks.

Table 2: Numbers of children on NHS PT waiting lists in April 2002.

NHS Board Area	No. of children currently waiting	No. waiting per WTE	Longest current wait in weeks
Argyll and Clyde	46	4.5	20
Ayrshire and Arran	0	0	-
Borders	20	6	10
Dumfries and Galloway	5	1.2	28
Fife	10	1	4
Forth Valley	66	8.6	60
Grampian	18	1.6	4
Greater Glasgow	28	0.8	16
Highland	1	0.1	6
Lanarkshire	38	2.4	20
Lothian	62	1.8	18
Orkney	0	0	0
Shetland	-	-	-
Tayside	6	0.7	7
Western Isles	0	0	0
Totals	**300**		

Notes:
Argyll & Clyde – Acute Trust waiting list figures for in-patients at Royal Alexandria Hospital not included.
Borders – Acute Trust waiting list figures were unavailable.
Dumfries & Galloway – waiting list data for Primary Care Trust only as acute trust has no waiting list as inpatients only.
Grampian – waiting list figures provided by the Primary Care Trust are not comprehensive.
Greater Glasgow – figures for waiting list refer to CDC team only.
Highland – waiting list figures are for Acute Trust only – figures from Primary Care Trust were unavailable.
Lanarkshire – waiting list figures provided by the Primary Care Trust are not comprehensive. Acute Trust figures were unavailable.
Shetland waiting list figures were unavailable.
Tayside – waiting list figures for Child Health services and Ninewells service in Acute Trust only. Primary Care Trust data were unavailable.

appendix J

Table 3: Numbers of children on NHS SLT waiting lists in April 2002.

NHS Board Area	No. of children currently waiting	No. waiting per WTE	Longest current wait in weeks
Argyll and Clyde	337	6.4	31
Ayrshire and Arran	70	2.5	11
Borders	146	10.9	20
Dumfries and Galloway	0	0	6
Fife	171	5.2	13
Forth Valley	397	13.3	49
Grampian	1234	29.7	40
Greater Glasgow	548	6	50
Highland	50	1.9	10
Lanarkshire	557	9.4	9
Lothian	191	1.9	33
Orkney	53	24.1	32
Shetland	5	2.3	6
Tayside	50	2.9	6
Western Isles	0	0	6
Totals	**3472**		

Notes:

Argyll and Clyde – longest wait in Lomond and Argyll PCT is 30 weeks and in Renfrewshire and Inverclyde PCT is 24 weeks.

Grampian waiting list figures made up of 21 waiting in UHT and 1213 waiting in PCT. Longest wait is 40 weeks in Primary Care Trust but only 5 weeks in the Acute Trust.

Lothian – Figure of 191 includes 165 in Edinburgh and 26 in West Lothian. Lothian University Hospitals Trust figures are for Edinburgh only and so exclude East Lothian and Midlothian. Longest wait is 33 weeks in the Lothian University Hospitals Trust in and 22 weeks in West Lothian.

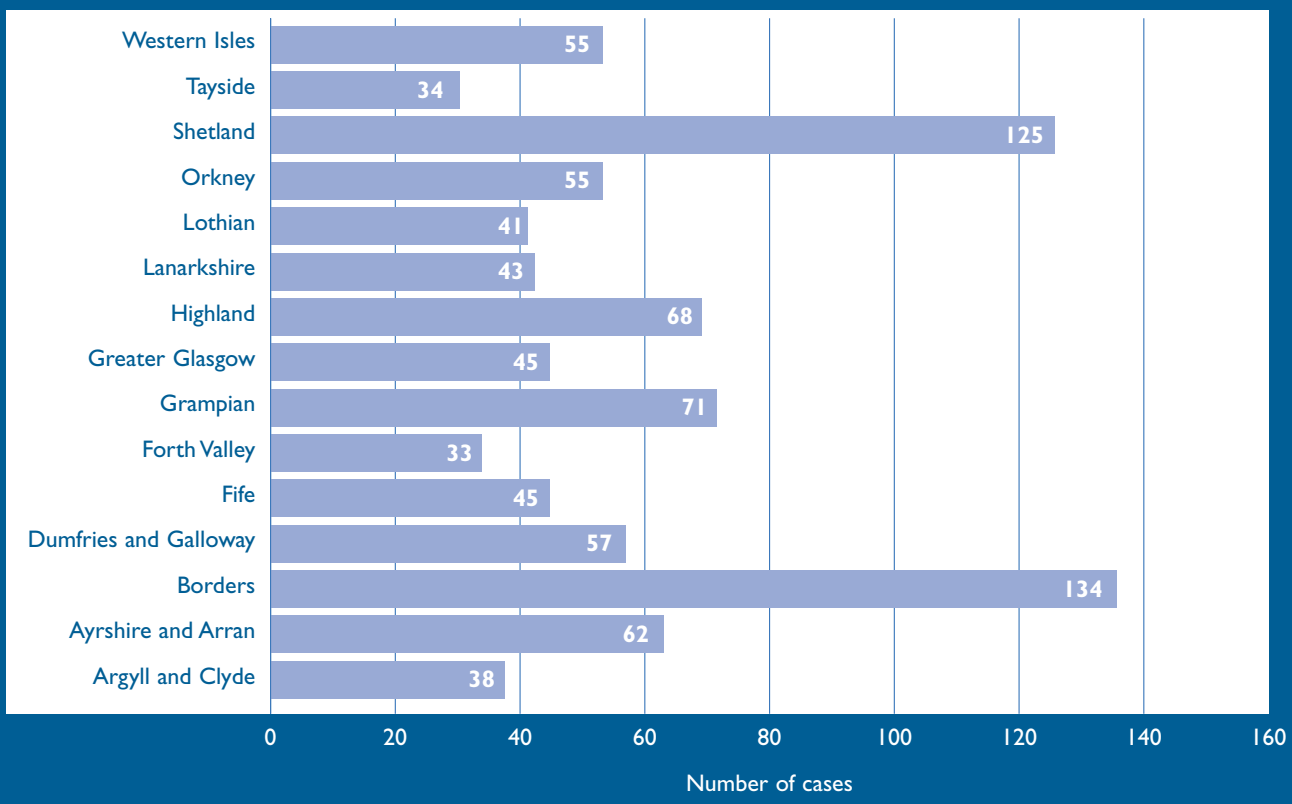
Tayside figures for acute trust only and include no waiting list at Ninewells Hospital and 50 children waiting at the Centre for Child Health. Figures from the PCT were unavailable.

Western Isles figures are estimated.

appendix K

Current cases of NHS OTs, PTs and SLTs at April 2002

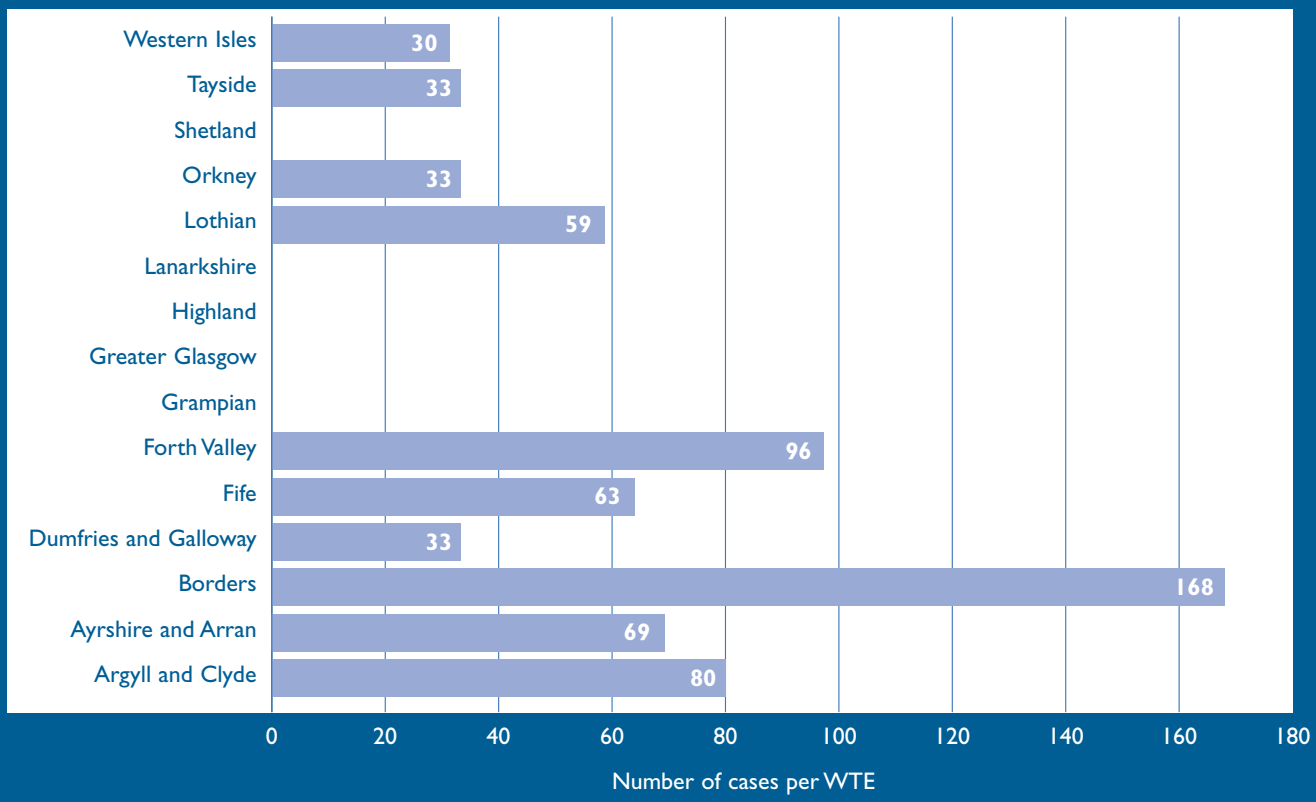
Table 1: Numbers of current child cases per NHS OT post in April 2002



Notes:
Grampian University Hospitals Trust, Highland, Lanarkshire and Shetland figures are estimated.
The mean number of cases per WTE = 60.

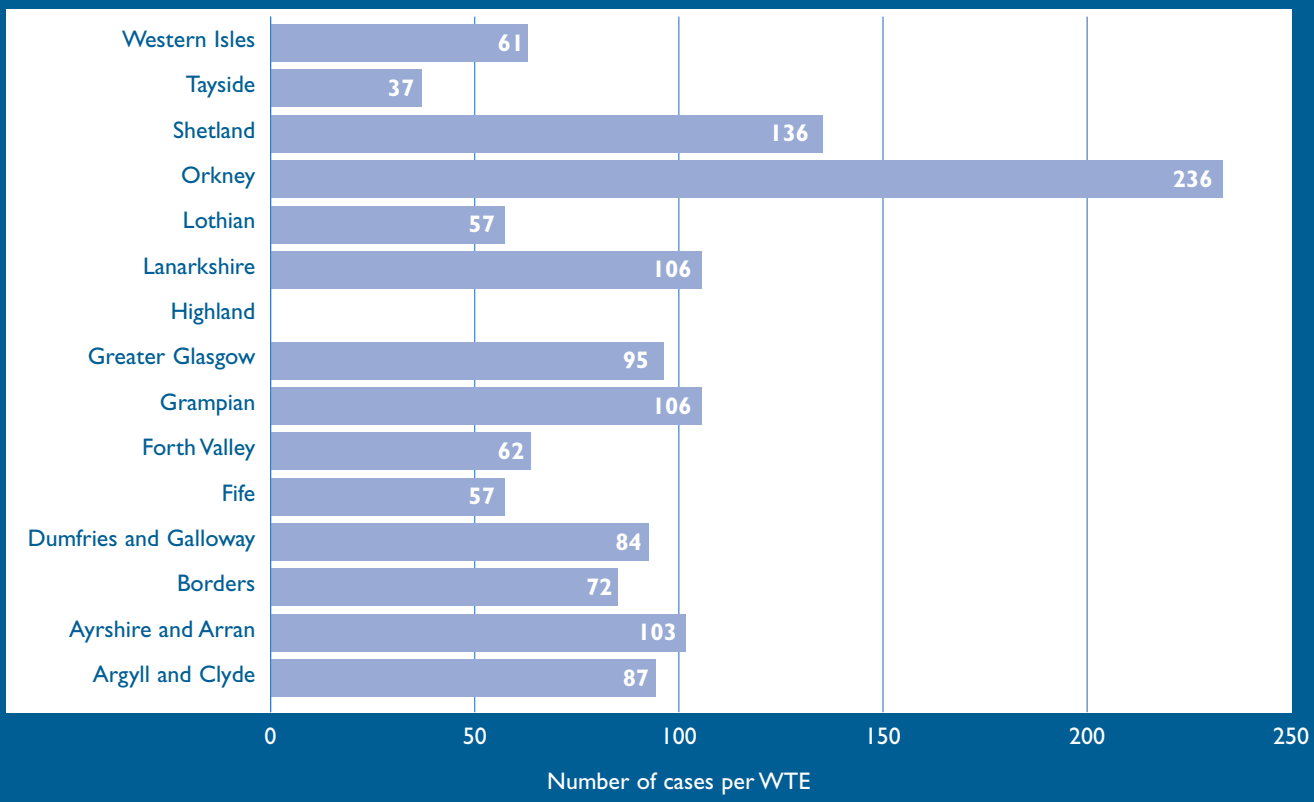
appendix K

Table 2: Numbers of current child cases per NHS PT post in April 2002



Notes:
Grampian – current case figures provided by the Primary Care Trust are not comprehensive.
Greater Glasgow – numbers of acute cases have not been provided.
Highland – current case figures are for Acute Trust only – figures from Primary Care Trust were unavailable.
Lanarkshire – current case figures provided by the Primary Care Trust are not comprehensive.
Shetland current case figures are missing.
Tayside – Data for Child Health services and Ninewells service in Acute Trust only. Primary Care Trust data were unavailable.
Mean number of cases per WTE = 66.

Table 3: Numbers of current child cases per NHS SLT post in April 2002

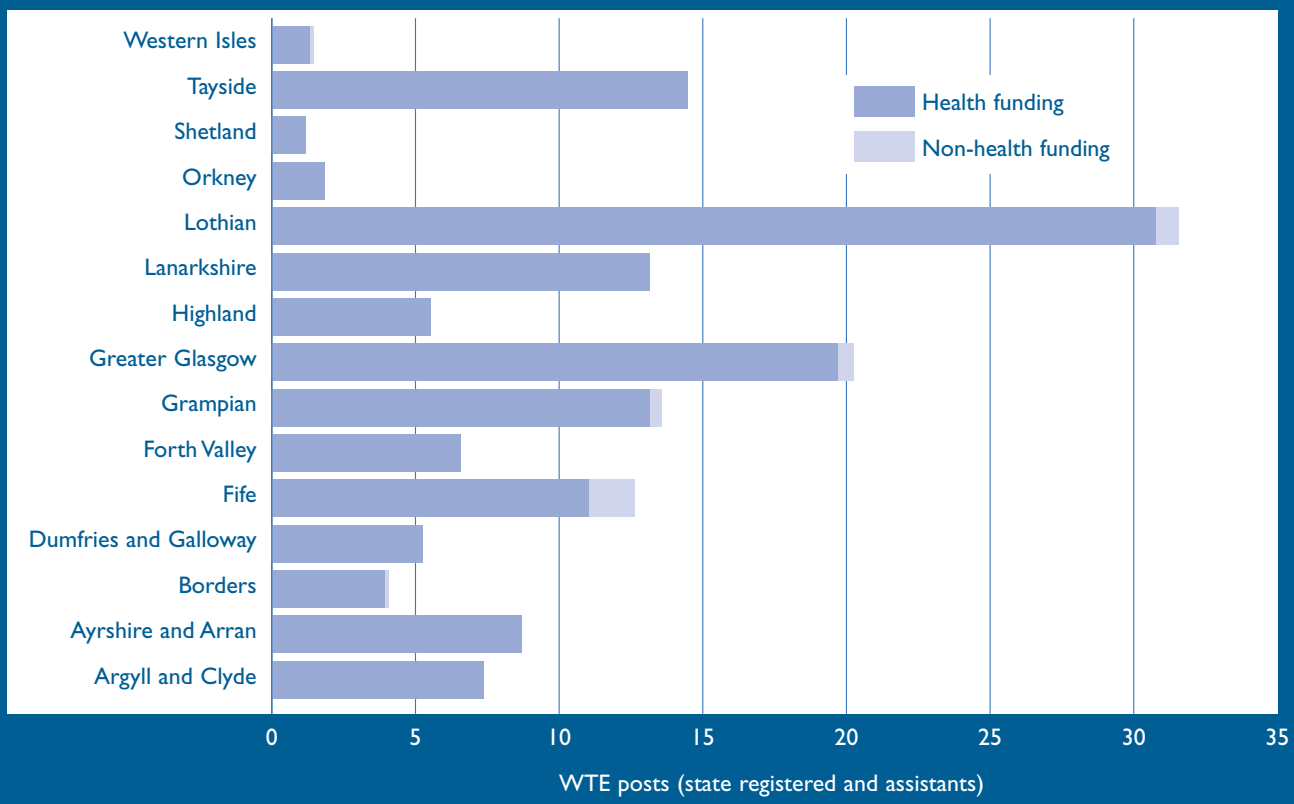


Notes:
Tayside – Figures for acute trust only including Ninewells Hospital and Centre for Child Health. Data for Primary Care Trust were unavailable.
Highland – Information unavailable.
Shetland figures are estimated.
Western Isles figures are estimated.
Mean number of cases per WTE = 93.

appendix L

Sources of funding for NHS OT, PT and SLT for children

Table 1: Sources of funding for NHS OT for children in Scotland

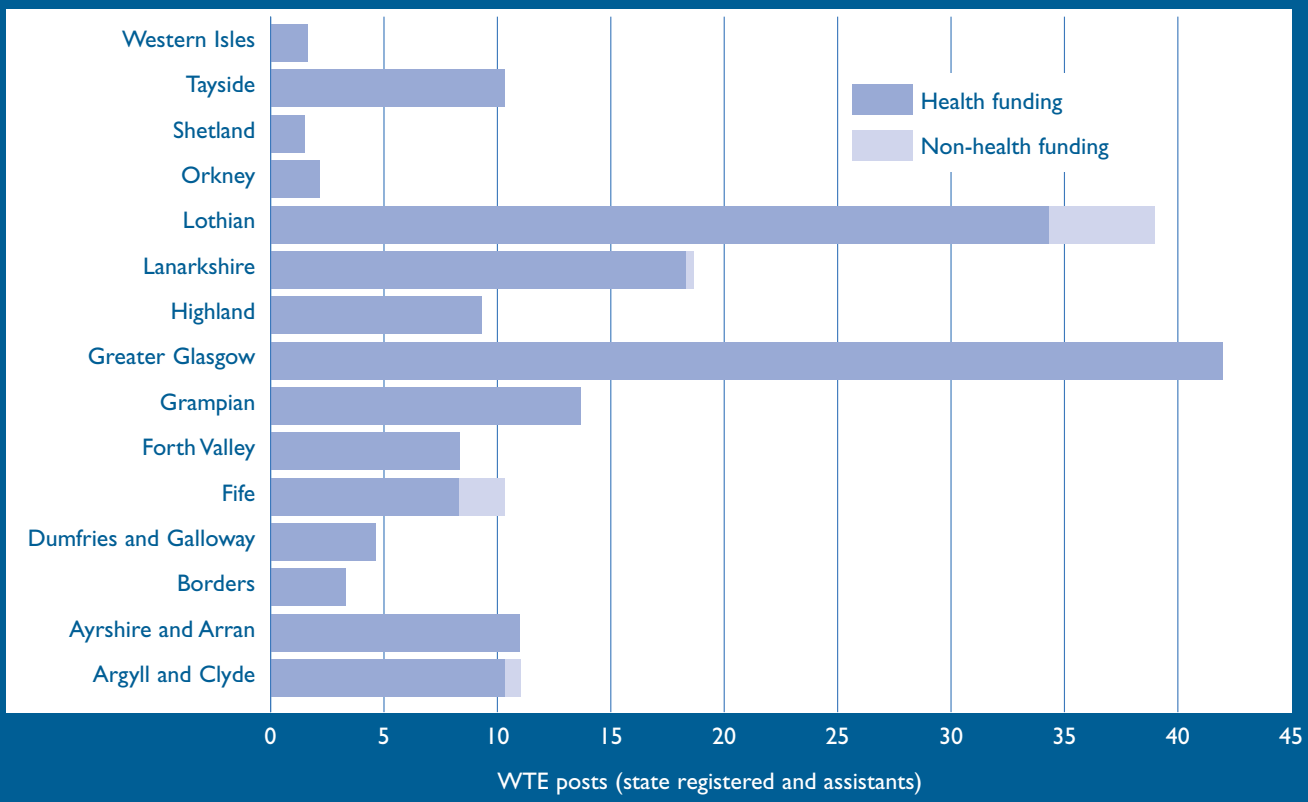


97.6% of OT posts providing a service to children in Scotland are funded by mainstream health funding. Six areas have posts funded from other sources.

In Borders 0.08 WTE post is funded by the Excellence Fund. In Fife 1.7 posts are funded by the education department. In Grampian 0.4 posts are funded by a private special school and in Greater Glasgow 0.4 posts are funded by Sure Start. In Lothian 0.9 posts are funded by a grant aided school. Finally, in the Western Isles – 100% of 1 WTE paediatric OT post is funded by health and approximately 45% of the 0.31 generic posts is funded by the Social Work Department.

In Argyll and Clyde some funding is provided by Capability Scotland. Whether this covers posts or travel only still needs to be clarified. A proportion of these posts is funded by the NHS Board. Borders also stated that equipment and training is funded through the Paediatric Endowment fund.

Table 2: Sources of funding for NHS PT for children in Scotland

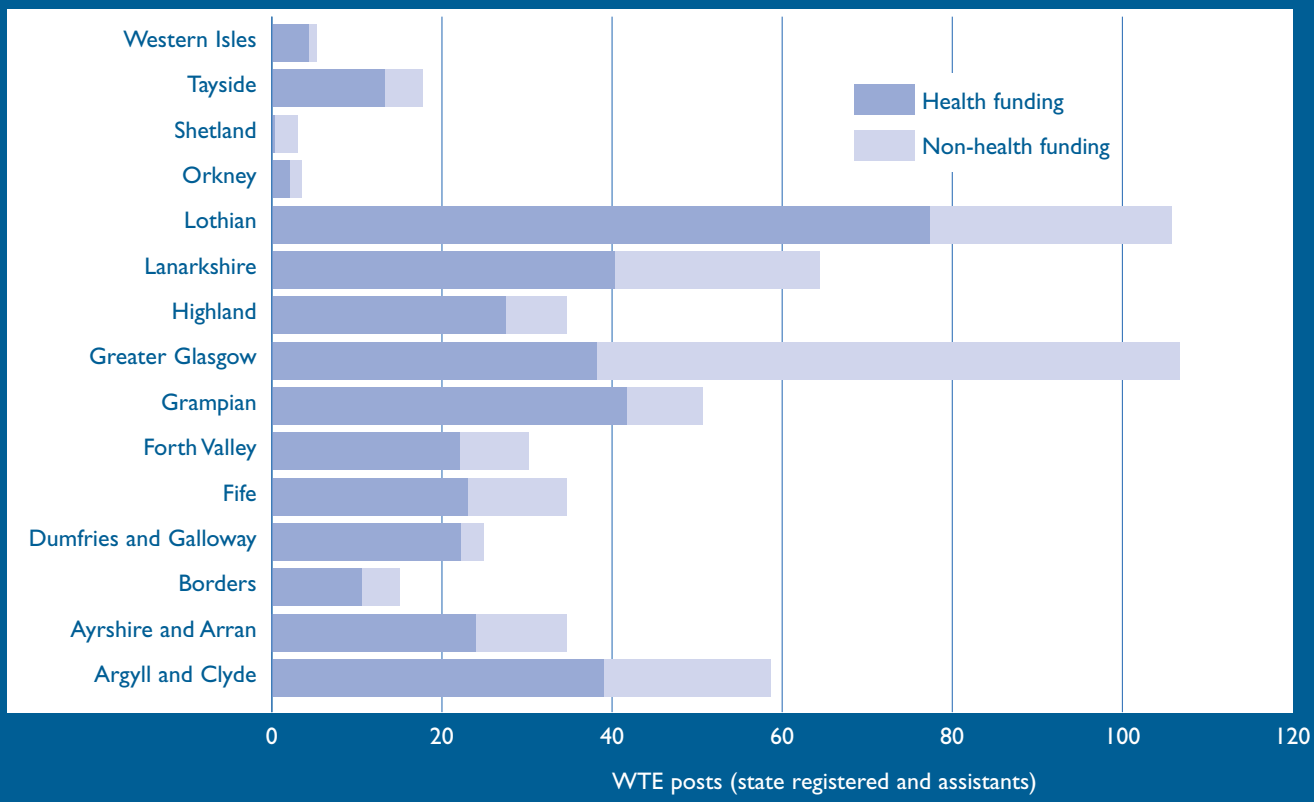


Notes:
NHS Tayside – Data for Child Health services in Acute Trust only. Acute in-patient service and Primary Care Trust data were unavailable.

96% of PT posts providing a service to children in Scotland are funded by mainstream health funding. Only 4 of the 13 Health Board areas have posts that are funded by other means. In Argyll and Clyde 0.5 WTE PT post is funded under the Innovation Fund. In Fife 2 WTE posts are funded by the education department. In Lanarkshire 0.2 WTE posts are funded by the New Community Schools fund. In Lothian, 3.43 WTE posts are funded by the Royal Blind School and 1 WTE post is funded by Capability Scotland.

appendix L

Table 3: Sources of funding for NHS SLT for children in Scotland



Notes:
Glasgow estimated that 60% of the service is funded by the education department.
Tayside figures include Ninewells Hospital and the Centre for Child Health within the acute trust. Figures from the PCT were not supplied.

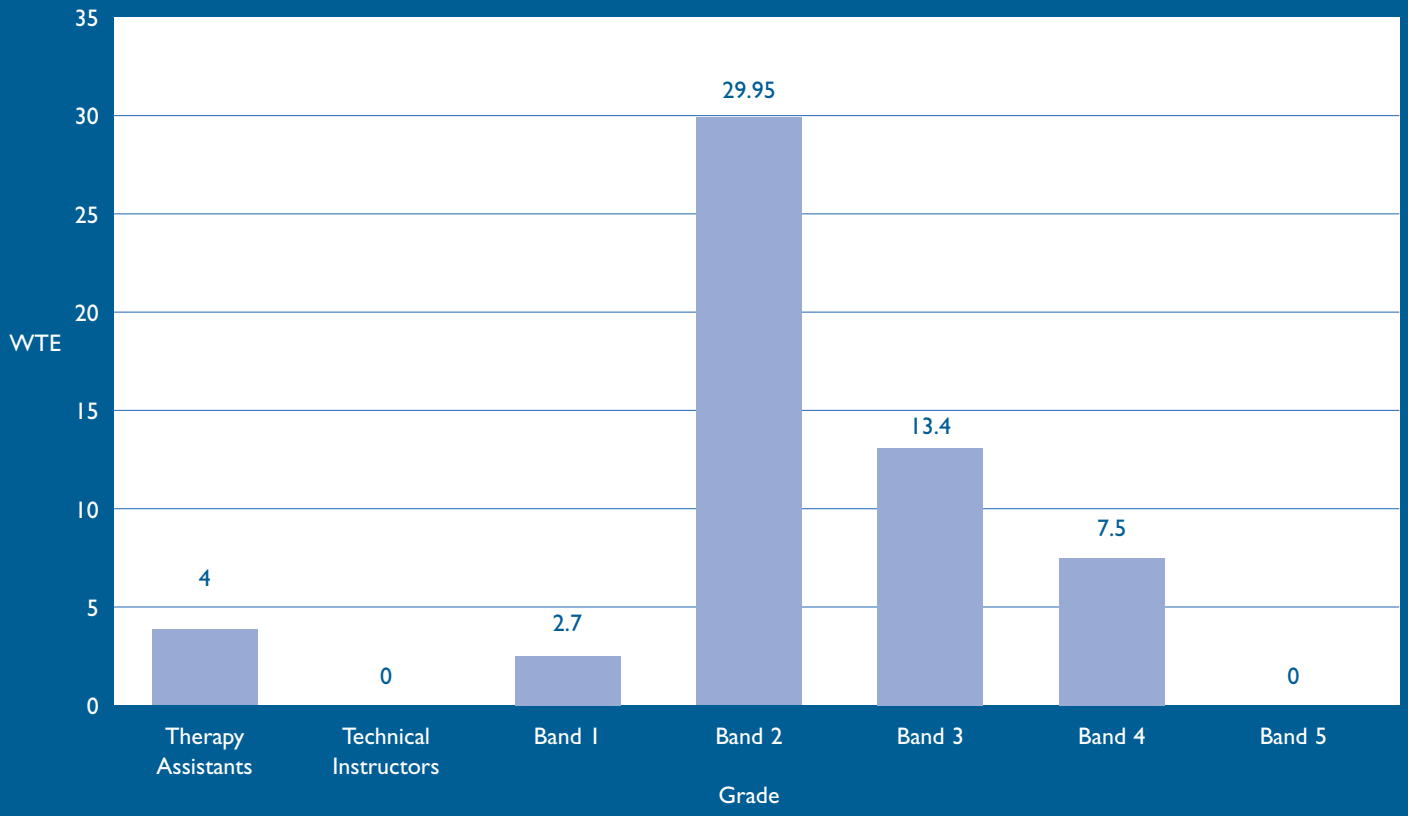
Just over two-thirds of NHS SLT service for children across Scotland are funded by health (68%) and approximately one-third by education (31%). Only 1.6% are funded from other sources. However, these figures vary considerably from area to area. In Dumfries and Galloway as little as 11% of the service is funded by education, whereas as much as 91% is funded from this source in Shetland.

Sources of funding other than health and education include grants form Sure Start, the Excellence Fund, the Health Improvement Fund, the Innovation Fund, Changing Children's Services Fund as well as funding from independent schools, community schools, voluntary services and private contracts.

appendix M

Grades of NHS SLT posts established to provide a service to adults with learning disabilities and/or autistic spectrum disorder

Table 1: Grades of NHS SLT posts established to provide a service to adults with learning disabilities and/or autistic spectrum disorder in Scotland

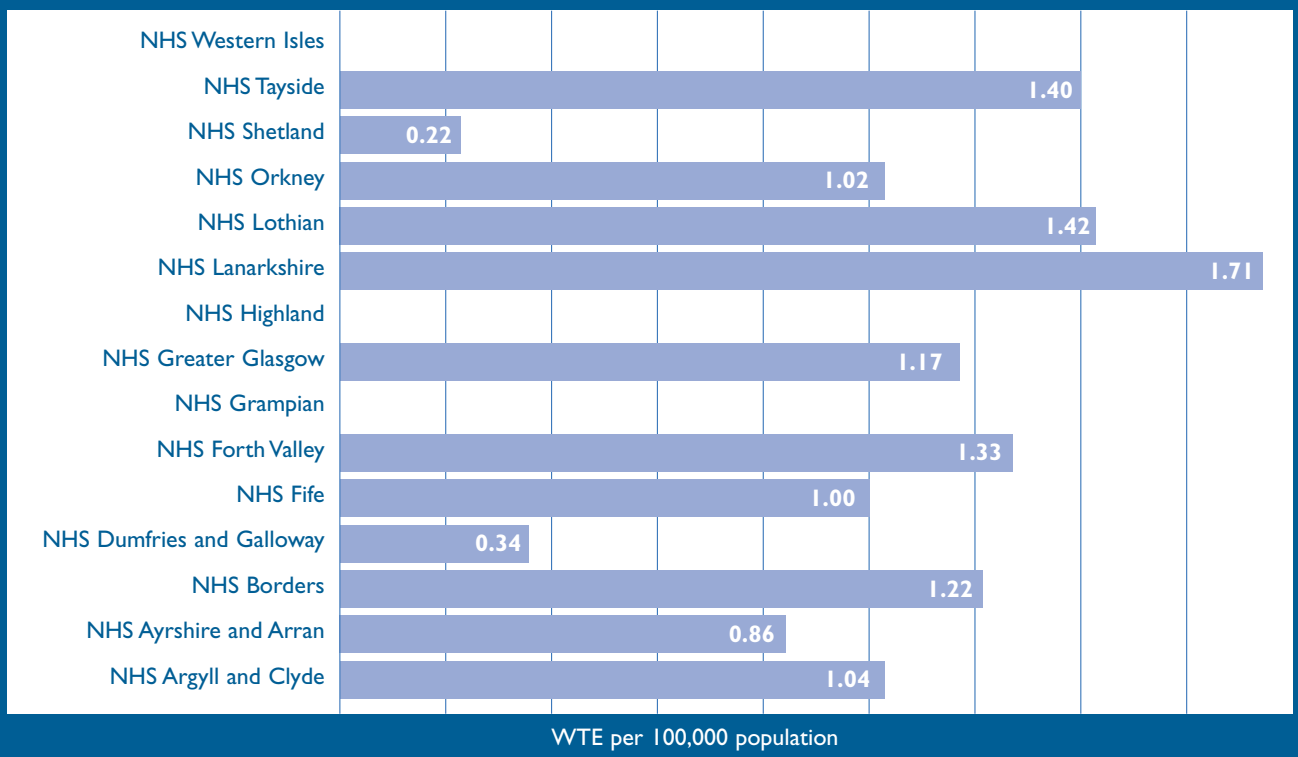


Notes:
Figures for Grampian and Highland were unavailable.
Greater Glasgow – 1 WTE Band 4 post is a Head of Profession.
Western Isles have 1 WTE SLT post covering both children and adults with learning disabilities. They were unable to estimate the proportion of the post providing a service to adults.

appendix N

Numbers of SLT posts for qualified staff providing a service to adults with learning disabilities and/or ASD in each NHS Board area per 100,000 population

Table 1: WTE qualified NHS SLT posts providing a service to adults with learning disabilities and/or autistic spectrum disorder per 100,000 population



Notes:
Missing figures indicate no data available or data incomplete.
Population figures based on GROS mid-year estimates for 2000.
Greater Glasgow – 1 WTE Band 4 post is a Head of Profession.

Vacancy rates for qualified SLTs working solely with adults with learning disability and/or ASD

Table 1: Vacancy rates for qualified SLTs working solely with adults with learning disability and/or ASD

NHS Board Area	Establishment of state-registered SLTs providing a service to adults with LD/ASD	Vacancies for state-registered SLTs working solely with adults with LD/ASD	Vacancy Rate
Argyll and Clyde	4.40	1.8	41%
Ayrshire and Arran	3.20	1.2	38%
Borders	1.30	0	0%
Dumfries and Galloway	0.50	0	0%
Fife	3.50	0	0%
Forth Valley	3.70	0	0%
Grampian	-	-	-
Greater Glasgow	10.60	0	0%
Highland	-	-	-
Lanarkshire	9.60	0.6	6%
Lothian	11.10	0.2	2%
Orkney	0.20	0	0%
Shetland	0.05	0	0%
Tayside	5.40	2	37%
Western Isles	-	0	-
Totals	**53.55**	**5.8**	

Notes:
Argyll and Clyde – Vacancies for qualified staff are all in the Renfrewshire and Inverlcyde PCT.
Lothian – Vacancy is in the East Lothian and Midlothian service.
Vacant generic posts were not counted.

appendix P

Numbers of adults with learning disabilities and/or ASD referred to SLT and rate per WTE SLT post

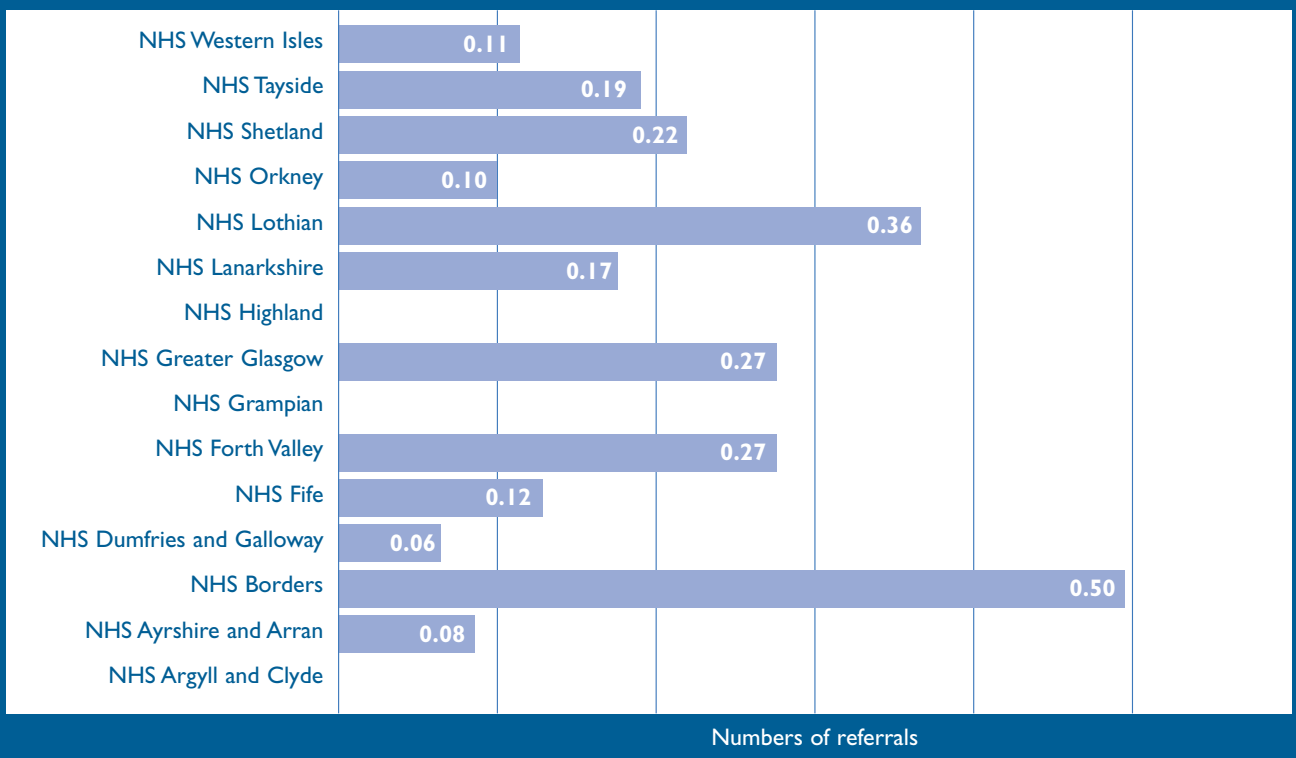
Table 1: Numbers of adults with learning disabilities and/or ASD referred to SLT and rate per WTE SLT post

NHS Board Area	Referral in 2001/2	WTE SLT posts for qualified staff	Referral rate per WTE qualified SLT
Shetland	5	0.05	100
Borders	53	1.3	41
Lothian	282	11.1	25
Greater Glasgow	244	10.6	23
Forth Valley	74	3.7	20
Dumfries and Galloway	9	0.5	18
Tayside	74	5.4	14
Fife	43	3.5	12
Ayrshire and Arran	31	3.2	10
Lanarkshire	97	9.6	10
Orkney	2	0.2	10

Notes:
NHS Board areas have not been included where figures are missing or incomplete.
Lothian figures are made up of 90 referrals in East and Midlothian and 192 referrals in Edinburgh and West Lothian.

Numbers of adults with learning disabilities and/or ASD referred to NHS SLT per 1000 population

Table 1: Numbers of adults with learning disabilities and/or ASD referred to NHS SLTs per 1000 population

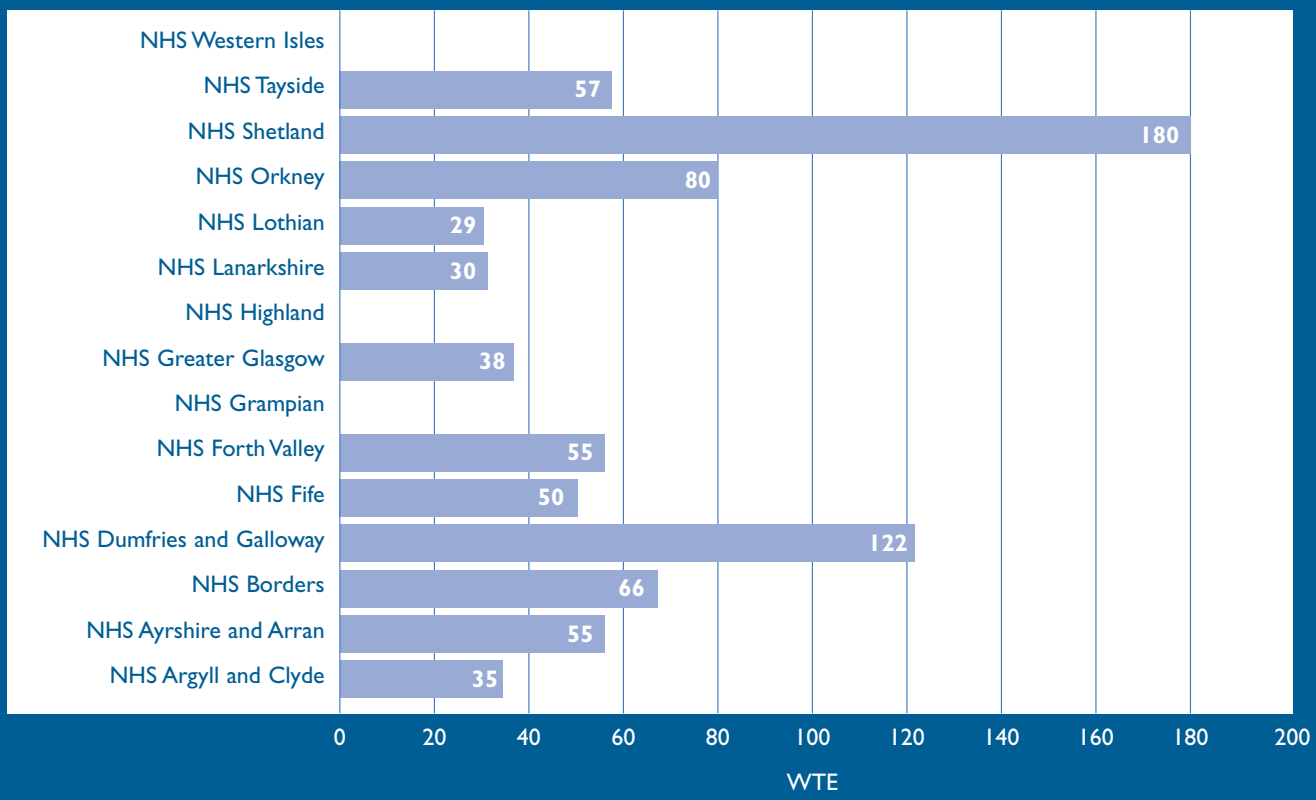


Notes:
Figures are not reported where data are incomplete or missing.
Population figures GROS mid-year estimates for 2000.

appendix R

Current cases per WTE NHS SLT providing a service to adults with learning disabilities and/or ASD

Table 1: Numbers of current cases per WTE NHS SLT providing a service to adults with learning disabilities and/or ASD



Notes:
Figures are not reported where data missing or incomplete.
Argyll and Clyde – Figures are for Renfrewshire and Inverclyde PCT only. Current cases are estimated. Lomond & Argyll PCT are not included as do not operate a referral-based system.

Adults with learning disabilities and/or ASD waiting for a SLT service

Table 1: Numbers of adults with learning disabilities and/or ASD waiting for a SLT service

NHS Board Area	No. of adults with learning disabilities/ ASD currently waiting	No. waiting per WTE	Longest current wait in weeks
Argyll and Clyde	11	3.2	>52
Ayrshire and Arran	5	1.6	11
Borders Area	55	42.3	36
Dumfries and Galloway	0	0	0
Fife	0	0	0
Forth Valley	20	5.4	32
Grampian	-	-	-
Greater Glasgow	78	7.4	20
Highland	-	-	-
Lanarkshire	33	3.4	24
Lothian	40	3.6	32
Orkney	0	0	0
Shetland	0	0	-
Tayside	42	7.8	36
Western Isles	0	-	-
Totals	**284**		

Notes:
Argyll and Clyde – figures relate to Renfrewshire and Inverclyde PCT only.
Borders – figure of 55 waiting made up of 22 on assessment waiting list and 33 on treatment waiting list.
Greater Glasgow – 28-week waiting period for Training for Care staff.
Lomond & Argyll Primary Care NHS Trust do not operate a referral-based system for these groups, so no waiting list information provided.
Lothian – 34 people were waiting in Edinburgh and West Lothian and 6 people were waiting in East and Midlothian. The longest wait was not reported in East and Midlothian.

appendix T

CASE STUDIES

Jeannie's story

Jeannie (not her real name) is a family carer who lives in a remote part of Scotland. She has direct experience of speech and language therapy as her daughters have communication disorders. She also knows about other people's experiences of services through her role in local groups and she has recently been diagnosed herself with a communication disorder.

Jeannie said that from her own experience and talking to others, access to the service was easier for children than for older people. Children tended to get referred by health visitors and GPs. Adults did not realise that they could self refer. SLTs were a scarce resource in this remote area.

Experiences of services could be patchy, depending on the individual therapist. What parents were looking for, she said, was regular assessment and then follow through. She would like to see continuity between work with the child at home and at school. 'The child does not exist solely at home or at school.' SLT approaches should take account of the child's stage of development and what is important and interesting to that child. She would like to see individualised programmes available for young people at transition which stretched them educationally and socially.

Accessing expertise could be an issue, particularly in a remote area. This applied to both assessments and intervention programmes. Expertise might be held in specialist schools. The availability of skilled assistants was important because the learning could be cascaded.

Jeannie felt that Speech and Language Therapy Services could be important for different reasons to people with communication disorders, depending on their level of need. Those with severe communication needs could become extremely frustrated if they were not able to get their message across. Whereas people who had, for example, a speech disorder that was less obvious, might need support to develop strategies for particular situations. Their needs might not be identified in mainstream services and they might end up being labelled because of behaviour that was the result of a communication problem.

Jeannie thinks that the contribution of Speech and Language Therapy is essential to a full assessment of Autistic Spectrum Disorder, especially for children. Such assessment, in her experience, is hard to get as an adult unless there is a really noticeable difficulty. However, she thinks that the contribution of SLTs for adults with autistic spectrum disorder would be particularly important in social skills groups. For example, someone going to a job interview might need support and preparation to interpret body language, judge the right tone to speak in and know how much it was appropriate to say, for example if a question is asked about hobbies or special interests. Another example she gave was of a young person with Asperger's who had lost several jobs because he did not know how to explain that he was off sick. In the end he did not return to work.

What makes a good SLT? Willingness to learn from the client and their parents or carers. They are the experts. 'They've learned the hard way.'

Michael's story

Michael (not his real name), with a supporter (his community nurse), was interviewed about his experiences of speech and language therapy within the context of his life as a whole.

Michael attends college. He has just met the Speech and Language Therapist whom he is going to be seeing for about eight weeks. Michael explained that the Speech and Language Therapist, who he called by her first name, had come out to see him at home. She had sat for while and watched him with his family and pet. She is going to record his voice and let him hear his speech. His supporter explained that he had asked to see a SLT because he wanted to slow his speech down and not speak too loudly.

Michael had been referred to the SLT by the community learning disability team. When he had been attending a school leavers' group organised by an OT he had experienced difficulties picking up social cues, taking his turn and with the volume of his speech. These seemed to be related to issues of both hearing and speech.

Michael had a health problem that could affect the success of this work. He said that he had pain in his good ear that made him dizzy. He does not like having to take painkillers because they make his head feel 'numb'. According to the nurse, the GP had been trying to get him a hospital appointment quickly. He had had an operation on his other ear in the past and the community nurse thought that it would be important for the SLT to know about these problems. Getting his ear problems sorted was a priority for Michael.

At school Michael had also had a Speech and Language Therapist. He had not been able to hear the television in class. He thought the Speech and Language Therapist was good. They had played games like 'Snap!' She also had been helping him to speak more slowly and she has been in contact with the Speech and Language Therapist he is seeing now.

Michael gave some instances of how his hearing problems adversely affect his life. He has had to leave his college class and indeed is talking about leaving college altogether. He has trouble speaking to his girlfriend on his mobile phone. It costs a fortune and they fall out quite a lot because he is always saying "what?" On the other hand he can easily sing along to videos because he uses headphones. Speaking too loudly also gives Michael problems socially. Michael likes being in company but has stopped attending the club he used to go to because it is 'too much'.

He has got several certificates from college and now has an appointment with the Careers office, though not for the area of employment he would really like to go for. He has been having travel training on the bus which he does not like but in fact he has been making a weekly train journey on his own to visit a member of his family.

Michael was very clear about how working with the Speech and Language Therapist could help. He said that it helped you get experience (in talking appropriately). It helped you to be calm and relaxed and to 'chill out when talking to people' instead of getting 'nervous and excited'. He thought the job of a speech therapist was useful. He said 'yes'. He could think of other people who had been seen by them and 'helped to speak right'.

appendix T

As to the qualities they should have, they should 'want to help folk'. Michael's main argument for the value of Speech and Language Therapy was based on his own experience of the social consequences of speech and hearing problems. He said that people tell you to slow down and call you names and that winds him up and he gets angry and into trouble. The benefits of effective intervention for him would be better social relationships and more respect from others, enabling him to make the contribution that he can and wishes to make.

Index

Indexer: Dr Laurence Errington

Note: Abbreviations used: ASD, autistic spectrum disorder; LD, learning disability; OTs, occupational therapists; PTs, physiotherapists; SLT, speech and language therapy; SLTs, speech and language therapist.

ISBN 0 7559 0881 3

Published by
Scottish Executive
St Andrew's House
Edinburgh

Produced for the Scottish Executive by Astron B31317 8-03

Further copies of this publication are available from
The Stationery Office Bookshop
71 Lothian Road
Edinburgh EH3 9AZ
Tel 0870 606 55 66

This document is produced from 100% elemental chlorine-free,
environmentally-preferred material and is 100% recyclable.